

# **Twenty Myths about Single-Payer Health Insurance**

**International Evidence on the Effects of  
National Health Insurance in Countries Around the World**

**by**

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# Introduction

When our original report “Twenty Myths About National Health Insurance”<sup>1</sup> was published in 1992, advocates of national health insurance were promoting it as a viable alternative to the decentralized health care system found in the United States. The cost of health care was increasing at double-digit rates in this country, and a growing number of people were without health insurance. At that time, many critics maintained that user fees and the profit motive, both salient features of a private health system, favor the wealthy and are unfair to the poor. These same critics argued that a national health care system — financed by taxes and controlled by the government — would be more efficient than the private sector model at controlling costs and maintaining a high quality of health care. As models for reforming the U.S. system, advocates of national health care frequently cited the perceived successes of socialized health care systems in many of Western Europe’s social welfare states. By following the example of these countries, they claimed the United States could find a way to grant every person equal access to health care while controlling costs.

Ironically, during the 1990s ideas flowed in the opposite direction. Over the course of the past decade, almost every European country with a national health care system has introduced market-oriented reforms and turned to the private sector to reduce the costs of care and increase the value, availability and effectiveness of treatments.<sup>2</sup> In making these changes, more often than not other countries have looked to the United State for guidance. For example:

- Canada uses the United States as a safety valve for its overtaxed health care system, with provincial governments and patients spending a combined total of more than \$1 billion a year on U.S. medical care.<sup>3</sup>
- Many Canadian provinces now send cancer patients to the United States for radiation therapy.<sup>4</sup>
- To reduce its waiting lists, the British National Health Service (NHS) recently announced the decision to treat some NHS patients in private hospitals, reversing a longstanding policy of only using public (NHS) hospitals.<sup>5</sup>

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<sup>1</sup> John C. Goodman and Gerald L. Musgrave, “Twenty Myths About National Health Insurance, National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

<sup>2</sup> Marshall W. Raffle, *Health Care and Reform in Industrialized Countries* (University Park, PA: The University of Pennsylvania Press, 1997). See also, Monique Jérôme-Forget, Joseph White and Joshua M. Wiener, *Health Care Reform Through Internal Markets: Experience and Proposal* (Washington, D.C.: Brookings Institution Press, 1995); and Wendy Ranade, ed. *Markets and Health Care: A Comparative Analysis* (New York: Longman, 1998).

<sup>3</sup> Victor Dirnfeld, “The Benefits of Privatization,” *Canadian Medical Association Journal*, Vol. 155, No. 4, August 15, 1996. pp. 407-410.

<sup>4</sup> For a discussion of Canadian cancer patients being sent to the U.S. for radiation treatment, see Mark Cardwell, “Que. Cancer Patients to Head South,” *Medical Post*, Vol. 35, No. 22, June 8, 1999; Robert Walker, “Alberta Centre May Soon Fly its CA Patients South,” *Medical Post*, Vol. 35, No. 34, October 12, 1999; Lynn Haley, Deana Driver, Mark Cardwell and Carol McLeod, “Guarding the Border,” *Medical Post*, Vol. 36, No. 01, January 4, 2000; Doug Brunk, “Canada Sends Overflow of Ca Patients Down South,” *Family Practice News*, May 1, 2000.

- Over 7 million people in Britain now have private health insurance, and since the Labor government's first year in office, the number of patients paying out-of-pocket for medical treatment has increased 40 percent to 160,000 annually.<sup>6</sup>
- Australia has turned to the private sector to reform its public health care system to such an extent that it is now second only to the United States among industrialized nations in the share of health care spending that is private.<sup>7</sup>
- Since 1993, the German government has been experimenting with American-style managed competition by giving Germans the right to choose among the country's competing sickness funds (insurers).
- The Netherlands also has American-style managed competition, with an extensive network of private health care providers and slightly more than one-third of the population insured privately.<sup>8</sup>
- Sweden is introducing reforms that will allow private providers to deliver more than 40 percent of all health care services and about 80 percent of primary care in Stockholm.<sup>9</sup>

In each of these countries, a history of failed government health programs has led to a re-examination of the fundamental principles of health care. As we first argued a decade ago, the best way to provide health care is to apply the same commonsense principles to medicine that we apply to other goods and services. Other developed countries have now begun to agree with us. Through bitter experience, many of the countries that once touted the benefits of government control have learned that the surest remedy for their countries' health care crises is not increasing government power, but increasing patient power, instead.<sup>10</sup>

Despite these developments, in the United States there is continued pressure to adopt the failed and discarded approaches of other countries, often under the euphemism of "single-payer health insurance." One group of advocates, Physicians for a National Health Program, contends

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<sup>5</sup> "UK to Strike New Deal with Private Health Sector," Reuters Health, December 4, 2001.

<sup>6</sup> "Thousands Shun the NHS," BBC Health, March 2002.

<sup>7</sup> "Health Data 2000," Organization for Economic Cooperation and Development, 2000.

<sup>8</sup> Kieke Okma, "Health Care, Health Policies and Health Care Reforms in the Netherlands," School of Public Policy Studies, Queen's University, Kingston, Ontario, March 2000.

<sup>9</sup> Johan Hjertqvist, "Swedish Health-Care Reform: From Public Monopolies to Market Services," Montreal Economic Institute, 2001, [http://www.iedm.org/library/Hjertqvist\\_en.html](http://www.iedm.org/library/Hjertqvist_en.html).

<sup>10</sup> Task Force Report, *An Agenda for Solving America's Health Care Crisis*, National Center for Policy Analysis, Policy Report No. 151, May 1990 and John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis*, (Washington D.C.: Cato Institute, 1992).



that “single-payer national health insurance would resolve virtually all of the major problems facing America’s health care system today.”<sup>11</sup>

The purpose of this report is to examine the most critical failures of national health insurance systems without focusing on minor blemishes or easily correctable problems. In doing so, our goal will be to identify the common problems that tend to emerge in all countries with national health insurance and explain the reasons for their overall failure. Most national health care systems are in a state of sustained internal crisis, and they are not meeting their governments’ stated goals of universal access and quality care. In almost all cases, the reason is the same: the politics of medicine. The problems of government-run health care systems flow inexorably from the fact that they are government run.

As in our first report, we have chosen to focus primarily (although not exclusively) in this report on the health care systems of English-speaking countries, whose cultures are most similar to our own. These countries — Britain, Canada, New Zealand and Australia — are often pointed to by advocates of national health insurance as models for the U.S. to emulate in reforming its health care system. As we will demonstrate, however, these systems are no better suited to serve as models for reform than they were ten years ago.

The failures of national health insurance are one of the great secrets of modern social science. Not only do ordinary citizens lack an understanding of the defects of national health insurance, all too often they have an idealized view of socialized medicine. For that reason, we have chosen to present the information in the form of rebuttal to commonly held myths.

**MYTH NO. 1 In countries with single-payer health care systems people have a “right” to health care.**

Virtually every government that has established a system of national health insurance has proclaimed health care to be a basic human “right.” Yet far from guaranteeing that right, most national health systems routinely “ration” care by delaying or denying needed care. In general, citizens of other countries have no enforceable right to any particular medical service. For example, they have no right to an MRI scan or open heart surgery. They do not even have a right to a place on the waiting list. The 100th person waiting for heart surgery is not “entitled” to the 100th surgery, for example. Some patients succeed in jumping the queue, while others never receive the treatments they need.

Not only do people in national health insurance schemes not have a right to health care, they may even have fewer rights to health care in their own country than foreigners have. For example, while large numbers of British patients were waiting for care, in 2001, about 10,000 patients (5,000 of which are British and 5,000 of which were foreign) received preferential private treatment in Britain’s top hospitals.<sup>12</sup> Advertisements from one such hospital boasted that

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<sup>11</sup> Don R. McCanne, “Would Single-Payer Health Insurance Be Good for America?” Physicians for a National Health Program, March 27, 2000.

<sup>12</sup> Anthony Browne, “Scandal of NHS Beds Auction,” *The Observer*, January 6, 2002.

patients come from all over the world, the rooms are well-furnished, and include televisions that even have Arabic language channels.<sup>13</sup>

By U.S. standards, rationing by waiting this is one of the cruelest aspects of government-run health care systems.<sup>14</sup> In most cases, these stem from the establishment of “global budgets.” A global budget is a pre-set limit on the total amount of expenditures in a health care system. When global budgets are used, each hospital or area health authority is given a fixed amount of money per year. The amount received is almost always insufficient to meet all the needs of all patients.<sup>15</sup> The result is a waiting list for medical treatments.

How much waiting is there? Beyond anecdotal reports that appear in the popular press that is not an easy questions to answer. Since waiting is viewed as an embarrassment to most governments, public officials are reluctant to collect and publish information about it. However, some facts are available:

- In England, with a population of about 53 million, government statistics show that more than 1 million are waiting to be admitted to hospitals at any one time.<sup>16</sup>
- In Canada, with a population of more than 31 million, private studies show that more than 878,000 are waiting for treatment of all types.<sup>17</sup>
- In Norway, with a population of almost 4.5 million, 270,000 are waiting in health queues on any given day for various types of medical treatments, including hospital admission.<sup>18</sup>
- In New Zealand, with a population of about 3.6 million, the government reports that the number of people on waiting lists for surgery and other treatments is more than 90,000.<sup>19</sup>

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<sup>13</sup> Ibid. Sales literature was from the Royal Brompton hospital.

<sup>14</sup> Enoch Powell, former British Minister of Health, argued that waiting lines are inevitable under the NHS, regardless of the resources devoted to health care. See Enoch Powell, *Medicine and Politics, 1975 and After* (New York: Pitman, 1976). For a discussion of British hospital rationing, see John C. Goodman, *National Health Care in Great Britain: Lessons for the U.S.A.* (Dallas: Fisher Institute, 1980), Ch. 6.

<sup>15</sup> A global budget differs from fee-for-service payments in that a hospital receives an annual lump sum from which to operate rather than charge each patient for respective procedures. Capital acquisition budgets are usually separate. By contrast, the American Medicare system pays a fixed DRG (e.g. diagnosis related group) payment for each patient procedure.

<sup>16</sup> “Statistical Press Release: Waiting List Figures November 2001,” Department of Health, January 11, 2002.

<sup>17</sup> Michael Walker and Greg Wilson, “Waiting Your Turn: Hospital Waiting Lists in Canada, 11th Edition,” Fraser Institute, Critical Issues Bulletin, September 2001.

<sup>18</sup> Michael Hoel and Erik Magnus Saether, “Private Health Care as a Supplement to a Public Health System with Waiting Time for Treatment,” Frisch Center for Economic Research, Oslo, 2000.

<sup>19</sup> “Purchasing for your Health 1996/97,” New Zealand Ministry of Health, March 1998.

Moreover, official waiting lists often understate the amount of time patients must wait because a given treatment might require waiting in more than one queue. For instance, a Canadian patient initially sees a general practitioner (GP) who functions as a gatekeeper to more advanced treatments. Once the GP makes a referral, a patient can then expect another wait to see a specialist. After the specialist examination, a patient usually will face another wait before treatment. In many cases, there are several waits involving a given treatment — a wait to see a specialist, a wait for a diagnostic test, and then a wait for surgery, for example.<sup>20</sup>

How serious is this problem? On the surface, the number of people waiting may seem small relative to the total population — ranging from one-half of one percent in Canada to around two and one-half percent in New Zealand. However, considering that only 16 percent of the people enter a hospital each year in developed countries<sup>21</sup> and that only a small percent require serious (and expensive) procedures, these numbers are quite high. In New Zealand, for example, if 11 percent (496,000) are admitted to a hospital each year then a waiting list of 90,000 would represent a ratio of almost one person waiting for every five who received treatment.

Moreover, for many patients the wait for treatment can last months or even years.<sup>22</sup> For example:

- Canadian patients waited an average of 7.2 weeks in 2000-01 from the time they were referred to a specialist until the actual consultation, and another 9.0 weeks before treatment – including surgery.<sup>23</sup>
- In New Zealand, the average waiting time for elderly patients in need of hip or knee replacement is 300 and 400 days respectively, and many wait for much longer.<sup>24</sup>
- Of the 90,000 people waiting in New Zealand in 1997, more than 20,000 were waiting for a period of over two years.<sup>25</sup>

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<sup>20</sup> Michael Walker and Greg Wilson, “Waiting Your Turn: Hospital Waiting Lists in Canada, 11th Edition,” Fraser Institute, Critical Issues Bulletin, September 2001.

<sup>21</sup> Hospital admissions as a percent of the total population average 16.01 percent for all OECD countries. The figures are 16.0 percent for the United Kingdom, 13.8 percent for New Zealand and 11.0 percent for Canada. See Gerald F. Anderson and Jean-Pierre Poullier, “Health Spending, Access, and Outcomes: Trends In Industrialized Countries,” *Health Affairs*, Vol. 8, No. 3, 1999, p. 178-192.

<sup>22</sup> In a 1997 Health Canada study on waiting times, the authors defended queuing as evidence of the absence of costly excess capacity. See Paul McDonald et al., “Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money?” Health Canada, Summary Report, July 1998. The study indirectly acknowledged that many of those waiting for treatment would never receive it because 20 percent to 30 percent of those on the waiting list have already died. See, Michael Hoel and Erik Magnus Saether, “Private Health Care as a Supplement to a Public Health System with Waiting Time for Treatment,” Frisch Center for Economic Research, Oslo, 2000, p. 25.

<sup>23</sup> Walker and Wilson, “Waiting Your Turn: Hospital Waiting Lists in Canada, 11th Edition.”

<sup>24</sup> “Purchasing for Your Health 1996/97,” New Zealand Ministry of Health, March 1998, Ch. 5, Figures 5.13 and 5.14.

<sup>25</sup> *Ibid.*

- In England, 43,900 patients, many of them needing hip or knee replacements, had been waiting for more than a year at the end of 2001.<sup>26</sup>

Although the British NHS claims about 95 percent of patients are treated within 12 months, obviously many are not.<sup>27</sup> The most recent NHS records show that 33,710 patients have been waiting between 12 and 17 months.<sup>28</sup> The UK-based Adam Smith Institute estimates the one million people currently on the NHS waiting list will wait one million years longer than should be acceptable.<sup>29</sup> Patients who wait are often waiting in pain. Many are risking their lives. An investigation by the British newspaper, *The Observer*, found that delays in colon cancer are so long in Britain that 20 percent of the cases considered curable at time of diagnosis had become incurable by the time of treatment.<sup>30</sup> Twenty-five percent of British cardiac patients die before receiving treatment.<sup>31</sup> During one 12-month period, 121 patients in Ontario were permanently removed from the waiting list for coronary by-pass surgery because they had become so sick that they could no longer undergo surgery with a reasonable risk of survival.<sup>32</sup>

In a British Consumers' Association survey, more than half of those polled said they thought the NHS should pay for treatment abroad if it could be provided more quickly and more cheaply than in the U.K.<sup>33</sup> The British government has resisted that option.<sup>34</sup> Until recently, British patients were generally allowed to seek (reimbursed) treatment abroad only under special circumstances. For example, in the year 2000, the NHS only sent 1,100 Britons abroad to get treatment in European hospitals. Many of these procedures were for hip replacement and cataract surgery for people who had waited for long periods. However, these figures also include coronary patients previously treated in Britain and suffering a subsequent heart attack while in Europe. An additional 200 Britons had attempted to obtain permission to seek treatment abroad but were turned down by their local health authorities.<sup>35</sup>

Crossing a border to obtain health care in a country other than the one in which a person resides, is not yet a common occurrence in Europe. However, this may change due to two recent European court rulings. The European court upheld the view that refusing reimbursement for cross-border medical treatment violated the free movement of goods provision in the Treaty of

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<sup>26</sup> Michael White and John Carvel, "Private Ops Offer to Cut NHS Queue," *The Guardian*, December 6, 2001.

<sup>27</sup> Hospital Inpatient statistics, NHS Trust Based: "Green Book" Index for 1999/00 Department of Health, 2000.

<sup>28</sup> Hospital Inpatient statistics, NHS Trust Based: "Yellow Book" Index for 1999/00 Department of Health, 2000.

<sup>29</sup> Matthew Young and Eamonn Butler, "The Million-Year Wait," The Adam Smith Institute, 2002.

<sup>30</sup> Anthony Browne, "Cash-Strapped NHS Hospitals Chase Private Patient 'Bonanza'," *The Observer*, December 16, 2001. Also see Anthony Browne, "Deadly Rise in Wait for Cancer Care," *The Observer*, March 3, 2002.

<sup>31</sup> Matthew Young and Eamonn Butler, "The Million-Year Wait," The Adam Smith Institute, 2002.

<sup>32</sup> "Canadian Health Care — A System in Collapse," Fraser Institute, Backgrounder, 1999.

<sup>33</sup> "More People 'Will Pay for Healthcare'," BBC News, May 30, 2001.

<sup>34</sup> See Panos Kanavos, Martin McKee and Tessa Richards, "Cross Border Health Care in Europe," *British Medical Journal*, Vol., 318, No. 7192, May 1, 1999, pp. 1157-58.

<sup>35</sup> Celia Hall, "Thousand NHS Patients Treated Abroad," *The Daily Telegraph*, August 21, 2001.

Rome. Due to these rulings Britons, like other Europeans, are increasingly using the health care system of other EU countries as a safety net to avoid long waiting lines at home.<sup>36</sup>

Many governments are justifiably worried at the thought of such patients seeking out care abroad due to perceived (or real) differences in quality. Although all European countries ration health care, there are different degrees of rationing for different services in different countries. If patients are able to cross borders at will and obtain (reimbursed) medical procedures, potentially they could circumvent any rationing scheme. Patients who go to a foreign country and get care are paying the full cost of care (or at least the home government is). So with perfect mobility, you would have a market for health care without rationing – defeating the global budgets of all the countries.

Where they exist, formal patient protections still don't afford patients the security often taken for granted by Americans. Norway's attempt to establish admission priorities failed to shorten waiting lines. So, in 1999 the government intervened again with a patients' bill of rights.<sup>37</sup> Today, patients who have been waiting for extended periods are sent abroad by the Norwegian government for treatment in the private sector.<sup>38</sup>

The issues involved in the "patients bill of rights" legislation being considered by the U.S. Congress is trivial by comparison. For example, some sticking points in Congress include such issues as limits on the rights of patients to sue their HMOs and patient out-of-network access to specialists, and coverage for clinical trials.<sup>39</sup> Two current federally mandated benefits to protect American patients include breast reconstruction surgery after mastectomy and a ban on "drive-through deliveries." At the same time, Europeans who are supposed to have universal access and care that is mostly free at the point of service are increasingly turning to foreign travel as the only way to fully secure these services.

**MYTH NO. 2: In countries with single-payer health insurance, all people have equal access to health care.**

One of the most surprising features of European health care systems is the enormous amount of attention given to the notion of equality and the importance of achieving it. Aneurin Bevan, father of Britain's National Health Service (NHS), declared that "everyone should be

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<sup>36</sup> Panos Kanavos, Martin McKee and Tessa Richards, "Cross Border Health Care in Europe," *British Medical Journal*, Vol., 318, No. 7192, May 1, 1999, pp. 1157-1158.

<sup>37</sup> "Highlights on Health in Norway," World Health Organization, December 1999, p. 35; and Michael Hoel and Erik Magnus Saether, "Private Health Care as a Supplement to a Public Health System with Waiting Time for Treatment," Frisch Center for Economic Research, Oslo, 2000, p. 25; and Paul Van Den Noord, Terje Hagen and Tor Iversen, "The Norwegian Health Care System," OECD Working Papers No. 198, Organization for Economic Cooperation and Development, 1998, pp. 18-19.

<sup>38</sup> Jan Ove Nesse, "Norwegian Patients in EU Hospitals: The Medical Treatment Abroad Project," Norwegian Insurance Administration, December 2001, p. 3.

<sup>39</sup> "Patients' Rights Bill - CCH Inc. Analysis of House vs. Senate Versions," Council for Affordable Health Insurance, August 7, 2001.

treated alike in the matter of medical care.”<sup>40</sup> The Beveridge Report, a blueprint for the NHS, promised “a health service providing full preventive and curative treatment of every kind for every citizen without exceptions.”<sup>41</sup> The *British Medical Journal* predicted in 1942 that the NHS would be “a 100 percent service for 100 percent of the population.”<sup>42</sup> The goal of NHS founders was to eliminate inequalities in health care based on age, sex, occupation, geographical location and — most importantly — income and social class. As Bevan put it, “the essence of a satisfactory health service is that rich and poor are treated alike, that poverty is not a disability and wealth is not advantaged.”<sup>43</sup> Similar statements have been made by politicians in virtually every country that has established a national health insurance program. Yet such rhetoric rarely corresponds with the facts.

**Inequality in Britain.** Britain’s ministers of health have long assured Britons that they were leaving no stone unturned in a relentless quest to root out and eliminate inequalities in health care. But 30 years into the program (in the 1980s), an official task force report (the Black Report) concluded that there was little evidence of more equal access to health care in Britain than when the NHS was started.<sup>44</sup> Almost twenty years later, a second task force (the Acheson report) found evidence that access had actually become more *unequal* in the years between the two studies.<sup>45</sup> In fact, across a range of indexes, NHS performance figures have consistently shown widening gaps between the best performing and worst performing hospitals and health authorities, as well as vastly different survival rates for different types of illness depending on where patients live. The problem of unequal access is so well known in Britain that the press has begun to refer to the NHS as a “postcode lottery,” in which a person’s chances for timely, high-quality treatment depend on the neighborhood (or the “postcode”) in which he or she lives.<sup>46</sup>

“Generally speaking, the poorer you are, and the more socially deprived your area, the worse your care and access is likely to be,” says *The Guardian* — a staunch defender of socialized medicine.<sup>47</sup> In addition to press reports, scholarly studies of the issue have pointed to similar conclusions. For example, a study by the Joseph Rowntree Research Trust found discrepancies between areas for all causes of death:<sup>48</sup>

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<sup>40</sup> Quoted in Economic Models, Ltd., *The British Health Care System* (Chicago: American Medical Association, 1976), p. 33.

<sup>41</sup> Quoted in Harry Swartz, “The Infirmity of British Medicine,” in Emmett Tyrrell, Jr., ed., *The Future That Doesn’t Work: Social Democracy’s Failures in Britain* (New York: Doubleday, 1977), p. 24.

<sup>42</sup> *British Medical Journal*, December 12, 1942, p. 700.

<sup>43</sup> Aneurin Bevan, *In Place of Fear* (London: Heinemann, 1952), p. 76.

<sup>44</sup> *Inequalities in Health* (Black report), (London: Department of Health and Social Security, 1980).

<sup>45</sup> *Independent Inquiry into Inequalities in Health: Report* (Acheson Report), (London: Stationery Office, 1998). See also, “Geographic Variations in Health,” Office for National Statistics, Decennial Supplement DS 16, 2001.

<sup>46</sup> See, for example, “Postcode Lottery in Social Services,” BBC News, October 13, 2000; “New Health Tables Reveal Postcode Lottery,” Ananova.com, July 14, 2000; and “‘Regional Lottery’ of Hospital Waiting Times,” Ananova.com, August 31, 2000.

<sup>47</sup> Patrick Butler, “Q&A: Postcode Lottery,” *The Guardian*, November 8, 2000.

<sup>48</sup> Dr. Richard Mitchell and Dr. Mary Shaw, “Reducing Health Inequalities in Britain,” Joseph Rowntree Foundation, September 2000.

- The 10 percent of nonelderly Britons living in areas with the worst performing hospitals are 42 percent more likely to die on any given day than the average for Britain as a whole.
- The 10 percent of the under-65 population living in regions with the best performing hospitals were 24 percent less likely to die than the average for Britain as a whole.
- Overall, the study found that if the death rates were merely decreased to 1983 levels, some 7,500 deaths of people younger than 65 would be avoided each year.
- One study found that if the proportion of cancer-related illnesses and deaths were the same in Britain's lowest socioeconomic groups as in the most affluent, there would be 16,600 fewer deaths from cancer each year.<sup>49</sup>
- According to a report from the British Heart Foundation (BHF), the premature death rate for working class men is 58 percent higher than non-working class men;<sup>50</sup> the BHF estimates more than 5,000 working class men under the age of 65 die of coronary heart disease each year in Britain because of variations in health care access for different socioeconomic groups.<sup>51</sup>

This disparity between rich and poor areas in Britain was confirmed by the *Good Hospital Guide*, the published results of a study that graded every hospital in Britain according to a mortality index.<sup>52</sup> The index was calculated so that a hospital with a survival rate that matched exactly the national average scored 100 points. Those hospitals that had a lower survival rate than the national average scored above 100, while those with a higher survival rate scored below. This disparity was especially striking among London hospitals. As Table 2-1 shows:

- The hospitals with the best performance, University College Hospital, Royal Free Hampstead and Chelsea/Westminster, are located in the center of London — in and around the wealthiest sectors of the city.
- The hospitals with the worst performance, Greenwich, Havering, Redbridge and Newham, are located in east London — the areas of the city that are most depressed economically.
- In addition, there are nearly four times as many doctors per 100 patients at Chelsea/Westminster (64) as in Greenwich (17).

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<sup>49</sup> "Cancer Trends in England and Wales, 1950-1999," *Health Statistics Quarterly*, Issue 8, Winter 2000, p. 18.

<sup>50</sup> Coronary Heart Disease Statistics, British Heart Foundation, Statistics Database, 1998.

<sup>51</sup> Sir Charles George, Coronary Heart Disease Statistics, British Heart Foundation, 1999. [www.dphpc.ox.ac.uk/bhfhprg/stats/1999/stats01.html](http://www.dphpc.ox.ac.uk/bhfhprg/stats/1999/stats01.html)

<sup>52</sup> *The Good Hospital Guide*, Dr. Foster, January 14, 2001. <http://www.drfooster.com>

Overall, the study found a correlation between a region's socioeconomic conditions, the quality of its health care services and the survival rates of its patients. In general terms, hospitals in richer areas are more likely to have more staff per hospital bed, and their patients are more likely to survive treatment than patients in poor areas.

As a result of these differences in levels of care, there are also differences in health outcomes. A man with prostate cancer in Bexley and Greenwich in southeast London, for example, has a 34 percent chance of surviving for five years, while a man in the Kensington/Westminster area has a 60 percent chance.<sup>53</sup>

**[Click here to see Table 2-1](#)**

**Inequality in Canada.** Canada is another country that puts a high premium on equality of access to medical care, if the official rhetoric is to be believed. How well have the Canadians done? The University of British Columbia routinely finds wide-spread inequality among British Columbia's twenty or so health regions. What makes this unique is that it identifies patients by the regions in which they live rather than the region in which they received care – something most other studies do not do. As an example, compare the amount of spending on the services of physician specialists for two areas in British Columbia: Vancouver, the largest city with a population of almost 2 million, and Peace River, a rural area of about 60,000. As Table 2-2 shows:<sup>54</sup>

- Residents of Vancouver receive almost three times more specialist services per person than residents of Peace River, and this inequality holds for both males and females across all age groups.
- The differences are even more striking for certain specialties, with a five-to-one difference in the services of internists and a 31-to-one difference in the services of psychiatrists.

**[Click here to see Table 2-2](#)**

One might suppose that the lower level of specialist services in Peace River would be offset by a higher level of general practitioner services. As Figure 2-1 shows, that is not the case. Vancouver residents also enjoy about 60 percent more GP services. In general, there are wide differences in spending on medical services between areas throughout British Columbia. As Table 2-3 shows:<sup>55</sup>

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<sup>53</sup> Data based on clinical indicators published by the department. See Sebastian O'Kelly, "Consumer: Lottery of Life and Death," *The Guardian*, October 1, 1998.

<sup>54</sup> Arminee Kazanjian et al., "Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians, 1993-1994," University of British Columbia, Centre for Health Services and Policy Research, 1995. The report is available online at <http://www.chspr.ubc.ca/feepract/index.html>.

<sup>55</sup> Ibid.



- Spending on specialist services in Vancouver is almost four times the level of spending on specialists in Cariboo.
- Per capita spending on all services are almost three times as high in the highest-spending area (\$609 in Vancouver) than the lowest-spending area (\$231 per capita in Peace River).
- The differences across British Columbia between (the lowest and the highest regions) are especially striking in certain specialties, such as internal medicine (four times higher), psychiatric (31 times higher) and OB/GYN (more than four times higher).

**[Click here to see Figure 2-1](#)**

**[Click here to see Table 2-3](#)**

There is substantial evidence that when health care is rationed, the poor are pushed to the rear of the waiting line. In general, low-income people in almost every country see physicians less often, spend less time with them, enter the hospital less often and spend less time there, when the use of medical services is weighted by the incidence of illness. Moreover, scholarly evidence suggests that the wealthy and powerful do not wait as long as others. For example, one study in Ontario found:<sup>56</sup>

- More than 80 percent of physicians, including 90 percent of cardiac surgeons, 81 percent of internists and 60 percent of family physicians, had been personally involved in managing a patient who had received preferential access on the basis of factors other than medical need.
- When asked about those patients most likely to receive preferential treatment, physicians reported that 93 percent had personal ties to the treating physician, 85 percent were high-profile public figures and 83 percent were politicians.

Other studies have reached similar conclusions. One found that the wealthy and powerful have significantly greater access to medical specialists than less well-connected, poor Canadians.<sup>57</sup> Another found that preferential treatment for high-profile patients resulted in more frequent services, shorter waiting times and greater choice in specialists.<sup>58</sup>

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<sup>56</sup> A.S. Basinski and C.D. Naylor, "A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada," *Annals of Internal Medicine*, Vol. 129, No. 7, 1998.

<sup>57</sup> David A. Alter, C. David Naylor, Peter Austin and Jack V. Tu, "Effects of Socioeconomic Status on Access to Invasive Cardiac Procedures and on Mortality after Acute Myocardial Infarction," *New England Journal of Medicine*, Vol. 341, No. 18, October 28, 1999, pp. 1359-67.

<sup>58</sup> Sheryl Dunlop, Peter C. Coyte and Warren McIsaac, "Socio-economic Status and the Utilization of Physicians' Services: Results from the Canadian National Population Health Survey," *Social Science and Medicine*, Vol. 51, No. 1, July 2000, pp. 123-33.

Such findings are supported by anecdotal evidence. In recent years, Canadian newspapers have resonated with stories of wealthy and prominent patients “jumping the queue” for quicker treatment, while ordinary citizens languish.<sup>59</sup> For example, the president of the Canadian Medical Association, Dr. Victor Dirnfeld, suggests that the Canadian system is in fact a two-tiered system, and says he knows of seven prominent political figures in British Columbia and Ontario who had received special treatment. “Instead of waiting three months for an MRI,” he said, “they will have it done in three or four days.”<sup>60</sup>

The issue of preferential treatment was highlighted when Canada’s Health Minister, Allan Rock, underwent a successful surgery after he was diagnosed with prostate cancer in January 2001. Since then, Rock has come under sharp criticism from other Canadians who are suffering from prostate cancer but who are waiting much longer periods — often more than a year — between diagnosis and surgery.<sup>61</sup>

**Access in the United States.** How does access to health care for low-income people in the United States compare with access in countries with national health insurance? Our poorest citizens — those enrolled in Medicaid, a government health program providing free care for more than 40 million people — probably have more access to better health care than low-income citizens in any other country. Being on Medicaid usually means access to all the technology of the U.S. health care system. Such technology is more available in the United States, and Medicaid will usually pay for it. Even though Medicaid rationing is prevalent, the United States probably has less rationing than most other countries.

In addition to Medicaid, low-income families without health insurance have access to free care at city and county clinics and hospitals. A study by the Texas Comptroller of Public Accounts found that public and private organizations in Texas spend, on average, approximately \$1,000 per year on care for each uninsured Texan.<sup>62</sup> This is equivalent to \$4,000 for a family of four, enough to buy health insurance in many Texas cities.

One international opinion survey found that 20 percent of people in the United States say they have had serious problems paying for health care compared to only 6 percent in Canada.<sup>63</sup> The same survey revealed that 12 percent of Americans had experienced an occasion on which they did not have access to needed medical care compared to 8 percent of Canadians.<sup>64</sup> It is not clear what the responses to the survey means. In the United States, we more frequently ask

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<sup>59</sup> “Well-Connected Patients Skip to Head of Line,” *Ottawa Citizen*, October 1, 1998; “Province to Pay Costs of MRI Scans Since ‘93,” *Calgary Herald*, April 10, 2001; “Politicians Jump Medicare Queue,” *Ottawa Citizen*, June 6, 1998; and “Queue-Jumping Privatizes Medicare,” *Toronto Star Health Reporter*, March 31, 1999.

<sup>60</sup> “Politicians Jump Medicare Queue,” *Ottawa Citizen*, June 6, 1998.

<sup>61</sup> Jake Rupert, “Man Protests Rock’s Speedy Surgery,” *Ottawa Citizen*, February 17, 2001.

<sup>62</sup> Naomi Lopez Bauman and Devon M. Herrick, “Uninsured in the Lone Star State,” National Center for Policy Analysis, Brief Analysis No. 335, August 29, 2000.

<sup>63</sup> Karen Donelan, Robert Blendon, John Benson, Robert Leitman and Humphrey Taylor, “All Payer, Single Payer, Managed Care, No Payer: Patients’ Perspectives in Three Nations,” *Health Affairs*, Vol. 15, No. 2, Summer 1996, p. 260.

<sup>64</sup> *Ibid.*

people to choose between money and health care. In Britain and Canada, people more frequently must choose between health care and other (rationing) costs, such as alternative uses of time. This is doubtless part of the reason that, in the United States, cost was cited as a major obstacle to health care access, while in other countries, like Britain or Canada, waiting times and physician shortages were the main barriers to care. We do not know if those surveyed would have obtained health care if they had perceived their medical needs as being more urgent, but that must often have been the case.

In every country, some people slip through the social safety net. But for the most part, the United States has already made considerable progress toward the goal of socialized medicine: the removal of financial barriers to health care. And, considering the rationing of medical technology in countries with national health insurance, the United States may have gone further in removing barriers to medical care than any other country in the world. In fact, one recent study found that uninsured, low-income, middle-aged Americans receive about the same level of health services as those with employment-based coverage, without incurring large out-of-pocket charges. According to the study:<sup>65</sup>

- Low-income persons without job-related health insurance spend only about \$50 per year more out-of-pocket for health services than Americans with employer-provided health benefits.
- On the average, they make 2.4 visits to physicians each year, compared to 3.4 visits for persons with employer-provided insurance coverage.
- When seriously ill, uninsured low- and moderate- income Americans receive about the same level of treatment and services as those with employment-based coverage, with no large increases in out-of-pocket payments.

This suggests that the health care safety net in the United States is actually quite reliable, providing low-income citizens routine access to high-quality services.

**MYTH NO. 3: Countries with single-payer health insurance make health care available on the basis of need rather than ability to pay.**

Most people in countries that ration health care believe that the wealthy, the powerful and the sophisticated move to the head of the rationing lines. Because government officials have little interest in verifying this fact, few formal studies exist. There is considerable evidence, however, that in the face of health care rationing those who can pay find other ways to obtain health care. For example:

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<sup>65</sup> Richard W. Johnson and Stephen Crystal, "Uninsured Status and Out-of-Pocket Costs at Midlife," *Health Services Research*, Vol. 35, No. 5, (Part. I) December 2000, pp. 911-32.

- In Britain, 13 percent of the population have private health insurance, and private sector spending makes up 15 percent of the country's total health care spending.<sup>66</sup>
- In Canada, the share of privately funded health care spending rose from 24 percent in 1983 to an estimated 30.3 percent in 1998.<sup>67</sup>
- In Australia, about one-third of the population has private health insurance, and private sector spending makes up around one-third of all health care spending.<sup>68</sup>
- In New Zealand, 35 percent of the population has private health insurance, and private sector spending is about 10 percent of total health care spending.<sup>69</sup>

**Paying Privately for Health Care in Britain.** From the time the National Health Service was formed, people who wanted to pay for private treatment could have access to it as well as to the NHS.<sup>70</sup> And despite the British claim that health care is a right that is not conditioned on the ability to pay, last year an estimated 100,000 patients elected to pay for private surgery rather than wait for “free” care.<sup>71</sup> These patients went to private hospitals, of which there are about 300 in Britain. Collectively, these hospitals account for an increasingly large share of total health care services in Britain, including 20 percent of all non-emergency heart surgery, 30 percent of all hip replacements and \$25 billion worth of total health care annually. Most of the patients in these hospitals pay for treatment through private, employer-provided insurance.

Altogether, 13 percent of the British public is covered by private health insurance – over 7 million people – and that 13 percent accounts for two-thirds of all patients in private hospitals. Because private hospitals are able to provide fast, efficient service without waiting lines, a growing segment of the British public has come to view them as a viable alternative to the NHS.<sup>72</sup> According to a survey by the Consumers' Association:<sup>73</sup>

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<sup>66</sup> Caroline Richmond, “NHS Waiting Lists Have Been a Boon for Private Medicine in the UK,” *Canadian Medical Association Journal*, Vol. 154, No. 3, February 1, 1996, pp. 378-81. Also see Timothy Besley, John Hall and Ian Preston, “The Demand for Private Health Insurance: Do Waiting Lists Matter?” Institute for Fiscal Studies, Working Papers, July 1996.

<sup>67</sup> “The Evolution of Public and Private Health Care Spending in Canada, 1960-1997,” Table C.2.4, Canadian Institute for Health Information, 1999. See [www.cihi.ca/pdf/evol.pdf](http://www.cihi.ca/pdf/evol.pdf).

<sup>68</sup> “Australian National Health Survey,” Australian Bureau of Statistics, 1995.

<sup>69</sup> Daniel Riordan, “Health Insurance Faces a Bitter Pill,” *New Zealand Herald*, January 24, 2002.

<sup>70</sup> See Nicholas Mays and Justin Keen, “The NHS's 50th Anniversary: Will The Fudge On Equity Sustain the NHS into the Next Millennium?” *British Medical Journal*, Vol. 317, No. 7150, July 4, 1998, pp. 66-69.

<sup>71</sup> “NHS Patients ‘Opt for Private Surgery,’” BBC News, January 15, 2002. The survey was conducted by Medix UK plc, an Internet service for doctors.

<sup>72</sup> Caroline Richmond, “NHS Waiting Lists have been a Boon for Private Medicine in the UK,” *Canadian Medical Association Journal*, 1996, pp. 378-381.

<sup>73</sup> “Forty Percent Would Go Private Unless Access to NHS Improved,” Consumers' Association, May 30, 2001. <http://www.which.net/whatsnew/pr/may01/general/nhs.html>

- Forty percent of Britons surveyed would consider going to a private facility to avoid waiting, even though 84 percent of those surveyed said they did not have private medical insurance to pay the bills.
- The affluent were more willing to use private facilities, but one-third of the less well-off said they would also consider it.

Clearly, the demand exists in Britain for both private insurance and private hospitals.

The existence of a large, viable private health care industry suggests that many Britons do not believe they can get adequate health care through “free” public channels.

**Private Care in Britain’s Private Hospitals.** Although it was ostensibly established to provide health care free of charge, regardless of ability to pay, Britain’s National Health Service is arguably the largest private care provider in Britain. Also noted above, while large numbers of British patients wait for care, 10,000 private pay patients – about half of whom are foreign – received preferential treatment in Britain’s top hospitals in 2001.<sup>74</sup> An investigation by *The Observer* found that one of the NHS’s leading cancer hospitals – the Royal Marsden in London – earns one-quarter of its revenue from private procedures treating cash-paying patients.<sup>75</sup> Overall, the NHS earns approximately \$500 million per year in fees from treating private patients.<sup>76</sup> Ironically, while NHS provides preferential services to British patients who can pay cash (and foreign ones), other British patients are traveling to places such as South Africa for care where many procedures can be purchased for fees lower than charged in private clinics in the U.K.<sup>77</sup>

**Canadian Medicare.** Since Canada does not allow private health insurance for services covered by the country’s “Medicare” system, Canadians who go to the country’s few private physicians or private hospitals must pay most of the cost out-of-pocket. For example, to bypass long waiting lines, Canadians sometimes choose to undergo cataract surgery on an outpatient basis in a private clinic. Although the government will pay the surgeon’s fee, private patients often pay \$1,000 to \$1,200 in *facilities fees* to obtain faster treatment.<sup>78</sup> Not only wealthy Canadians pay for private care. A study by the Manitoba Centre for Health Policy and

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<sup>74</sup> Anthony Browne, “Scandal of NHS Beds Auction,” *The Observer*, January 6, 2002.

<sup>75</sup> Anthony Browne, “Cash-Strapped NHS Hospitals Chase Private Patient ‘Bonanza’,” *The Observer*, December 16, 2001.

<sup>76</sup> Ibid.

<sup>77</sup> Anthony Browne, “NHS Cases Pay for Quick Ops in South Africa,” *The Observer*, March 17, 2002.

<sup>78</sup> Carolyn DeCoster et al., “Surgical Waiting Times in Manitoba,” Manitoba Centre for Health Policy and Evaluation, June 1998; and Pippa Wyson, “The Waiting Game,” *Medical Post*, Vol. 34, No. 28, August 25, 1998. Although Canadian Medicare covers all medically necessary services, those services considered elective in nature are often performed in private facilities. Day surgery centers, not requiring overnight stays, provide some private services. For a discussion of a parallel public/private system in Canada, see Charlotte Gray, “Visions of Our Health Care Future: Is a Parallel Private System the Answer?,” *Canadian Medical Association Journal*, Vol. 154, No. 7, April 1, 1996, pp. 1084-87.

Evaluation found that of cataract surgery patients in Winnipeg, 40 percent were from neighborhoods in the lowest two income quintiles.<sup>79</sup>

For many procedures, a growing number of Canadians go to the United States. In 1996, Canadians spent an estimated \$1 billion on care in this country.<sup>80</sup> Sometimes the Canadian province pays the bill. In other cases, patients spend their own money. The Canadian Society of Surgical Oncology recommends that cancer treatment, including surgery, be initiated within two weeks of completion of any necessary preoperative tests. However, a study found that the median wait from treatment decision to surgery was almost three weeks because of a shortage of operating room time and necessary equipment.<sup>81</sup> The waiting time for surgery also varied by type of cancer. For instance, the median wait for colorectal cancer surgery was 29.0 days and 64.0 days for urologic cancers.<sup>82</sup> Due to long waits and the lack of equipment, seven of the 10 Canadian provinces have begun sending some of their breast and prostate cancer patients to the United States for radiation therapy.<sup>83</sup>

**MYTH NO. 4: Although the United States spends more on health care per capita than countries with single-payer health insurance, Americans do not get better health care.**

This myth is often supported by reference to two facts: 1) that life expectancy is not much different among the developed countries and 2) that the U.S. infant mortality rate is one of the highest among developed countries. However, neither statistic is a very good indicator of the quality of a country's health care system.

**Life Expectancy and Health Care.** General life expectancy rates tell us almost nothing about the efficacy of health care systems, because, throughout the developed world, there is very little correlation between health care spending and general life expectancy – either among or within countries. While a good health care system may, by intervention, extend the life of a small percentage of a population, it has very little to do with the average life span of the whole population. In fact, the number of years a person will live is primarily a result of genetic and social factors, including lifestyle, environment and education.<sup>84</sup> The American population is a mixture of ethnic groups with strikingly different live expected life spans:

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<sup>79</sup> C. A. DeCoster and M.D. Brownell, "Private Health Care In Canada: Savior Or Siren?," *Public Health Reports*, Vol. 112, No. 4, August 1997, pp. 298-305.

<sup>80</sup> Victor Dirnfeld, "The Benefits of Privatization," *Canadian Medical Association Journal*, Vol. 155, No. 4, August 15, 1996, pp. 407-410.

<sup>81</sup> Marko Simunovic et al., "A Snapshot of Waiting Times for Cancer Surgery Provided by Surgeons Affiliated with Regional Cancer Centres in Ontario," *Canadian Medical Association Journal*, Vol. 165, No. 4, August 21, 2001, pp. 421-425.

<sup>82</sup> Ibid.

<sup>83</sup> For a discussion of Canadian cancer patients being sent to the U.S. for radiation treatment, see Mark Cardwell, "Que. Cancer Patients to Head South," *Medical Post*, Vol. 35, No. 22, June 8, 1999; Robert Walker, "Alberta Centre May Soon Fly its CA Patients South," *Medical Post*, Vol. 35, No. 34, October 12, 1999; Lynn Haley, Deana Driver, Mark Cardwell and Carol McLeod, "Guarding the Border," *Medical Post*, Vol. 36, No. 01, January 4, 2000.

<sup>84</sup> "How Not To Judge Our Health Care System," National Center For Policy Analysis, Brief Analysis No. 141, November 15, 1994.

- In 1999, the life expectancy for a white, non-Hispanic man was 74.7 years, compared to 68.4 years for a Black man, 72.9 years for an American Indian man, 80.9 years for an Asian man and 77.2 for a Hispanic man.<sup>85</sup>
- That same year, the life expectancy for a white, non-Hispanic woman was 80.1 years, compared to 75.1 years for a Black woman, 82 years for an American Indian woman, 86.5 years for an Asian woman and 83.7 for a Hispanic woman.<sup>86</sup>

The life expectancy rate for the United States as a whole, 74.1, is therefore a composite of the widely differing rates for these different racial and ethnic groups. Not surprisingly, white Americans have life expectancy rates (74.7 years for men and 80.1 for women) that are similar to the rates for Western Europe (75 years for men and 81 years for women).<sup>87</sup> The differences that exist between the expected life spans of groups in the United States cannot be explained by differences in access to health care. Take the case of Japanese-Americans. At 78.6 years, Japan has the longest life expectancy of any industrialized country – about three years longer than that found in the United States. If the health care system were the cause of shorter life spans in the United States, one would not expect a Japanese-American to live as long as their counterparts living in Japan. But they do.<sup>88</sup> As a percentage of the total population, the United States has historically had a larger immigrant population and a larger refugee population than any other developed country.<sup>89</sup> With a few exceptions, such as the Japanese, immigrant groups tend to have poorer health and shorter life spans than the native U.S. population, and therefore have caused the composite national rate to decrease.

**Infant Mortality and Health Care.** The United States has a relatively high infant mortality rate: 7.2 deaths per 1,000 live births in 1998, compared to a developed country average of about 5.0.<sup>90</sup> However, like the life expectancy rate, the U.S. infant mortality rate is a composite average.<sup>91</sup> Overall, the chances that an infant will die at birth vary widely according to a number of factors, the most important of which are race, geography, income and education:

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<sup>85</sup> National Projections Program, Population Division, U.S. Census Bureau, January 13, 2000. By contrast, the 1998 figures for men in other countries are 74.8 for Britain, 75.2 for New Zealand, 76.1 for Canadians, and 76.9 for Sweden. See more information, see OECD Health Data 2001.

<sup>86</sup> The 1998 figures for women in other countries are 79.7 for Britain, 80.4 for New Zealand, 81.5 for Canadians, and 81.9 for Swedish males. See more information, see OECD Health Data 2001.

<sup>87</sup> EU Statistical Yearbook, 2000. (Figures are for 1998.)

<sup>88</sup> “How Not To Judge Our Health Care System,” National Center For Policy Analysis, Brief Analysis No. 141, November 15, 1994.

<sup>89</sup> “Replacement Migration: Is it a Solution to Declining and Ageing Population,” US Population Division Report, March 21, 2000.

<sup>90</sup> “Kids Count: 2001 Data Book Online,” The Annie E. Casey Foundation, May 17, 2002 and “Health, United States, 2000,” National Center for Health Statistics, 2000.

<sup>91</sup> The overall infant mortality rate has been falling in recent years. For example, according to OECD health data from 1998, the United States infant mortality deaths rate had fallen to 7.2 per 1,000 births from 9.2 eight years earlier. The rate for the United Kingdom was 5.7 versus 7.9 eight years earlier. And the rate in Canada had dropped to 5.3 from 6.8, Australia fell to 5.0 from 8.2, and New Zealand fell to 6.8 from 8.4 during the same time period. See Organization for Economic Co-operation and Development, OECD Health Data, 2001.

- Race: According to the National Center for Health Statistics, in 1997, the mortality rate for infants born to white, non-Hispanic mothers was 6.0 (per 1,000 live births), compared to 5.0 for Asian mothers, 8.7 for American Indian mothers, 13.7 for Black mothers and 7.9 for Puerto Rican mothers.<sup>92</sup>
- Geography: Studies of U.S. infant mortality by region document wide, persisting disparities. Among the 60 largest U.S. cities alone, rates ranged from a low of 4.5 (Seattle) to a high of 15.4 (Memphis). Among U.S. states, rates varied from a low of 4.4 (New Hampshire) to a high of 10.2 (Alabama).<sup>93</sup>
- Income and education: Infants born to low income mothers who did not finish high school are about 50 percent more likely to die than infants whose mothers finished college.<sup>94</sup>

According to the National Healthy Start Association, the reason for the poor overall ranking of the U.S. in infant mortality rates is the high incidence of low birth weight (e.g. <2,500 grams) deliveries, which increase the probability of infant death by as much as 20 times.<sup>95</sup> Several factors are known to increase the likelihood of low birth weight babies, but the most significant is race. African-American women deliver lower birth weight babies at twice the rate of white American women. This is true even when controlling for mother's age, income and education,<sup>96</sup> and even holding constant the number of prenatal medical visits.<sup>97</sup> The reason that some ethnic groups have disproportionate numbers of low birth weight babies is not fully understood.<sup>98</sup>

**Infant Mortality: Comparing the U.S. and Other Countries.** So why does the U.S. have such a higher infant mortality rate than Europe? The explanation lies in the higher degree

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<sup>92</sup> Infant Mortality Statistics from the 1997 Period Linked Birth/Infant Death Data Set, National Vital Statistics Reports, Volume 47, Number 23, July 30, 1999.

<sup>93</sup> "Racial and Ethnic Disparities in Infant Mortality Rates: 60 Largest U.S. Cities, 1995-1998," Center for Disease Control, April 19, 2002 and Infant Mortality: State Rankings, U.S. National Center for Health Statistics, Table 125, 2000.

<sup>94</sup> "Racial and Ethnic Disparities in Infant Mortality Rates: 60 Largest U.S. Cities." See also: "U.S. Childhood Mortality, 1950 through 1993: Trends and Socioeconomic Differentials," *American Journal of Public Health* Vol. 86, No. 4, April, 1996, pp. 505-512; George A. Kaplan, "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways," *British Medical Journal*, Vol. 312, April 20, 1996, pgs. 999-1003; and Bruce P. Kennedy, "Income Distribution and Mortality: Cross Sectional Ecological Study of the Robin Hood Index in the United States," *British Medical Journal* Vol. 312 April 20, 1996, pgs. 1004-1007.

<sup>95</sup> Nicholas Eberstadt, *The Tyranny of Numbers: Mismeasurement & Misrule*, (Washington, D.C.: American Enterprise Institute, 1995). See also: "Infant Mortality, Low Birthweight and Racial Disparity in Perinatal Outcomes," National Healthy Start Association, 2001; See also: "Healthier Mothers and Babies 1900-1999," Morbidity and Mortality Weekly Report, *Journal of the American Medical Association* Vol. 282, No. 19, November 17, 1999 and "Closing the Gap: Addressing the Disparity of Infant Mortality Among African American and White Infants," Maryland Commission on Infant Mortality Prevention, 1998.

<sup>96</sup> Nicholas Eberstadt, *The Tyranny of Numbers: Mismeasurement & Misrule*, (Washington, D.C.: American Enterprise Institute, 1995).

<sup>97</sup> Ibid.

<sup>98</sup> Ibid. Note: Studies of twins have attributed 40 percent of low birth weight to genetic causes. See Olga Basso, et al., "Change in Social Status and Risk of Low Birth Weight in Denmark: Population Based Cohort Study," *British Medical Journal*, Vol. 315, No. 7121, December 6, 1997, pp. 1498-1502.



of demographic and socioeconomic variation that is found in the U.S. compared to Europe. With an average influx of more than 760,000 new entrants a year, the U.S. takes in more immigrants – both in total numbers and on a per capita basis – than all the countries of Europe combined (5 times more than Europe as a whole and 25 times more than the average European country).<sup>99</sup> This is especially important because, by and large, the people coming into the U.S. bring with them the life expectancies of their native countries.

If these factors are accounted for, the infant mortality rates for some segments of the U.S. population are similar to (and in many cases lower) than European countries. For example, Both Norway and the American state of New Hampshire have small, culturally and racially homogenous populations with similarly demographics. Not surprisingly, the rates for both are very similar at 4.1 and 4.4 respectively.<sup>100</sup>

Wide variations in infant mortality occur in other developed countries as well. Take Canada, which is often praised for its low overall infant mortality rate of 6.1 deaths per 1,000 live births.<sup>101</sup>

- At 7.5 deaths per 1,000, the infant mortality rate among the lowest quintile income group of Canadians is two-thirds higher than the infant mortality among the wealthiest quintile income group (4.5 per 1,000).<sup>102</sup>
- Among Canadian provinces, infant mortality rates vary from a low of 4.6 on Prince Edward Island to a high of 9.1 in Saskatchewan.<sup>103</sup>

Not surprisingly, these differences tend to reflect socioeconomic differences, with wealthier provinces enjoying lower rates than poorer ones.

There are also significant differences between different income groups and regions within in Britain:

- Overall, infant mortality rates in Britain are considerably higher in the north and in urban areas than in the south and in rural areas, even though all participate in the same National Health Services.
- Infant mortality in Leeds, an industrial city in central England, is more than twice as high as in rural Dorsetshire; and children born in Manchester, Britain's third largest city, are eight times as likely to die before reaching age 4 as are children born in rural Gloucestershire.<sup>104</sup>

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<sup>99</sup> "Replacement Migration: Is It a Solution to Declining and Ageing Populations?" U.N. Population Division Report, March 21, 2000.

<sup>100</sup> "Infant Mortality Rates and International Rankings," Center for Disease Control, 2001 and Nicholas Eberstadt, *The Tyranny of Numbers: Mismeasurement & Misrule*, (Washington, D.C.: American Enterprise Institute, 1995).

<sup>101</sup> Statistics Canada, *Births and Deaths, 1995*, Catalogue 84-210-XPB.

<sup>102</sup> Ibid and R. Wilkins, *Mortality by Neighbourhood Income in Urban Canada, 1986-1991*. Presentation to the Canadian Society for Epidemiology and Biostatistics, St. John's, Newfoundland, August 16-19, 1995.

<sup>103</sup> Statistics Canada, *Births and Deaths, 1995*, Catalogue 84-210-XPB.

<sup>104</sup> Daniel Dorling, "Death in Britain: How Local Mortality Rates Have Changed," Policy Brief Report, Joseph Roundtree Foundation, 1997.

- Across Britain, the rate among the second lowest income quintile (“manual classes”) was 6.2 in 1999, compared to 4.3 among the highest income quintile (“professional classes”).<sup>105</sup>
- In the past three years alone, the rate for the lowest income group (“unskilled manual class”) has increased to double the rate of the highest income group – a widening of nearly 10 percent.<sup>106</sup>

No one has seriously claimed that these differences between income groups and regions are the result of the Canadian or British health care systems. Yet many critics still attempt to draw a correlation between the infant mortality rate in the U.S. and our health care system.

Another reason may have to do with how the U.S. and other countries measure infant mortality. For example, in 1998 Switzerland’s infant mortality of 4.8 per 1,000 births was only two-thirds of the rate found in the United States (7.2 per 1,000).<sup>107</sup> However, Switzerland does not treat the death of an infant born less than 30 centimeters in length as a live birth. This threshold effectively excludes many very low birth weight babies such as those weighing less than one kilogram (2.2 pounds). Yet, close to one-third of all infant deaths recorded in the United States are among infants weighing 2.2 pounds or less. If these very low birth weight infants (most of which measure less than 30 centimeters) were reclassified in the United States vital statistics as “stillborn” rather than “live births,” the respective rates of the two countries would be similar. In fact, if you remove accounting factors of this type, the rates of low birth weight babies born in America are about the same as the rest of the OECD countries:

- The composite rate for low birth weight is 6.6 percent of live births. However, the rate for white Americans is 5.6 percent.<sup>108</sup>
- In Canada, approximately 5.5 percent of live births are low birth weight.<sup>109</sup>
- In Britain, the rate is 7.6 percent – up from 6.9 percent only a few years earlier.<sup>110</sup>
- The rate of low birth weight babies in Denmark is 5.3 percent.<sup>111</sup>

None of the factors listed above as influencing a nation’s composite mortality rate – race, geography, income, education or low birth weight measurement procedure – have anything to do with the quality of (or access to) our health care system.

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<sup>105</sup> “Health Inequalities – National Targets on Infant Mortality and Life Expectancy,” Health Statistics Quarterly, Number 12, November 2001.

<sup>106</sup> Ibid.

<sup>107</sup> Organization for Economic Co-operation and Development, *OECD Health Data, 2001*.

<sup>108</sup> Ibid. Note: the low birthweight rate for Black Americans is 12.2.

<sup>109</sup> *The Health of Canada's Children: A CICH Profile* (2nd Edition), Canadian Institute of Child Health, 1995.

<sup>110</sup> Sheffield Health Authority reports 7.1 percent for England and Wales whereas the North West Lancashire Health Authority reports 6.9 percent. By 2000, this figure had risen to 7.6 percent. See *Births, Perinatal and Infant Mortality Statistics 2000*, Health Regional Office and Health Authority of Usual Residence, Office of National Statistics, 2000.

<sup>111</sup> Sundhedsstyrelsen *Medicinsk fødselstatistik 1993. Sundhedsstatistikken*. (Copenhagen: Sundhedsstyrelsen, 1995) cited in Olga Basso, et al., “Change in Social Status and Risk of Low Birth Weight in Denmark: Population Based Cohort Study,” *British Medical Journal*, Vol. 315, No. 7121, December 6, 1997, pp. 1498-1502.

**Where Health Care Makes a Difference.** Although a population's general mortality is affected by many factors over which doctors and hospitals have little control, for those diseases and injuries modern medicine can affectively treat, it makes a big difference what country a patient lives in. For premature babies, for children born with spina bifida or for people who have cancer, a brain tumor, heart disease, chronic renal failure or almost any other serious illness, the chances of survival are best in the United States, where modern medical technology is most likely to be available and accessible. Take prostate cancer for example. In the United States, the male mortality rate for prostate cancer is slightly lower than in most other OECD countries, even though the incidence is apparently much greater. [See Figure 4-1.] Similarly, although the incidence of breast cancer is relatively high in the United States (arguably because of lifestyle and diet), the proportion of women who die from breast cancer is among the lowest of any industrial country. [See Figure 4-2]

**[Click here to see Figure 4-1 and Figure 4-2](#)**

**MYTH NO. 5: Countries with single-payer systems have access to the latest technology.**

One could argue that the “need” for technology varies from country to country. For example, the incidence of AIDS, and cancers such as breast and prostate are higher in the US than many developed countries.<sup>112</sup> [See Figure 5-1] The incidence of chronic renal failure may also vary in population groups or among developed countries.

However, every country needs certain critical, lifesaving technologies to diagnose and treat disease. Whether or not a country's population has access to these types of technology is a determinant of the effectiveness of that health care system. The ability and willingness of a given country's health care system to sufficiently invest in the development or purchasing of modern medical technology is an indication of a commitment to health care. By this measure, the United States fares better than its single-payer counterparts.<sup>113</sup>

**[Click here to see Figure 5-1](#)**

**Willingness to Adapt to New Technology.** The United States has not always been the first country to adopt new technology (even technology that works and is cost-effective). We do not always purchase the most technology. And we have not always made cost-effective choices among competing technologies. In 1970, before a dialysis benefit was extended to the entire population under Medicare, the U.S. treatment rate for patients with renal failure was on a par with Britain's and less than half that of Sweden and Denmark. Only after Medicare provided a virtual blank check did the U.S. treatment rate soar.<sup>114</sup>

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<sup>112</sup> Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

<sup>113</sup> Uwe Reinhardt, Peter S. Hussey and Gerard F. Anderson, “Cross-National Comparisons of Health Systems Using OECD Data, 1999, *Health Affairs*, Vol. 21, No. 3, May/June 2002, pp. 169-181, Exhibit 5.

<sup>114</sup> Jönsson, “What Can Americans Learn From Europeans?”, Table 8, p. 88.

How we treat kidney patients was also dictated by government reimbursement policies. Studies show that home dialysis is less expensive than dialysis in a hospital or clinic and, prior to the Medicare expansion about 40 percent of U.S. dialysis treatment was home-based. But because Medicare gave physicians incentives to avoid home-based dialysis, the rate fell to 12 percent by 1978. There is also evidence that kidney transplants are more cost-effective (over the long run) than dialysis. But because Medicare reimbursement policy favored dialysis, the United States was 12th of 20 developed countries in the percent of kidney patients treated by transplant in 1985.<sup>115</sup>

**The Politics of Medical Technology.** Overall, the best way to think about government policies toward technology is in terms of the politics of medicine. As the role of government expands, health care tends to evolve from a pro-technology phase to an anti-technology phase. In the first stage, government tends to spend on items perceived as under-provided by the market or by conventional health insurance. Thus, practically every less-developed country has used government funds to build at least one modern hospital, usually in the largest city, and to stock it with at least one example of each new technology — even though the vast majority of citizens lack basic medical care and public sanitation.

As government's role in medicine expands, more and more interest groups must be accommodated. In this stage, government policy tends to become anti-technology because the small number of people who need expensive technology are so heavily outnumbered by the many who desire amenities. Along the way, these general trends may be violated with respect to any particular technology because of the varied, even random, ways in which special interest pressures are exerted.

**Use of Modern Medical Procedures.** As a result of these political pressures, patients in countries with single-payer health systems usually have less access to critical medical procedures. Figure 5-2 compares the rate of use for high-tech medical procedures in Britain, Canada and the United States. As the figure shows:

- The use of coronary bypass surgery in United States is slightly more than three times as high per capita as in Canada and almost five times as high in Britain.
- The use of coronary angioplasty in United States is almost five times as high per capita as in Canada and almost ten times as high in Britain.
- The use of renal dialysis in United States is double that of Canada's and almost three times that of Britain's.

We analyze how the politics of medicine affects patients in Britain and Canada in more detail below.

**[Click here to see Figure 5-2](#)**

**Access To Medical Technology in Britain.** Even though Britain has been a pioneer in developing important medical technology, it has been slow to make that technology available to its own population. For example, Britain was the co-developer (with the United States) of

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<sup>115</sup> Ibid., pp. 88-89.

kidney dialysis, yet Britain consistently has had one of the lowest dialysis rates in all of Europe. According to British renal specialists, today the country has only enough kidney dialysis capability to meet 82 percent of the need.<sup>116</sup> This implies that among Britons in need of kidney treatment, one in eight does not receive it. Also, CT scanners, which are vital in the diagnosis and treatment of cancer and strokes, were invented in Britain. For years Britain exported about half the CT scanners used in the world. Yet, at the same time, the British government purchased very few scanners for the NHS, and even discouraged private gifts of CT scanners to the NHS.<sup>117</sup> As Figure 5-3 shows, Britain's National Health Service also suffers from an acute shortage of MRI scanning units that use magnetism instead of x-rays. Britain has (3.4 per million population compared to 16.0 per million in the U.S.) and even today has a meager number of CT Scanners (6.3 per million population compared to 26.9 in the U.S.)<sup>118</sup>

**[Click here to see Figure 5-3](#)**

A recent study by the Institute of Economic Affairs argues that one effect of this under-investment is that Britain has the lowest survival rates for victims of lung cancer and heart disease among European countries.<sup>119</sup> There is strong evidence of a general under use of other valuable therapies as well.<sup>120</sup> For instance:

- ACE inhibitors are only being prescribed to 20 percent to 30 percent of patients with heart failure.<sup>121</sup>
- Echocardiography – a diagnostic test that uses ultrasound waves to make images of the heart is not available to all patients; in some regions, only about one-third of British heart failure patients receive one even though it is low-cost and highly effective.<sup>122</sup>
- Not only is the survival rate for heart disease poor in Britain, the country also is not doing much to prevent it; the British Cardiac Society conducted a survey which found

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<sup>116</sup> David Green and Laura Casper, *Delay, Denial and Dilution: The Impact of NHS Rationing on Heart Disease and Cancer* (London: Institute of Economic Affairs, 2000).

<sup>117</sup> Goodman, *National Health Care in Great Britain*, pp. 96-104.

<sup>118</sup> Gerard F. Anderson and Jean Pierre Poullier, "Health Spending, Access and Outcomes: Trends in Industrialized Countries," *Health Affairs*, Vol. 18, No. 3, May/June 1999, p. 177; and Stephen Pollard, "European Health Care Consensus Group Paper," Centre for the New Europe, January 4, 2001.

<sup>119</sup> David Green and Laura Casper, *Delay, Denial and Dilution: The Impact of NHS Rationing on Heart Disease and Cancer* (London: Institute of Economic Affairs, 2000).

<sup>120</sup> For a framework of NHS goals for coronary care in Britain, see "National Service Framework for Coronary Heart Disease," Department of Health, London, 2000.

<sup>121</sup> Ibid. Also see Martin Eccles, Nick Freemantle, and James Mason, "North of England Evidence Based Development Project: Guideline for Angiotensin Converting Enzyme Inhibitors in Primary Care Management of Adults With Symptomatic Heart Failure," *British Medical Journal*, Vol. 316. No. 7141, May 2, 1998, pp. 1369-1375.

<sup>122</sup> David Green and Laura Casper, *Delay, Denial and Dilution: The Impact of NHS Rationing on Heart Disease and Cancer* (London: Institute of Economic Affairs, 2000).

the management of risk factors and preventive treatment to be far less than it should.<sup>123</sup>

Even though Britain has a much greater rate of cancer deaths every year than the U.S. (275 deaths per 100,000 in the UK compared to 194 deaths per 100,000 in the U.S.), the NHS spends much less on treatment: \$1.35 per capita on cancer services, compared to around \$24.35 per capita in the U.S.<sup>124</sup> Indeed, a World Health Organization study calculated that 25,000 people die unnecessarily in Britain each year because they are denied the highest quality cancer care.<sup>125</sup>

**Access To Modern Medical Technology in Canada.** While critics of the U.S health care system claim that we have too much technology, all the evidence suggests that Canada has too little — as a result of the conscious decisions of government officials. In terms of availability of advanced medical technology, Canada now ranks at the bottom of the twenty-nine members of the OECD in spite of the fact that Canadian spending on health care as a percentage of GDP is fifth in the world.<sup>126</sup> It is easy to understand why many Canadian doctors are complaining. Figure 5-3 compares the availability of modern medical technology in the United States, Britain and Canada. As the figure shows:

- On a per capita basis, the United States has over nine times as many magnetic resonance imaging (MRI) units as Canada.<sup>127</sup>
- The United States also has nearly four times as many lithotripsy units (to destroy kidney stones and gallstones with sound waves) per person.<sup>128</sup>
- In CT Scanners, the United States has more than three times as many per capita as Canada.<sup>129</sup>

In addition, much of the medical technology that is available in countries with national health insurance is archaic and ineffective. In Canadian hospitals, for example, 63 percent of all

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<sup>123</sup> Ibid.

<sup>124</sup> Nick Bosanquet, “A Successful NHS: from Aspiration to Delivery,” Adam Smith Institute, 1999, p. 10.

<sup>125</sup> Karol Sikora, “Cancer Survival in Britain,” *British Medical Journal*, Vol. 319, No. 7208, August 21, 1999, pp. 461-462.

<sup>126</sup> David Harriman, William McArthur and Martin Zelder, “The Availability of Medical Technology in Canada: An International Comparative Study,” Fraser Institute, Public Policy Source #28, August 6, 1999.

<sup>127</sup> Gerald F. Anderson and Jean-Pierre Poullier, “Health Spending, Access, and Outcomes: Trends In Industrialized Countries,” *Health Affairs*, Vol. 8, No. 3, 1999, p. 178-192.

<sup>128</sup> Stephen Pollard, “European Health Care Consensus Group Paper,” Centre for the New Europe, January 4, 2001. For a comparison of OECD countries, see David Harriman, William McArthur and Martin Zelder, “The Availability of Medical Technology in Canada: An International Comparative Study,” Fraser Institute, Public Policy Source #28, August 6, 1999.

<sup>129</sup> Gerald F. Anderson and Jean-Pierre Poullier, “Health Spending, Access, and Outcomes: Trends In Industrialized Countries,” *Health Affairs*, Vol. 8, No. 3, 1999, p. 178-192.

general X-ray equipment is severely outdated and half of all diagnostic imaging units require replacement.<sup>130</sup>

At the regional level, the difference in the level of access that Americans and Canadians have to such technologies is even more striking. Figure 5-4 shows the percentage of regional and community hospitals in British Columbia, Washington and Oregon that are equipped to provide specialized services. As the figure shows:<sup>131</sup>

- Angioplasty – a procedure to dilate obstructed coronary arteries – was only available at one regional hospital in British Columbia, while it was available in 80 percent of the facilities in Washington and Oregon.
- Cardiac catheterization facilities – which assess the extent of blockage in coronary arteries – were available at only 20 percent of the hospitals in British Columbia but were widely available south of the border.

**[Click here to see Figure 5-4](#)**

In addition to these services, there is also a wide difference in the availability of other technologies:<sup>132</sup>

- In the state of Washington, virtually 100 percent of community and regional hospitals have access to MRI units, compared to 20 percent in neighboring British Columbia.
- In the state of Oregon, 90 percent of community and regional hospitals have access to lithotripsy units, while there are none whatsoever in British Columbia.
- The median wait time in Canada for an MRI scan is about 12 weeks.

When the United States had a pure cost-plus health care system (from the end of WWII until the 1980s), technology tended to be adopted quickly because physicians — unconstrained by considerations of cost — found the technology useful. When the role of government was minimal, it was easier to acquire public funds where conventional insurance coverage was lacking (e.g., kidney dialysis and organ transplants). It is not surprising that the United States made great use of technological innovations.

Our experience in the future may be very different, however. In the United States we pay more for health care. We also get more. And what we get may save our lives. However, during the 1990s managed care organizations attempted to reduce the use of unnecessary use of technology and advanced procedures.<sup>133</sup> This may be partly responsible for the aforementioned

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<sup>130</sup> Canadian Association of Radiologists. Reported in Tom Arnold, “X-Ray Labs Dangerously Outdated,” *National Post*, Oct. 12, 2000.

<sup>131</sup> David Harriman, William McArthur and Martin Zelder, “The Availability of Medical Technology in Canada: An International Comparative Study,” Public Policy Source #28, Fraser Institute, 1999.

<sup>132</sup> Ibid.

<sup>133</sup> For example, areas with a high penetration of managed care experience fewer MRI scanning procedures, and have fewer MRI scanners. See Laurence C. Baker and Susan K. Wheeler, “Managed Care and Technology

backlash. But increasingly, our health care system is acquiring the characteristics of the health care systems of other countries, in which access to medical technology is determined by rationing and politics.<sup>134</sup>

**MYTH NO. 6: Countries with single-payer health care systems maintain a high quality of health care.**

Proponents of a single-payer system for the United States maintain it would “provide access to high quality care for everyone at an affordable price.”<sup>135</sup> However, if the experiences of countries that already have national health insurance are used as a guide, there is no reason to believe that claim.

In countries where the government controls health care resources, advanced, high quality treatment for many serious conditions is simply not available to all patients. As Figure 6-1 shows, British and Canadian hospitals perform only a fraction of the coronary bypass operations that U.S. hospitals perform, on a per capita basis, even though the demand for these operations is similar in all three countries. The same can be said of kidney dialysis and many types of cancer. Another way of assessing quality is to compare the incidence of a disease with resulting mortality from it. As figure 6-2 illustrates, the ratio of those who die of their breast cancer is almost one in two in New Zealand and the U.K. The corresponding figure for Germany and France is almost one in three. This contrasts sharply to the U.S. where only one in four of those diagnosed with breast cancer die of the disease.

**[Click here to see Figure 6-1 and Figure 6-2](#)**

The mortality ratio of prostate cancer is far lower in the United States than countries with national systems of single-payer health insurance. In the United Kingdom, 57 percent of those diagnosed with prostate cancer die of the disease. France and Germany are slightly better with 49 percent and 44 percent respectively. At 30 percent and 25 percent respectively, the death rate from prostate cancer in New Zealand and Canada are still well above the United States. [See Figure 6-3] In the United States slightly less than one in five succumbs to the disease. These cases are not isolated incidences. Anecdotal evidence from Canadian and British doctors as well as news reports are replete with examples of patient deaths and near-deaths, precisely because of government limits on access to technology and health care rationing.

**[Click here to see Figure 6-3](#)**

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Diffusion: The Case of MRI,” *Health Affairs*, Vol. 17, No. 5, September/October 1998, pp. 195-207. However, others disagree about whether managed care slows the diffusion of medical technology. See Michael Chernen, A. Mark Fendrick and Richard A. Hirth, “Managed Care And Medical Technology: Implications For Cost Growth,” *Health Affairs*, Vol. 16, No. 2, March/April 1997, pp. 196-206.

<sup>134</sup> See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America’s Health Care Crisis* (Washington, DC: Cato Institute, 1992).

<sup>135</sup> Don R. McCanne, “Would Single Payer Health Insurance Be Good for America?” Physicians for a National Health Program, March 27, 2000.



**Quality Problems in Canada.** Canadian federal health care payments to the provinces for Medicare, were greatly reduced in the years following the 1995-1996 budget. As a result, many hospitals were closed or consolidated with others because of a lack of funds needed to operate them.<sup>136</sup> The frustration felt by physicians who witnessed firsthand the deteriorating standards of care in Canada's hospitals is apparent in a survey conducted by the Canadian Medical Association. Among its findings:<sup>137</sup>

- Of physicians surveyed, only 27 percent rated their access to advanced diagnostics services as excellent, very good or good.
- Fewer than two-thirds rated their access to acute institutional care on an urgent basis as excellent, very good or good.

The Canadian press has featured many stories and anecdotes about those harmed by rationing or inadequate care. Among the cases:

- When Jeyaraanie Kaneshakumar, a pregnant woman in the Toronto suburb of Scarborough, collapsed at home from what turned out to be a brain hemorrhage, a referral service set up specifically to place critically ill patients who need specialized treatment couldn't find a hospital with an available bed for four hours. She died.<sup>138</sup>
- Dan Smith of Brampton, Ontario, was denied a double-lung transplant — his only hope for long-term survival — when his surgery was cancelled due to a shortage of intensive care unit (ICU) beds. The donated lungs — which had already arrived — were wasted although 30 other Ontarians were also waiting for lung transplants.<sup>139</sup>
- Twila Harris was diagnosed with colon cancer in November 1997, but her surgery was canceled four times because of a shortage of ICU beds. She finally received an operation the following March.<sup>140</sup>
- Kyle Martyn, a 5-year old boy taken to the emergency room with toxic shock, died from complications from having to wait three hours to see a doctor. The ER was backlogged because three-fourths of its beds were occupied with already-admitted patients awaiting transfer to acute-care beds. The acute-care beds were full of “bed

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<sup>136</sup> “Ottawa Eyes Cure for Health Funding,” *Toronto Star*, November 4, 1997.

<sup>137</sup> “Physician Resource Questionnaire,” Canadian Medical Association, January 1998 and Canadian Medical Association, “Canadians’ Access to Quality Health Care: A System in Crisis,” submitted to The House of Commons Standing Committee on Finance, August 31, 1998.

<sup>138</sup> Kellie Hudson, “Patient’s Death ‘Anomaly;’ Despite Futile Bed Search Agency Says System Works but Doctors Disagree,” *Toronto Star*, July 3, 1998.

<sup>139</sup> Vince Talotta, “The Sickness in Our Health System,” *Toronto Star*, February 6, 1999.

<sup>140</sup> David Trifunov, “A Deadly Waiting Game,” *Ottawa Citizen*, March 5, 1998.

blockers” — long-term care patients who had nowhere to go due to shortage of long-term care beds.<sup>141</sup>

**Quality Problems in Britain.** National Health Service officials are repeatedly embarrassed by popular press accounts that tell stories of poor quality. The BBC, reporting on a leaked government report, claimed that Britons are now more likely to be killed by an infection caught in hospital than by a car accident.<sup>142</sup> Like the Canadian press, the British press teems with reports of harm to patients caused by inadequate quality of care:

- Nine-year-old Tony Clowes, in a hospital to have the tip of his right index finger reattached after an accident with a bicycle chain, died under anesthetic from lack of oxygen when a breathing tube became blocked. The \$1.50 tube, designed for one use only, had been in use for six weeks. Evidence emerged that reusing the disposable tubes was common practice across the country to reduce costs.<sup>143</sup>
- George Mitchell, Sr., 73, who was undergoing treatment for bladder cancer at Scotland’s biggest cancer treatment center, was sent off in a taxi to a hotel with no access to medical care before the treatment was finished because the hospital was short of beds. Hospital officials said it was a mistake.<sup>144</sup>
- Five times as many patients in England and Wales died from receiving the wrong medicine in 2000 as a decade earlier. Britain’s Audit Commission said hospital pharmacies don’t have the computer systems needed to keep pace with modern medicine.<sup>145</sup>

**MYTH NO. 7: Countries with single-payer health insurance systems have been more successful than the United States in controlling health care costs.**

The United States spends more on health care than any other country in the world, both in dollars per person and as a percent of gross domestic product (GDP). Does this mean that the United States, with a predominantly private system, is less able to control health care spending than are developed countries with national health insurance? Not necessarily.

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<sup>141</sup> “The Boy Who Ran Out of Time,” *Toronto Star*, December 12, 1999.

<sup>142</sup> BBC Online News, Watchdog Healthcheck (Hospitals) January 15, 2001. Research by the Public Health Laboratory Service and the London School of Hygiene and Tropical Medicine set the cost of hospital-acquired infections at £1 billion. The National Audit Office is the source of the estimate that as many as 5,000 people die each year of the infections. See “Hospital Infections Cost £1 Billion a Year,” BBC News, January 18, 2000; and “NHS Bugs ‘Kill 5,000 a Year,’” BBC News, February 17, 2000.

<sup>143</sup> Olga Craig, “How Could Someone Look Down at My Little Boy and End His Life, in a Hospital, Where He Should Be Safe?” *Sunday Telegraph*, August 19, 2001.

<sup>144</sup> Aine Harrington, “Beatson Put Dying Man in a Hotel; Son Tells of Father Being Moved ‘from Pillar to Post,’” *Glasgow Herald*, November 16, 2001.

<sup>145</sup> Lorna Duckworth, “Obsolete Systems Blamed for Rise in NHS Drug Deaths,” *Independent*, December 18, 2001.

As we shall see, international comparisons of health care spending are difficult, not least because of differences in the measuring techniques used by different countries.<sup>146</sup> But first we should note that the United States is wealthier than other countries. Almost without exception, international comparisons show that wealthier countries spend a larger proportion of their GDP on health care.<sup>147</sup> In his classic 1977 and 1981 studies, health economist Joseph Newhouse found that 90 percent of the variation in health care spending among developed countries is based on income alone.<sup>148</sup> This should give pause to anyone who believes that the United States will significantly lower health care spending by adopting the system or institutions of some other country. Apparently, as people have more income, they spend more on health care, whether their spending takes place through the market, the political system or quasi-public institutions.

Some believe that countries with national single-payer health insurance have a coercive “advantage” the United States does not — they can deny access to care. In those countries the government can, in principle, limit health care dollars and force hospitals and doctors to ration services. But that power is more apparent than real, and politicians who exercise it risk being replaced by their competitors. In the political systems of other countries, just as in the United States, there is unrelenting pressure to spend more on health care

**The United States vs. Other Developed Countries.** Most international statistics on health care spending are produced by the Organization for Economic Cooperation and Development (OECD). However, OECD statistics are not always reliable because the various countries use widely differing methods for reporting costs.<sup>149</sup> Because there are no effective guidelines for international comparability in health care, some countries include services that others do not.<sup>150</sup> For instance, the OECD defines health care expenditures as including nursing home care. But while Germany includes nursing home care as part of total health expenditures, Britain does not.<sup>151</sup> Some countries count hospital beds simply by counting metal frames with

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<sup>146</sup> For a discussion of the problems associated with international comparisons of health care spending, see Adrian Towse and Jon Sussex, “‘Getting U.K. Health Care Expenditure Up to the European Union Mean’ — What Does That Mean?” *British Medical Journal*, Vol. 320, No. 7235, March 4, 2000, pp. 640-42; and Panos Kanavos and Elias Mossialos, “The Methodology of International Comparisons of Health Care Expenditures: Any Lessons for Health Policy?” London School of Economics and Political Science, LSE Health, Discussion Paper No. 3, April 1996, available at [http://www.lse.ac.uk/Depts/lsehsc/papers/Discussion\\_Papers/dp3.pdf](http://www.lse.ac.uk/Depts/lsehsc/papers/Discussion_Papers/dp3.pdf).

<sup>147</sup> Pedro P. Barros, “The Black Box of Health Care Expenditure Growth Determinants,” *Health Economics*, Vol. 7, No. 6, September 1, 1998, pp. 533-544. See Further, of two countries with the same GDP, the country with the fastest growing economy will likely have the higher expenditure. R. Mark Wilson, “Medical Care Expenditures and GDP Growth in OECD Nations,” *American Association of Behavioral and Social Sciences Journal*, Vol. 2, Fall 1999, pp. 159-171.

<sup>148</sup> Joseph Newhouse, “Medical Care Expenditure: a Cross-National Survey,” *Journal of Human Resources*, Vol. 12, 1977, pp. 115-25; and Joseph Newhouse et al., “Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance,” *New England Journal of Medicine*, December 17, 1981.

<sup>149</sup> Kanavos and Mossialos, “The Methodology of International Comparisons of Health Care Expenditures: Any Lessons for Health Policy?”

<sup>150</sup> “OECD health systems: facts and trends 1960-1991,” Organization for Economic Cooperation and Development, 1993.

<sup>151</sup> Towse and Sussex, “‘Getting UK Health Care Expenditure Up to the European Union Mean’ — What Does That Mean?”

mattresses, whether or not they are in use. In others, a “bed” is counted only if it is staffed and operational.<sup>152</sup>

Although the percentage of the population admitted as inpatients in the United States (12.2) is below the OECD average of 16 percent, the U.S. figures exclude procedures performed in outpatient facilities while OECD figures most likely include these surgeries.<sup>153</sup> In addition, payments made in the “informal health sector” (under-the-table payments, common in many countries) are generally missed in official estimates.<sup>154</sup>

Figure 7-1 shows the average annual increase in the percentage of per capita spending on health care by OECD countries between 1960 and 1998 after an effort to develop more accurate health care spending measurements among OECD countries. As can be seen, the countries of the OECD have been no more successful than the United States in controlling costs and many have been far less successful:<sup>155</sup>

- During the 1990s, health care spending in all but three of 15 OECD countries studied grew at about the same rate as the United States or higher.
- The real rate of expenditures on hospitalization and physician services actually decreased in the United States in the 1990s (2.5 percent and 1.0 percent, respectively), well below the OECD median for both categories.

**[Click here to see Figure 7-1](#)**

These results are surprising considering that the United States has far less rationing of care and offers greater access to medical technology. Further, the United States confronts a wider range of health problems than most other OECD countries. For example, the incidence of AIDS is almost 10 times more prevalent in the United States than in Canada and obesity is also a greater problem in the U.S. than in other developed countries. [see Figure 7-2].<sup>156</sup> These factors, of course, put greater demand on the U.S. health care system.

**[Click here to see Figure 7-2](#)**

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<sup>152</sup> Martin Hensher, Nigel Edwards and Rachel Stokes, “The Hospital of the Future: International Trends in the Provision and Utilisation of Hospital Care,” *British Medical Journal*, Vol. 319, No. 7213, September 25, 1999, pp. 845-848.

<sup>153</sup> Gerard F. Anderson, “In Search of Value: An International Comparison of Cost, Access, and Outcomes,” *Health Affairs*, Vol. 14, No. 6, November/December 1997, p.164.

<sup>154</sup> Mark V. Pauly, “U.S. Health Care Costs: The Untold True Story,” *Health Affairs*, Vol. 12, No. 3, Fall 1993, pp. 152-59; and Kanavos and Mossialos, “The Methodology of International Comparisons of Health Care Expenditures: Any Lessons for Health Policy?”

<sup>155</sup> Gerard F. Anderson, “Health Spending and Outcomes: Trends in OECD Countries, 1960-1998,” *Health Affairs*, May/June 2000, pp. 150-157.

<sup>156</sup> Gerald F. Anderson, “Health Spending, Access, and Outcomes: Trends In Industrialized Countries,” *Health Affairs*, May/June 1999, p. 183” with “Gerald F. Anderson and Jean-Pierre Poullier, “Health Spending, Access, and Outcomes: Trends In Industrialized Countries,” *Health Affairs*, Vol. 18, No. 3, May/June 1999, p. 183.

**The United States vs. Canada.** During the 1990s Canada achieved an impressive feat by limiting the real rate of growth in health care to 1.7 percent per year. By contrast, the rate of growth in health care spending in the United States was equal to the OECD median of 3.0 percent per year.<sup>157</sup> However, Canada was able to hold the line on spending by cutting funding for services in ways that caused people to suffer.

In 1999, the United States spent 12.9 percent of GDP, or \$4,358 per person, on health care. By contrast, Canada spent 9.3 percent of GDP, or \$2,463 per person – only 57 percent of the U.S. number.<sup>158</sup> Here again, the spending figures are almost certainly not complete. In both Canada and the United States, the costs of administering government health care spending are largely hidden. In addition, there are larger, systemic differences in the two countries.<sup>159</sup>

- The Canadian figures do not include the opportunity cost of capital spending to the same extent that the U.S. figures do.
- The United States spends far more on research and development than Canada. The U.S. spending results in technological innovations that benefit Canada and the rest of the world.
- The U.S. population is slightly older, and older people inevitably consume more health care.
- According to one study, correcting for these differences between the two countries cuts in half the gap in the fraction of GDP spent on health care.<sup>160</sup>

In addition to aches and obesity, the United States has other demands on its health care system that Canada does not. For example, the U.S. male homicide rate is three times that of Canada.<sup>161</sup> The United States also has health care costs related to war injuries (including those of Vietnam veterans). And as Figure 7-3 illustrates, teenage girls, who are more likely to have premature babies and other complications stemming from pregnancy, become pregnant almost twice as often in the United States as in Canada, and give birth nearly two and one-half times as often.<sup>162</sup>

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<sup>157</sup> Uwe Reinhardt, Peter S. Hussey and Gerard F. Anderson, “Cross-National Comparisons of Health Systems Using OECD Data, 1999,” *Health Affairs*, Vol. 21, No. 3, May/June 2002, 169-181.

<sup>158</sup> Both figures are expressed in U.S. dollars. Ibid.

<sup>159</sup> Jacques Krasny and Ian R. Ferrier, “A Closer Look at Health Care in Canada,” *Health Affairs*, Summer 1991, pp. 152-58. See a critique of this approach in Daniel R. Waldo and Sally T. Sonnefeld, “U.S./Canadian Health Spending: Methods and Assumptions,” *Health Affairs*, Summer 1991, pp. 159-64.

<sup>160</sup> Jacques Krasny, *The Canadian Health Care System in Perspective* (Morristown, N.J.: Bogart Delafield Ferrier, Inc., 1989).

<sup>161</sup> Don B. Kates, “Guns and Public Health: Epidemic of Violence or Pandemic of Propaganda?” *Tennessee Law Review*, Vol. 61, 1994, pp. 513-596.

<sup>162</sup> Susheela Singh and Jacqueline E. Darroch, “Adolescent Pregnancy and Childbearing: Levels and Trends in Developing Countries,” Alan Guttmacher Institute, *Family Planning Perspectives*, Vol. 32, No. 1, January/February 2000.

**[Click here to see Figure 7-3](#)**

Another example of how the two systems differ is the cost control measures implemented by Canada in the 1990s, including draconian cuts in facilities and services.

- The Canadian federal government reduced block grants to provinces for health care as a percentage of GDP in 1986 and again in 1989, froze them at 1989-90 levels through 1994-95, then made further cuts through the last half of the 1990s.<sup>163</sup>
- The provincial governments reduced global budgets (already in existence), which limited the funds available to hospitals, began limiting the total expenditures for physicians' fees, severely limited the purchase of new technology, and removed some services from coverage by provincial insurance plans.<sup>164</sup>
- Many smaller hospitals were closed — 50 in Saskatchewan, for example — and the number of hospital beds available nationwide was reduced from 6.6 per thousand population in 1987 to 4.1 in 1995.<sup>165</sup>

Unfortunately, these reductions in the availability of medical services had more to do with budgetary shortfalls than lack of medical need. As we have seen, when medical resources are allocated based on limited global budgets, patients often must do without needed care. As we shall see below, satisfaction with the Canadian health care system has fallen throughout the 1990s as waiting lists have increased.

**MYTH NO. 8: Countries with single-payer systems of national health insurance hold down costs by operating more efficient health care systems.**

Advocates of single-payer health insurance often point to the low level of health care spending in countries with national health insurance as “proof” of efficient management. But cheap is not the same as efficient. By and large, countries that have slowed the growth of health care spending have done so by *denying services*, not by using resources more efficiently. In Britain, it is not unusual to find a modern laboratory and an antiquated radiology department in the same hospital. Nor is it unusual to find one hospital with a bed shortage near another with a bed surplus. Where excellence exists, it usually is distributed randomly — often the result of the energy and enthusiasm of a few isolated individuals rather than decisions by hospital managements.

How much does it cost a hospital to perform an appendectomy? Outside the United States, it is doubtful that any public hospital could provide the answer. Nor do government-run

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<sup>163</sup> Gwen Gray, “Access to Medical Care under Strain: New Pressures in Canada and Australia,” *Journal of Health Politics, Policy and Law*, Vol. 23, No. 6, December 1998, pp. 905-47.

<sup>164</sup> Ibid.

<sup>165</sup> Canada's acting director of health insurance said the government was aiming to bring the ratio down to two beds per thousand. See Suzanne Rene Posschl, “Northern Plights,” *Hospitals & Health Networks*, Vol. 71, No. 17, September 5, 1997, pp. 56-60.

hospitals typically keep records that would allow anyone else to find out.<sup>166</sup> In organizational skills and managerial efficiency, the public hospitals of other countries lag far behind hospitals in the United States. Nor is it easy for other countries to change course. One reason there is so much inefficiency abroad is precisely because health care is political. Health economist Alain Enthoven observes that, because health care in Britain is so politicized, “it is more difficult to close an unneeded [British] hospital than an unneeded American military base.”<sup>167</sup>

**Hospital Bed Management in Britain.** Britain has about 20 percent fewer inpatient hospital beds per capita than the US does and about 44 percent fewer than the OECD median of 4.3 per 1000 population.<sup>168</sup> Partly as a result of this reduced capacity, Britain has experienced a persistent shortage of hospital beds that in recent years has reached critical proportions. In addition to a shortage of beds, Britain also suffers from staffing shortages needed to operate all available beds as well as an inappropriate utilization of the beds. The statistics are quite telling:

- An estimated 500,000 surgeries were cancelled in the past five years due to a shortage of NHS hospital beds.<sup>169</sup>
- While more than 1 million people wait for medical treatment in Britain, close to 30,000 beds are empty on any given day in Britain (16 percent of 186,091).<sup>170</sup>
- By some estimates, an additional 15 to 16 percent of British hospitals beds are filled with patients who do not belong in a hospital at all.<sup>171</sup>

An inappropriate mix of hospital beds forces many patients to wait for admission (and treatment) while others wait for discharge to an appropriate facility.<sup>172</sup> Much of the crisis is attributed to “bed blockers”— patients in acute care beds who should be in nursing homes, geriatric wards or some form of long-term care. The official estimates of bed blocking are relatively low and tend to understate the problem.<sup>173</sup> However, anecdotal evidence in the popular press points to a more widespread problem.<sup>174</sup> For example:

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<sup>166</sup> For Britain, see the discussion in Alain C. Enthoven, “Internal Market Reform of the British Health Service,” *Health Affairs*, Fall 1991. A Canadian observer reports that “Ontario hospitals lag at least a decade behind their U.S. counterparts in expenditure tracking and management information systems.” See C. David Naylor, “A Different View of Queues in Ontario,” *Health Affairs*, Vol. 10, No. 3, Fall 1991, p. 112.

<sup>167</sup> Enthoven, “Internal Market Reform of the British Health Service,” p. 62. 1991.

<sup>168</sup> Gerard Anderson and Peter Sotir Hussey, “Comparing Health System Performance in OECD Countries,” *Health Affairs*, Vol. 20, No. 3 May/June 2001, [Exhibit 2], p. 222.

<sup>169</sup> Valerie Elliott, “‘Bed blockers’ Farmed Out for B&B Recovery,” *The Times* (London), February 9, 2002.

<sup>170</sup> The U.S. occupancy rate of approximately 65 percent is far below Britain’s rate of 84 percent. See “Publication of Latest Statistics on Bed Availability and Occupancy for England, 2000-01,” Department of Health Press Release, reference 2001/0429, September 19, 2001.

<sup>171</sup> For example, see Karen Allen, “Analysis: How to Beat NHS Gridlock,” BBC News, October 10, 2001 and “Bed-Blocking a Massive Problem,” BBC News, April 17, 2002.

<sup>172</sup> For example in 2000 the occupancy rate for geriatric beds – the type needed to relieve bed blocking – was 90 percent, while only 60 percent of maternity beds were occupied. See “Publication of Latest Statistics on Bed Availability and Occupancy for England, 2000-01,” Department of Health Press Release, reference 2001/0429, September 19, 2001.

<sup>173</sup> For example, a BBC report claimed that on any given day, around 6,000 (out of a total 186,000 hospital beds) are occupied by “bed blockers.” Two-thirds of these are elderly patients in need of less-expensive community facilities.

- In an attempt to free more hospital beds, the Department of Health launched a pilot project that sends patients to recover at bed & breakfast establishments in the country side.<sup>175</sup>
- A survey of a hospital in Coventry found that three-fourths of patients occupying a bed no longer needed acute care but had nowhere suitable to go.<sup>176</sup>
- Nicola Sturgeon, a member of the Scottish Parliament, reported that 10 percent of acute care beds in Scotland are “blocked” by geriatric patients needing residential care.<sup>177</sup>

The true nature of how many beds are occupied by patients no longer needing acute care may never be known.<sup>178</sup>

**Efficiency Measure: Hospital Length of Stay.** One widely used measure of hospital efficiency is average length of stay (LOS).<sup>179</sup> Hospital-related services are the largest component of health care costs in most countries.<sup>180</sup> Consequently, using an acute care hospital bed for a patient awaiting tests or non-emergency care, or for a geriatric patient awaiting transfer to long-term or home care, or simply because the hospital has not got around to discharging that patient is not an efficient use of resources, particularly when there are lengthy waiting lists for hospital admission. In general, the more efficient the hospital, the more quickly it will admit and discharge patients.<sup>181</sup> By this standard, U.S. hospitals are far in front of their international

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See Karen Allen, “Analysis: How to Beat NHS Gridlock,” BBC News, October 10, 2001 and “Bed-Blocking a Massive Problem,” BBC News, April 17, 2002.

<sup>174</sup> Analysis of government statistics for 2000-01 show some hospitals had 15 per cent of their beds occupied by patients who are well enough to leave. See Nigel Hawkes and Helen Rumbelow, “Thousands Losing the Health Lottery in Sick Hospitals,” *The Times* (London) February 20, 2002.

<sup>175</sup> Valerie Elliott, “‘Bed blockers’ Farmed Out for B&B Recovery,” *The Times* (London), February 9, 2002.

<sup>176</sup> Karen Hambridge, “Shocking Truth Behind Lack of Hospital Beds; Wards Full of Patients Who Shouldn’t be There,” *Coventry Evening Telegraph*, June 30, 2001.

<sup>177</sup> Scottish Parliament Official Report, Vol. 9, No. 2, November 16, 2000.

<sup>178</sup> For example, the best estimates, including those of the shadow health spokesman for the Conservative party, Dr Liam Fox, is that up to 15 percent of the beds are filled with “bed blockers.” See Jenny Booth, “Scandal of Stranded Hospital Pensioners Labour Accused Over the Shortage of Money and Nursing Home Places that Leaves Patients Blocking NHS Beds, Reports Jenny Booth,” *Sunday Telegraph* (London), August 12, 2001.

<sup>179</sup> See, for example, “The New NHS, Modern and Dependable: A National Framework for Assessing Performance,” Department of Health, 1998, Attachment A.iv. Efficiency, and Attachment B.xviii, available at <http://www.doh.gov.uk/newnhs/consdoc/info.htm>; Harald Buhaug, “Length of Stay in General Hospitals,” at <http://www.valm.lv/orahs99/Abstr24.html>; and Marni D. Brownell and Noralou P. Roos, “Variation in Length of Stay as a Measure of Efficiency in Manitoba Hospitals,” *Canadian Medical Association Journal*, Vol. 152, No. 5, March 1, 1995, pp. 675-82.

<sup>180</sup> In the United States, hospitalization accounts for 42.2 percent of health costs.

<sup>181</sup> The actuarial firm Milliman & Robertson is the market leader in devising guidelines called the “Length of Stay Efficiency Index,” where average length of stay is compared by diagnosis related group (DRG) code and other factors, available at <http://www.op.net/~jcookson>. For a discussion of length of stay, see Helen Lippman, “The Bottom Line on Length of Stay,” *Business and Health*, April 2001.



counterparts.<sup>182</sup> [See Figure 8-1]. The average length of hospital stay in the United States is 7.8 days compared to 14.3 days in Germany, 15.5 in Australia, 32.5 in the Netherlands and 43.7 in Japan. Whereas patients from other countries routinely convalesce in a hospital, patients in the United States are more likely to recover at home after a brief stay.

**[Click here to see Figure 8-1](#)**

**Cost Comparison: Britain’s NHS vs. United States HMOs.** An analysis comparing the costs and performances of the NHS and the large U.S. health maintenance organization Kaiser Permanente concluded that the per capita costs of the two systems were similar. However, the analysis found that Kaiser provided its members with more comprehensive and convenient primary care services and much more rapid access to specialists and hospital admissions. After adjustments for differences between countries, the NHS costs were \$1,764 per capita and the Kaiser costs \$1,951.<sup>183</sup> However, as Figure 8-2 shows:

- Kaiser had two and one-half times as many pediatricians, twice as many obstetricians-gynecologists and three times as many cardiologists per enrollee as the NHS.
- After referral, waiting times to see a specialist are more than six times as long in the NHS.
- Ninety percent of Kaiser patients wait less than three months for non-emergency hospital admission; one-third of NHS patients wait more than five months.

**[Click here to see Figure 8-2](#)**

One of the most striking differences between the two health systems was in the length of stay in hospitals. Kaiser had 270 acute care bed days per 1,000 population, whereas NHS patients stayed in the hospital more than three times as long – an average of 1,000 acute care bed days per 1,000 population.<sup>184</sup> In summary, the study found:

The widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment are not supported by this analysis. Kaiser achieved better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition and greater investment in information technology.

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<sup>182</sup> Gerard F. Anderson and Jean-Pierre Poullier, “Health Spending, Access, and Outcomes: Trends in Industrialized Countries,” *Health Affairs*, Vol. 18, No. 3, May/June 1999 (Exhibit 3).

<sup>183</sup> Richard G.A. Feachem, Neelam K. Sekhri and Karen L. White, “Getting More for Their Dollar: A Comparison of the NHS with California’s Kaiser Permanente,” *British Medical Journal*, Vol. 324, No. 7330, January 19, 2002, pp. 135-143.

<sup>184</sup> *Ibid.* The authors noted, “There is ample evidence that reduced length of hospital stay does no harm and, in view of the risk of staying in hospital, may be beneficial,” p.143.

**Administrative Inefficiency in Britain.** Britain also experiences wide differences in the cost of services within the NHS. Medical costs vary by as much as 58 percent between England's most expensive hospitals and its least expensive ones. For example:<sup>185</sup>

- The cost of a hip replacement varies from \$2,616 to \$9,264 — a difference of 254 percent.
- The cost of a vasectomy ranges from \$211 to over \$1,427 — a difference of 550 percent.

The cheapest hospital trust in England has costs that are 30 percent less than the average for the country, while the most expensive trust has costs that are 60 percent above the average.<sup>186</sup>

**Inefficiency in Canada.** In Canada, a large percentage of acute care hospital beds are being used for patients who do not need acute care. Research shows that between 7 percent and 51 percent of adult admissions and from 27 percent to 59 percent of hospital days do not require acute care, although most do need some form of supervised care.<sup>187</sup> For example:

- The Manitoba Centre for Health Policy found 23 percent of bed days spent by short-stay patients did not require a hospital (acute care) setting.<sup>188</sup>
- Further, studies of Winnipeg hospitals found that 40 percent of the acute care beds were used by only a few patients, each staying more than 30 days.<sup>189</sup>

Although the less efficient use of acute care beds generally is attributed to a lack of other facilities, especially for patients needing long-term care, global budgets create incentives to keep patients in the hospital:

- Physicians find it easier and faster to arrange a diagnostic test like a CT scan or stress test for an inpatient, and easier to locate the results because they are in the patient's chart.<sup>190</sup>

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<sup>185</sup> Linda Beecham "Cost of NHS Operations Varies Widely," *British Medical Journal*, Vol. 317, No. 7169, November 14, 1998, p. 1393.

<sup>186</sup> Ibid.

<sup>187</sup> Carolyn DeCoster, Sandra Peterson and Paul Kasian, "Alternatives to Acute Care," Manitoba Centre for Health Policy and Evaluation, July 1996.

<sup>188</sup> Sharon Bruce et al., "Acuity of Patients Hospitalized for Medical Conditions at Winnipeg Acute Care Hospitals," Manitoba Centre for Health Policy and Evaluation, June 2001.

<sup>189</sup> Carolyn DeCoster and Anita Kozyrskyj, "Long-Stay Patients in Winnipeg Acute Care Hospitals," Manitoba Centre for Health Policy and Evaluation, September 2000.

<sup>190</sup> DeCoster, Peterson and Kasian, "Alternatives to Acute Care."

- Hospital managers, assigned “global budgets” find it less expensive when a bed is occupied by a long-term patient needing mostly “hotel” services than when it is occupied by a patient who is there for what may be high-cost treatment.<sup>191</sup>

**Private Solutions for the Problems of National Health Insurance.** Several European countries with single-payer health care systems have discovered the value of competition, albeit sometimes reluctantly. European Union regulations that force reductions in taxes have driven some countries to experiment with “internal markets” that introduce private health care providers within the public-financed system. One example is in Stockholm, the capital of Europe’s most heavily socialized welfare state. After first allowing competition by contractors for non-medical services, the city’s Health Services Council began privatizing all primary care in 1998 and sold St. Göran’s, one of Sweden’s largest hospitals, to a private company in 1999. Most of the funding still comes from the government, which is getting far more for its money than before. A study of the privatization program found:<sup>192</sup>

- The cost per consultation in private practices compared to public hospital outpatient clinics ranges from 13 percent lower in general surgery, internal medicine and dermatology, to 17 percent lower among ear, nose and throat specialists, to 28 percent lower in ophthalmology.
- At St. Göran’s costs for lab and x-ray services fell by 50 percent and overall costs were down 30 percent.
- Private nursing home costs were 30 percent lower.
- St. Göran’s is on the average treating 100,000 more patients each year that it did as a public hospital, even though it uses fewer resources.

As a result of the experiment, the Health Services Council now plans to sell all seven remaining public acute care hospitals in Stockholm to private investors.

**MYTH NO. 9: Countries with single-payer systems eliminate unnecessary medical care.**

A frequent criticism of the U.S. health care system is that it is wasteful because a considerable number of procedures are “unnecessary.” For example, in 1989 Robert Brook of the RAND Corporation asserted that “perhaps one-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without.”<sup>193</sup> In support of this

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<sup>191</sup> Raisa Deber, a professor of health policy at the University of Toronto, described this incentive thus: “Since hospitals have budgets to follow, they may have to ration the use of expensive procedures even though this might result in waiting lists.” Raisa Deber, “Canada’s Healthcare System,” presentation for the Maine Development Foundation, 2000.

<sup>192</sup> A. Wess Mitchell, “Sweden Edges Toward Free-Market Medicine,” National Center for Policy Analysis, Brief Analysis No. 369, August 31, 2001.

<sup>193</sup> Robert H. Brook, “Practice Guidelines and Practicing Medicine: Are They Compatible?” *Journal of the American Medical Association*, Vol. 262, No. 21, December 1, 1989, p. 3028. The Rand Corporation has published a number of studies over the past decade examining the appropriateness of various medical and surgical procedures.

contention, RAND researchers pointed to wide variations in 123 medical procedures for Medicare patients in various parts of the country.<sup>194</sup> The rate at which the procedures were performed varied by as much as 6, 7 or 8 to 1, with no apparent explanation. Areas that were high in performing one procedure were often low in performing another. Other studies have found similar results.<sup>195</sup> But knowing there are variations does not reveal whether some patients are being shortchanged and others over-treated.<sup>196</sup>

**The RAND study of unnecessary care.** A subsequent RAND study collected medical records for 5,000 Medicare patients treated in 1981 and convened a panel of experts to judge the appropriateness of three procedures.<sup>197</sup> The results showed that in slightly more than a fifth of the cases, the procedure performed was judged inappropriate and therefore unnecessary. For carotid endarterectomy (the removal of plaque in major arteries to the brain), the procedure was judged appropriate only about one-third of the time.<sup>198</sup> National media widely reported these results, and they became Exhibit A in building the case for the managed care revolution during the 1990s. But a closer examination reveals there was more going on than first meets the eye. For example, why did RAND need to convene a panel of experts? The reason was that researchers could not answer questions about appropriateness by merely consulting the medical literature. Once the experts were convened, they were far less unified than media reports suggested.

**Reexamining the Evidence of Unnecessary Care.** The classifications depicted in Table 9-1 were decided by a majority vote. Table 9-2 presents a different way of looking at the RAND study, showing the number of times that 7 of 9 experts agreed. (The two opinions ignored are the two most extreme views, on either side of the middle.) As the table shows, 7 of the 9 found only 12 percent of the procedures to be inappropriate, not 22 percent. And even this degree of

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For a summary and selected bibliography of Rand research, see "Assessing the Appropriateness of Care," Rand Corporation, Health Research Highlights, RB-4522, 1998. The methodology used in the studies is described by Robert H. Brook, "The RAND/UCLA Appropriateness Method," in K.A. McCormick, S.R. Moore and R.A. Siegel, eds., "Clinical Practice Guidelines Development: Methodology Perspectives," available as Rand Reprint RP-395, 1995.

<sup>194</sup> A summary of RAND Corporation research may be found in Mark R. Chassin, ed., *The Appropriateness of Selected Medical and Surgical Procedures* (Ann Arbor, Mich.: Health Administration Press, 1989).

<sup>195</sup> See, for example, John E. Wennberg, "Understanding Geographic Variations in Health Care Delivery" *New England Journal of Medicine*, Vol. 340, No.1, January 7, 1999, pp. 52-53.

<sup>196</sup> John W. Dawson, "Practice Variations: a Challenge for Physicians," *Journal of the American Medical Association*, Vol. 258, No. 18, November 13, 1987, p.2570.

<sup>197</sup> Chassin, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures," *Journal of the American Medical Association*, Vol. 258, No. 18, November 13, 1987, pp.2533-2537; Jacqueline Kosecoff, et al., "Obtaining Clinical Data on the Appropriateness of Medical Care in Community Practice," *Journal of the American Medical Association*, Vol. 258, No. 18, November 13, 1987, pp.2538-2542; Chassin, et al., "How Coronary Angiography is Used: Clinical Determinants of Appropriateness," *Journal of the American Medical Association*, Vol. 258, No. 18, November 13, 1987, pp.2543-2547.

<sup>198</sup> "Appropriateness" was not determined by Monday morning quarterbacking. It was based on indications prior to the procedure. A procedure was judged appropriate if the expected benefit (increased life expectancy, relief of pain, etc.) exceeded the expected negative consequences (mortality, morbidity, etc.) by a margin sufficient enough to justify the procedure.

consensus is misleading. In the RAND study, each expert initially expressed a personal judgment. Then they met for discussions in which group pressure favored consensus and members often changed their minds.<sup>199</sup> Indeed, the most remarkable fact about the RAND study was that even with all of those efforts to arrive at a definitive judgment, 7 of 9 experts could agree less than half the time that the procedures were either definitely appropriate or definitely inappropriate.

**[Click here to see Table 9-1 and Table 9-2](#)**

**Evidence Today.** What inferences can we draw from a study of medical records in 1981 for the practice of medicine today? Since then, there have been major changes in the way hospitals are run. For better or for worse, American physicians today are scrutinized more closely by peers and third-party payers than physicians anywhere else in the world. This scrutiny coupled with the prospect of malpractice liability limits the likelihood of procedures that promise more harm than good. It still may happen in HMOs as well as fee-for-service insurance plans, but it is much less likely than two decades ago. The results of three studies of surgery in New York State in 1990 are consistent with this judgment. In all three cases, the fraction of inappropriate procedures was judged to be 4 percent or less.

**Medical Art vs. Medical Science.** Within the past two decades there have been clean advances on medical science. Despite that fact, there remain wide differences of opinions among practicing physicians about the appropriateness of care.

More than half the procedures in the RAND study [Table 9-1] fell between the do-no-harm standard and the conservative standard of performing a procedure only if it is definitely appropriate. In the New York studies, the “uncertain” range was as high as 38 percent. These findings imply an enormous range over which discretion can be exercised and still fall within the bounds of good science and medical ethics. They also imply that often there is no objective, “right” answer and that the practice of medicine is often as much of an art as it is a science. Thus, the debate about unnecessary or inappropriate treatments is far from over.<sup>200</sup> Put crudely, these studies point to the prospect of a health plan being able to make a great deal of money by substantially reducing the number of procedures performed without violating any professional code of conduct.

**The Find-No-Harm Approach to Identifying Inefficient Care.** Researchers at Milliman & Robertson (M&R), a leading actuarial consulting firm, have taken a different approach to this issue. Rather than attempting to determine whether procedures are appropriate, M&R analysts have sought to determine whether fewer days in a hospital can cause detectable harm. If they could detect none, M&R concluded that the extra days represented unnecessary (read: inefficient) care.

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<sup>199</sup> “Disagreement among the panelists diminished following their discussions, but by no means disappeared.” Chassin, *The Appropriateness of Selected Medical and Surgical Procedures*, p. 8.

<sup>200</sup> John W. Dawson, “Practice Variations: a Challenge for Physicians,” *Journal of the American Medical Association*, Vol. 258, No. 18, November 13, 1987, p.2570. Also see David H. Mark, “Variations and Inappropriateness Are Not the Same,” *Journal of the American Medical Association*, Vol. 263, No. 23, June 20, 1990, pp.3149-3150.

For example, take groups of similar patients hospitalized for two, four and six days for a specific condition. Suppose medical records show that the health outcomes for patients with a two-day hospital stay are no different than the outcomes for patients with four- or six-day stays. M&R would conclude that the four-day stay involved two days of unnecessary hospitalization and the six-day stay involved four days of unnecessary hospitalization. Using a similar methodology, suppose people treated as outpatients fared just as well as people hospitalized for the same condition. Then M&R would conclude that all the inpatient days were unnecessary. Proceeding in this way, M&R estimated the total number of unnecessary hospital days for the country as a whole. As Table 9-3 shows:<sup>201</sup>

- M&R estimated that two-thirds of hospital days of nonelderly patients were unnecessary in Newark, Philadelphia, Pittsburgh and New Orleans.
- The range was from 35 percent in Portland to 72 percent in New York City.
- Nationwide, M&R estimated that 54 percent of all inpatient days were unnecessary.<sup>202</sup>

For the elderly (Medicare) population, M&R estimated that 53 percent of inpatient care was unnecessary, ranging from 34 percent in Honolulu to 65 percent in New York City.

**[Click here to see Table 9-3](#)**

Two critical assumptions lie behind these estimates. First, in deciding whether hospital stays were unnecessary, M&R looked only at outcomes and not at risk reduction. For example, even if the four-day hospital stay produced the same medical outcome as the two-day stay, the risks to which patients were exposed were different. On the one hand, simply being in a hospital adds to risk. According to one study, two million Americans pick up infections during a stay in the hospital each year — almost 10 infections for every 1,000 patient days, and 106,000 of these cases were fatal. This implies that one of every 300 patients dies of adverse drug reaction, making that one of the leading causes of death.<sup>203</sup> Although these results have been disputed,<sup>204</sup> no one thinks the risks are negligible. But being in a hospital reduces risk in other ways. If the patient's health worsens, for example, the hospital brings highly specialized resources to bear right away.

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<sup>201</sup> David V. Axene, Richard L. Doyle and Dirk van der Burch, "Research Report: Analysis of Medically Unnecessary Inpatient Services," Milliman & Robertson, 1997; and "Length of Stay Efficiency Index for 1996," Milliman & Robertson, 1997.

<sup>202</sup> M&R's estimate is based upon a population of under-65, private-sector insured patients which excludes a small number of highly efficient managed care patients. See David V. Axene, Richard L. Doyle and Dirk van der Burch, "Research Report: Analysis of Medically Unnecessary Inpatient Services," Milliman & Robertson, 1997.

<sup>203</sup> Jason Lazarou, Bruce H. Pomeranz and Paul N. Corey, "Incidence of Adverse Drug Reactions in Hospitalized Patients: A Meta-analysis of Prospective Studies," *Journal of the American Medical Association*, Vol. 279, No. 15, April 15, 1995, pp. 1200-05. See also Lawrence K. Altman, "Experts See Need to Control Antibiotics and Hospital Infections," *New York Times*, March 12, 1998.

<sup>204</sup> Arthur Allen, "Overreaction," *New Republic*, June 8, 1998, pp. 14-15.

The less time spent in the hospital, the better — other things being equal. But not everyone shares these sympathies. Take well baby delivery, for example. Managed care organizations have decided that two nights in a hospital and perhaps even one night is unnecessary. Hence, the practice of “drive-through deliveries.” But one study found that babies released from the hospital less than 72 hours after birth have a small increased risk of readmission.<sup>205</sup>

A second assumption is that because a length-of-stay objective is met somewhere in the United States, it can be met everywhere. M&R encouraged this interpretation by publishing guidelines on appropriate lengths of stay for surgical procedures.<sup>206</sup> HMOs and other managed care organizations used the guidelines to pressure providers. Physicians were appalled. The reason: M&R’s recommended lengths of stay are very different from what most doctors think is appropriate for their patients.<sup>207</sup>

- Whereas M&R recommends that women stay in a hospital a little over one day for a normal baby delivery and 2 1/2 days for a cesarean, the average for the country is more than two days for the former and more than four days for the latter.
- Whereas M&R recommends that mastectomies be done on an outpatient basis, the average length of stay for the country as a whole is 2.5 days.
- In the case of the high-risk procedure of esophagectomy (removal of the esophagus), M&R recommends five days compared to an average actual patient stay of 13 days.
- For a mid-shaft femur fracture (broken thigh bone), M&R recommends one day, while the average patient stay is six days.
- For craniotomy (brain surgery), the difference is five days and for a radical hysterectomy, seven days.

Clearly, what M&R recommends is not what most doctors do. And the use of such guidelines to pressure premature patient releases has caused political turmoil. For example, in response to patient complaints about drive-through deliveries, a 1997 federal law now guarantees mothers the right to hospital stays of two days for well baby delivery and four days for a cesarean, and Congress is considering legislation to prohibit “drive-through” mastectomies. Dozens of states have passed similar laws. Who is right? M&R, the doctors or the politicians? In some cases M&R may simply be wrong. In other cases, M&R may theoretically be right, but its guidelines cannot be met through the simple expedient of early release. As in the following

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<sup>205</sup> The risk is of readmission for hyperbilirubinemia, an elevated level of bilirubin in the blood that can cause jaundice. See M. Jeffrey Maisels and Elizabeth Kring, “Length of Stay, Jaundice, and Hospital Readmission,” *Pediatrics*, Vol. 101, No. 6, June 1998, pp. 995-98.

<sup>206</sup> The length of stay numbers in Table VI were taken from the *Bulletin of the American College of Surgeons*, April 1997.

<sup>207</sup> Eileen Kurtz, “The Length of Stay Efficiency Index,” Milliman & Robertson, Perspectives, July 1995, with examples available online at <http://www.op.net/~jcookson/hlos.html>; and Robert Rutledge et al., “An Analysis of 25 Milliman & Robertson Guidelines for Surgery,” Milliman & Robertson, unpublished.

case study, meeting the guidelines may require completely changing the way doctors practice medicine.

**Case Study: Mastectomies.** M&R guidelines state that an ordinary mastectomy can be performed outpatient with a stay as short as six hours. There is a facility that meets this standard, but it is the only place in the country that does so — the Johns Hopkins Breast Center. Under the leadership of Dr. William Dooley and Lillie Shockney, the center has revolutionized breast surgery by investing time, effort and energy in learning how to do the procedure differently from standard practice.

For example, whereas a mastectomy would ordinarily average about two hours, Dr. Dooley does it in 47 minutes. Because the center uses a different anesthesia and anesthetizes the patient for much less time, recovery is quicker and there are fewer side effects. Patients have the option of spending the night in the hospital, but almost all choose to go home. They can do so because several days prior to surgery they go through a three-hour training session with their care partner (usually someone who lives in the home with the patient). Such training is important, because patients need to be able to monitor their own progress and recognize signs of potential trouble. In addition, after surgery a nurse visits the patients in their homes twice.

The result is lower cost, higher quality and satisfied patients. Yet if an HMO insisted on outpatient surgery without changes in hospital technique and patient training, the risk of unhappy patients reappearing in the emergency room with further complications might greatly increase.<sup>208</sup>

**Economic Implications of the M&R and Rand Studies.** What the Johns Hopkins Breast Center has designed is a *more efficient* way to perform breast surgery. Women are not simply sent home earlier; they are enabled go home early. And the fact that more hospitals around the country have not copied the techniques indicates just how inefficiently our health care system functions compared with other markets.

The RAND study focused on the decision to perform surgery and strongly implied that unnecessary care was being delivered for economic reasons. However, the opposite incentive is present with respect to length of stay. Most physicians have a direct or indirect economic incentive to reduce length of stay.<sup>209</sup> The fact that it takes so long for efficient surgical techniques to be widely adopted implies that doctors are not responding quickly enough to economic incentives!

Why not? It is tempting to conclude that physicians find it easier to continue inefficient surgical procedures and the risks of early release than to invest in learning more efficient techniques. Unfortunately, this conclusion is consistent with the idea that managed care rewards cost reduction at the expense of quality more than it rewards cost reduction produced by greater efficiency and subsequent quality improvement.

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<sup>208</sup> Among fee-for-service patients, about 10 percent of mastectomies without complications are performed as outpatient procedures, with a hospital stay of less than 24 hours. The risk of rehospitalization would be about 3.0 percent to 3.5 percent if all women were treated outpatient. See Joan L. Warren et al., "Trends and Outcomes of Outpatient Mastectomy in Elderly Women," *Journal of the National Cancer Institute*, Vol. 90, No. 11, June 3, 1998, pp. 833-40.

<sup>209</sup> Almost all physicians under managed care contracts have a direct financial interest in lowering hospitalization costs by reducing the length of stay. Fee-for-service insurance, including Medicare, often pays fixed fees for hospital procedures as well.



**Unnecessary Care in Other Countries.** One might suppose that in countries where health care is rationed and many medical needs are unmet, doctors would tend to provide only “necessary” care. That turns out not to be the case. According to Rand research, those who receive care may not be those most in need of care. A review of the medical records on coronary artery bypass surgery performed in the Trent region of Britain found many were performed for less than appropriate reasons using both British and American criteria.<sup>210</sup> In Britain, for example:<sup>211</sup>

- Using methodology similar to that used in the United States, a Rand study of medical practices in Britain found that 21 percent of coronary angiographies and 16 percent of coronary artery bypass graft surgeries were performed for inappropriate reasons.
- In some regions, coronary angiography and coronary artery bypass procedures were found to be inappropriate about 50 percent of the time.
- In the North West Thames region, 60 percent of gall bladder removals with a laparoscope were judged to be inappropriate when reviewed by a panel of experts.

Despite waiting lists, there is no evidence that health authorities question whether the procedures for which patients are waiting are appropriate.<sup>212</sup> Rand researcher, Dr. Brook, told a U.S. Senate committee, “I was shocked to find that half of the people who actually got cardiac revascularization did not meet criteria established by physicians in the U.K. for getting those procedures.”<sup>213</sup>

The research by Rand found similar results in other countries with national health insurance. For example:

- A study in Israel found that 29 percent of gall bladder removals were performed for what it termed “less-than-appropriate” reasons.<sup>214</sup>
- Another report found that 19 percent of referrals of Swedish patients for coronary revascularization were judged by a panel of reviewers to be inappropriate.<sup>215</sup>

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<sup>210</sup> Steven J. Bernstein et al., “The Appropriateness of the Use of Cardiovascular Procedures: British Versus U.S. Perspectives, RAND Corporation, publication RP-269, 1994.

<sup>211</sup> Robert H. Brook, “Appropriateness: The Next Frontier,” *British Medical Journal*, Vol. 308, Issue 6923, January 22, 1994, pp. 218-19. Also see Robert H. Brook et al., “A Method for the Detailed Assessment of the Appropriateness of Medical Technologies,” *International Journal of Technology Assessment in Health Care*, Vol. 2, 1986, pp. 53-63.

<sup>212</sup> Harry Hemingway and Bobbie Jacobson, “Queues for Cure?” *British Medical Journal*, Vol. 310, No. 6983, April 1, 1995, pp. 818-819.

<sup>213</sup> Robert H. Brook, Ensuring Delivery of Necessary Care in the U.S., statement before the U.S Senate Committee on Health, Education and Labor and Pensions, March 2, 1999. Also see Steven Bernstein, Jacqueline B. Kosecoff, D. Gray, John R. Hampton and Robert H. Brook, “The Appropriateness of the Use of Cardiovascular Procedures: British Versus U.S. Perspectives,” *International Journal of Technology Assessment in Health Care*, Vol. 9, No. 1, 1993, pp. 3-10.

<sup>214</sup> “Assessing the Appropriateness of Care.”

The Rand summary concluded, “Contrary to the researchers’ expectations, habitual rationing of resources did not restrict use of these sophisticated and expensive treatments to only those who would most clearly benefit from them.”<sup>216</sup> Similar findings apply to other European countries besides Britain.<sup>217</sup>

**MYTH NO. 10: Single-payer health insurance would reduce the administrative costs of the U.S. health care system.**

A frequent claim by advocates of single-payer health insurance is that private health insurance is inefficient because of the administrative cost associated with multiple insurance firms. By one estimate health care costs could be reduced by close to one-third with the same level of care by introducing a Canadian-style single-payer insurance system. Marcia Angell, Spokesperson for The Physicians' Working Group on Single Payer National Health Insurance, and former Editor of the *New England Journal of Medicine*, has touted estimates of cost savings from a single-payer health care system of \$150 billion a year. This reduction in costs supposedly could be obtained “by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services.”<sup>218</sup> This argument is based on three mistaken assumptions: (a) that low administration costs and efficiency are synonymous, (b) that the higher administrative costs of private programs result in worse outcomes, and (c) that the relatively low administrative costs of public programs results in better outcomes.

**Administrative Costs and Efficiency.** Conventional wisdom holds that the less a health care system spends on administration as a proportion of total costs, the more efficient it must be. By this measure, the U.S. health care system, which spends 16 percent of its total budget on administration, would appear to be less efficient than the Canadian system, which sends about 5 percent.<sup>219</sup> However, when analyzing the relative efficiencies of competing health care models, we have to consider more than arbitrary ratios that compare administrative costs to operating costs. In general, nobody knows how to measure administrative costs in ways that allow fair comparisons of these two different types of system. Furthermore, the argument that a single-

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<sup>215</sup> Steven J. Bernstein, et al., “Appropriateness of Referral of Coronary Angiography Patients in Sweden,” *Heart*, Vol. 81, No. 5, May 1999, pp. 470-477.

<sup>216</sup> “Assessing the Appropriateness of Care.”

<sup>217</sup> Using the RAND methodology, a team composed of members from the Netherlands, Spain, Sweden, Switzerland and the United Kingdom rated the appropriateness and necessity of percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass graft surgery (CABG). For both PTCA and CABG, 60 percent were either uncertain or inappropriate. See K. Fitch, “European Criteria For the Appropriateness and Necessity of Coronary Revascularization Procedures European,” *Journal of Cardiothorac Surgery*, Vol. 18, No. 4, 2000, pp. 380-387.

<sup>218</sup> The Physicians’ Working Group is an ad hoc committee of prominent physicians who favor national health insurance organized by Physicians for a National Health Program. See “The Physicians’ Working Group on Single-Payer National Health Insurance, Proposal for Health Care Reform” presented to the Congressional Black Caucus and the Congressional Progressive Caucus, May 1, 2001.

<sup>219</sup> Mark Litow and the Technical Committee of the Council for Affordable Health Insurance, “Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs,” Council for Affordable Health Insurance “ March 1994.

payer system is more efficient than America's decentralized system because its administrative costs are lower assumes that administrative costs do not produce offsetting benefits.

The administrative costs of any health care system could be reduced by firing all of the administrators and abolishing all reporting requirements. But most systems would perform far less efficiently as a result. The real goal is not to get administrative costs as low as possible but to make the overall system perform as efficiently as possible. To accurately measure the net cost (or gain) to society from administrative procedures, one has to compare them with the benefits they produce.

A similar observation holds for marketing and other costs of competition. Money could be saved, for example, by abolishing all car dealerships and advertising by auto producers. Additional money could also be saved by eliminating competition among different automakers (producing numerous models) by building a single model of automobile. Sally C. Pipes and Michael Lynch of the Pacific Research Institute put it like this:

Most likely, administrative costs – marketing, selling and invoicing – were a lot lower for the East German Trabant than for a Honda or a Ford. But it does not logically follow that the Trabant is superior. Indeed, the opposite is the case. Multiple payers, or producers, whether in cars, housing, food, clothing or health care, produce product differentiation and spur competition that promotes the production of excellence. In the health care sector, multiple payers provide personalized health care options for U.S. citizens.<sup>220</sup>

We could simply pay taxes and have government provide us with a new automobile every few years. But the end result would be decreased efficiency and less consumer satisfaction – both of which are characteristic of socialist systems. If socialism had worked, the economies of communist countries would not have collapsed.

**Administrative Costs of Private Insurance.**<sup>221</sup> Why are the administrative costs of the American health care system high compared to Canada? On the surface, a system of multiple (often disparate) insurance plans gives the appearance of burdening patients and providers with higher overhead costs than could be obtained by a monopolistic single-payer health care system. However, the size of the burden associated with these costs has been over-estimated, while the benefits derived from multi-players have been ignored. The presence of multiple payers in the U.S. system reflects different tastes and preferences among consumers for amenities such as varied levels of co-payment, choice of physician network, limited waiting for physician visits, etc. In fact, all private health insurance companies use a portion of a policyholder's premium to assure the remaining funds are spent wisely while providing quick and convenient service. In doing so, American health plans control moral hazard (e.g. the tendency to over-consume when the service is perceived as being free) rather than rely on the Canadian approach of using waiting

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<sup>220</sup> Sally C. Pipes and Michael Lynch, "False Promise of Single-Payer Health Care: A Close Look Inside the 'California Health Security Act,'" Pacific Research Institute, 1998.

<sup>221</sup> This section is largely based on Patricia M. Danzon, "Hidden Overhead Costs: is Canada's System Really Less Expensive?" *Health Affairs*, Vol. 11, No. 1, Spring 1992.

lines as a method of rationing services. In simple terms, Americans pay for the ability to receive medical services when needed rather than having to wait for treatment.

**Government Distortions of Private Insurance.** The fact remains, however, that the administrative costs and paperwork burdens of the U.S. health care system are much too high. However, that is not a consequence of the private provision of health care, but rather of federal policy. The excessive burdens of Medicare and Medicaid are immense. Because Medicare heavily subsidizes inpatient care while providing little in the way of primary care, the system discourages those services not covered such as preventive care and to some degree, outpatient treatments. Moreover, Medicare enrollees often do not have prescription drug coverage. Consequently, many procedures are performed in a hospital (e.g. where they are covered) when they could be performed in non-covered outpatient settings or with drug therapy.

Medicaid distorts the health insurance market by offering a “free” alternative to the purchase of health insurance. Eligible patients often don’t even bother to enroll until they become ill. The resulting paperwork to verify eligibility and enroll them after the fact, create burdens for those providers who must care for them.

Furthermore, federal tax policy distorts the health care market by subsidizing health insurance purchased through an employer. Under our tax system, employees (through their employers) can spend unlimited amounts on third-party health insurance. At the same time, funds that middle-income employees set aside as self-insurance for small medical bills face a 27 percent income tax, a 15.3 percent FICA tax and, usually, a 4, 5 or 6 percent state and local income tax.<sup>222</sup>

As a result of federal tax policies, most employees are over-insured. They use third parties to pay for routine checkups, diagnostic tests and other small medical bills that could more efficiently be paid out of pocket. Too much insurance encourages people to be wasteful consumers in the medical marketplace. It also adds to administrative costs.<sup>223</sup>

**Administrative Costs of Public Programs.** As we noted earlier, the total administrative costs of the U.S. health care system are often cited as substantially higher than those of the Canadian system. A number of studies have agreed, often claiming to show that the Canadian system is simply better at controlling costs.<sup>224</sup> However, these studies only focus on inputs into

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<sup>222</sup> See John C. Goodman, “Characteristics Of An Ideal Health Care System,” National Center for Policy Analysis, NCPA Policy Report No. 242, April 2001.

<sup>223</sup> “Smart Cards Allow Instant Health Claims and Payments,” *e-commerce@lert.com* (Element K Journals) Vol. 3, 1998.

<sup>224</sup> A study by a national health insurance advocacy group, Citizen Fund, claimed that 33.5 cents of every dollar spent by private health insurance was for overhead expenses. See Richard Koenig, “Insurers’ Overhead Dwarfs Medicare’s,” *Wall Street Journal*, November 15, 1990. A 1991 study put administrative costs in the U.S. health care system at between 19.3 percent and 24.1 percent of total spending, or \$400 to \$497 per capita, compared to between 8.4 percent and 11.1 percent of health care spending, or \$117 to \$156 per capita, in Canada. See Steffie Woolhandler and David U. Himmelstein, “The Deteriorating Administrative Efficiency of the U.S. Health Care System,” *New England Journal of Medicine*, Vol. 324, No. 18, May 2, 1991, pp.1253-58. For a critique of the study’s methodology by the Health Insurance Association of America, see *Medical Benefits*, Vol. 8, No. 10, May 30, 1991, p. 5. In 1993 Woolhandler and Himmelstein updated their 1991 figures, putting administrative costs at \$911

administration (administrative salaries, costs of paperwork, etc.) while ignoring the effects of administration (i.e., how efficiently the health care system meets consumer needs). Many administrative costs in the U.S. system exist not merely to oversee the exchange of money between suppliers and third-party payers, but also to prevent inappropriate care and maintain quality.

Another problem with these studies is that government accounting practices invariably underestimate the real cost of government provision of goods and services. The true cost is often hidden under a complex bureaucratic reporting and tracking system. In both countries, auditing expenses are usually included in the budgets of other public agencies. Accounting for public administrative costs also does not include many of the resources the legislative and executive branches devote to managing and directing Medicaid and Medicare. For example, collecting taxes or lobbying for additional funding would not be considered an overhead expense of a public program whereas collecting premiums and marketing would count towards the cost of a private health insurer.

A study funded by private insurance companies that attempted to estimate these hidden costs (inclusive of taxes) found:<sup>225</sup>

- Medicare and Medicaid spend 26.9 cents for every dollar of benefits, compared to 16.2 cents spent by private insurance [see Figure 10-1].
- Thus government spends 66 percent more than the private sector per dollar of benefits paid.

**[Click here to see Figure 10-1](#)**

Furthermore, cost estimates of administering public insurance programs also do not account for those expenses that are shifted to the private sector, including costs foisted on physicians, including the cost of signing up patients who won't register for Medicaid until the time of medical need. Accounting for costs in this way makes U.S. health care seem less efficient than it actually is.

Keep in mind a public insurer essentially must perform most of the same functions found in private insurance. They must reimburse providers for services performed, collect "premiums" (usually from taxes) and attempt to control moral hazard (e.g. limit utilization).<sup>226</sup> Likewise,

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in the United States and \$270 in Canada. Steffie Woolhandler and David Himmelstein, "Cost of Care and Administration at For-Profit and Other Hospitals in the United States," *New England Journal of Medicine*, Vol. 336, No. 11, March 13, 1997, pp. 769-74.

<sup>225</sup> Mark Litow and the Technical Committee of the Council for Affordable Health Insurance, "Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs," Council for Affordable Health Insurance, March 1994.

<sup>226</sup> Patricia M. Danzon, "Hidden Overhead Costs: is Canada's System Really Less Expensive?" *Health Affairs*, Vol. 11, No. 1, Spring 1992.

public insurers incur overhead costs — but these are often difficult to analyze using traditional cost accounting methods.

One cannot legitimately calculate administrative savings in those systems without including the adverse effects on patients. These costs include excessive time constraints (patient waiting), lost productivity caused by a lack of advanced medical equipment, and reduced quality of life when certain procedures are unavailable. The costs of rationing by waiting and the waste of resources caused by perverse incentives are real costs of administering a national health insurance system. For example, the physician fee structure found in Canada (and elsewhere) is designed to limit the volume of procedures performed in doctor's offices. As a result, patient contact is cut short and patients are often forced to make multiple visits to get the same services previously received in one visit. Roughly speaking, the administrative (overhead) costs associated with private insurers are more than offset by hidden costs of public insurers.<sup>227</sup>

**Reducing Administrative Costs with Medical Savings Accounts.** As we have seen, neither public programs nor the current government-burdened private system is operating very efficiently. So what is the solution? A handful of countries have begun to use systems of funding that many provide the answer. In Singapore, for example, People there are required to deposit 6 percent of their salaries each year in personal medical savings accounts, called Medisave accounts. When Singapore residents need medical care, they pay the bills from their Medisave funds and avoid many of the administrative burdens of health insurance.<sup>228</sup> They also have catastrophic insurance — which is mainly how they pay hospital bills.

Medical savings accounts also exist in South Africa. Since their introduction in 1994, MSA plans have captured about half the private insurance market. Under some plans, when a patient purchases a medical service, they pay for it by an automatic withdrawal from the MSA in a manner similar to a cash withdrawal from ATM machines. The insurer, Discovery Health, is working on the same type of system for pharmaceutical purchases. Information from a Discovery Health card (and the drug prescribed) is entered into the pharmacy computer. The pharmacy then sends this information electronically to Discovery Health. At this point, Discovery Health checks the patient's Medisave balance and verifies drug coverage and any deductible. Within a few seconds the system tells the pharmacist how much of the drug purchase:

- Whereas the administrative costs of private health insurance average about 11 to 12 percent of premiums, payment of medical bills with Medisave funds could be

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<sup>227</sup> Patricia M. Danzon, "Hidden Overhead Costs: is Canada's System Really Less Expensive?" *Health Affairs*, Vol. 11, No. 1, Spring 1992.

<sup>228</sup> Thomas A. Massaro and Yu-Ning Wong, "Medical Savings Accounts: The Singapore Experience," National Center for Policy Analysis, NCPA Policy Report No. 203, April 1996. Also see the description in Mukul G. Asher, "Compulsory Savings in Singapore: An Alternative to the Welfare State," National Center for Policy Analysis, NCPA Policy Report No. 198, September 1995.

accomplished by use of health care debit cards — with administrative costs between 1 and 2 percent.<sup>229</sup>

- There is no economic reason why we could not move to a system in which most medical bills are paid by patients with health care debit cards, relying on third-party insurance to pay only catastrophic expenses.<sup>230</sup> the member must pay out of pocket and how much the Medisave account will cover.<sup>231</sup>

The United States has Medical Savings Accounts as well. *The Health Insurance Portability and Accountability Act of 1996* created a 5-year demonstration but for MSAs but imposed unnecessary complexity on them.<sup>232</sup> MSAs are so burdened with undue regulation in the United States that most people find it impossible to obtain one. Consequently, of the 700,000 accounts allowed by the pilot project, only an estimated 100,000 are in existence. However, if the U.S. government gave as much tax encouragement to self-insurance through MSAs as it now gives to third-party insurance for the employers and employees of large companies, the administrative costs of U.S. health care could be drastically reduced.

Some companies are already working with health care debit cards, including RealMed Corp. in Carmel, Ind.<sup>233</sup> RealMed has other promising technologies such as health insurance claims processing on the Internet. Increasingly, claims are being sent electronically rather than on paper. Dr. David Allen, the Kentucky network medical director for the health insurance company Aetna, estimates that it costs Aetna close to five times more to process a claim submitted on paper than it does a claim submitted electronically.<sup>234</sup> Several companies are experimenting with technology that would put a patient's entire medical record online.<sup>235</sup> This would allow physicians immediate access to each patient's complete medical history. Putting medical records online could be costly. But it might be less costly than the current system under

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<sup>229</sup> See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992. According to estimates by Hay/Huggins Company, the "load factor" for private health insurance ranges from 5.5 percent for groups of 10,000 or more to 40 percent for groups of less than five people. See Uwe Reinhardt, "Breaking American Health Policy Gridlock," *Health Affairs*, Vol. 10, No. 2, Summer 1991, Exhibit 1, p. 100.

<sup>230</sup> See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

<sup>231</sup> Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000.

<sup>232</sup> Victoria Craig Bunce, "Medical Savings Accounts. Progress and Problems under HIPAA," Cato Institute, Policy Analysis No. 11, August 8, 2001.

<sup>233</sup> Matt Hamblen, "Smart Cards Enter Health Care Community," *Enterprise Network News*, December 9, 1997. For a white paper on smart card technology, see Soon-Yong Choi and Andrew B. Whinston, "Smart Cards: Enabling Smart Commerce in the Digital Age," KPMG and Center for Research in Electronic Commerce, University of Texas at Austin, May 1998. <http://cism.bus.utexas.edu/works/articles/smartcardswp.html>

<sup>234</sup> Cheryl Jackson, "Insurers Test Direct-Deposit Pay For Claims" *American Medical News*, Vol. 44, No. 12, March 26, 2001.

<sup>235</sup> Tom Spring, "Put Your Medical Records Online. Doctors Launch a Private Medical Registry to Provide Patient Information in Emergencies," *PC World*, December 3, 1998. Also see Elisa Batista, "The Push for Online Medical Info," *Wired News*, May 9, 2000.

which physicians often treat patients without access to their records and spend far too much of their time dealing with paperwork.<sup>236</sup> However, it is no coincidence that most of these innovations are occurring in the U.S. or in countries with less regulated health care systems.

**MYTH NO. 11: Under Single-payer health systems, health care dollars would be allocated so that they have the greatest impact on health.**

Of all the characteristics of foreign health care systems, the one that strikes American observers as the most bizarre is the way in which limited resources are allocated among competing needs. Foreign governments do not merely deny life-saving medical technology to patients under national insurance schemes. They also take millions of dollars that could be spent to save lives and cure diseases and spend them to provide services to people who are not seriously ill.<sup>237</sup> Often, these services have little if anything to do with health care.

**Spending Priorities in Britain.** Throughout the British National Health Service, there is a tendency to divert funds from expensive care for the small number who are seriously ill toward the large number who seek relatively inexpensive services for minor ills. Take the British ambulance service, for example:<sup>238</sup>

- English “patients” take between 18 million and 19 million ambulance rides each year — about one ride for every three people in England.
- Almost 80 percent of these rides are for non-emergency purposes (such as taking an outpatient to a hospital or an elderly person to a local pharmacy) and amount to what might be described as little more than free taxi service.

While as many as 25,000 people die each year from lack of the most advanced treatments for cancer,<sup>239</sup> the NHS provides an array of comforts for the many chronically ill people who have less serious health problems [see Table 11-1]. For example:<sup>240</sup>

- The NHS provides nonmedical services to about 1.5 million people a year.
- These include daycare services to more than 260,000, homecare or home help services to 578,000, home alterations for 375,000 and occupational therapy for 300,000.

**[Click here to see Table 11-1](#)**

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<sup>236</sup> Joseph Conn, “Instant Response: Online Claims Authorization System Speeds Up Resolution,” *Modern Physician*, December 1, 2000.

<sup>237</sup> John C. Goodman, *National Health Care in Great Britain: Lessons for the U.S.A.* (Dallas: Fisher Institute, 1980)

<sup>238</sup> “Statistical Bulletin — Ambulance Services, England: 2000-2001,” Department of Health, 2001, Table 1.

<sup>239</sup> Sikora, “Cancer Survival in Britain.”

<sup>240</sup> “Community Care Statistics 2000-2001, Referrals, Assessments and Packages of Care for Adults,” Department of Health, 2001, Table P2f.1.



While more than 1 million people wait to be admitted to NHS hospitals,<sup>241</sup> the NHS wastes millions on time lost by general practitioners and outpatient departments because patients don't show up for their appointments and don't cancel:<sup>242</sup>

- An estimated 10 million GP appointments totaling more than 2.5 million hours are missed each year.
- The Doctor Patient Partnership, a British health education group, has calculated that this represents the work done by an additional 1,692 doctors.

If the NHS did nothing more than charge patients the full costs of missed appointments, enough money would be freed to treat thousands of additional cancer patients each year. Yet such options are not seriously considered.<sup>243</sup>

**[Click here to see Table 11-2](#)**

**Spending Priorities in Canada, Australia and New Zealand.** Although not as pronounced, similar trends can be observed in Canada, Australia and New Zealand, where the government has expanded the services of general practitioners while tightly controlling access to modern medical technology. All these countries encourage the provision of routine services for the many mostly healthy people at the expense of specialized care for the few seriously ill. For example:

- In the United States, only 11 percent of all physicians are engaged in general practice or family practice.<sup>244</sup>
- In Canada, just over half of all physicians are general practitioners.<sup>245</sup>
- Approximately two in three Australian physicians are general practitioners.<sup>246</sup>
- In New Zealand, nearly half of all physicians general practitioners and account for more than one-third of the entire medical workforce.<sup>247</sup>

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<sup>241</sup> "Waiting List Figures November 2001," Department of Health, Statistical Press Release, January 11, 2002.

<sup>242</sup> Survey published by the Doctor Patient Partnership and Institute of Healthcare Management, August 14, 2001.

<sup>243</sup> Some physicians have called for a flat £10 charge — approximately \$14 to \$15 — to provide patients with an incentive to keep appointments, although the British Medical Association opposes this measure.

<sup>244</sup> "Occupational Outlook Handbook," Bureau of Labor Statistics, U.S. Department of Labor, 2002-03 Edition, Physicians and Surgeons, Percent Distribution of M.D.s by Specialty, 1999, Table 1, January 2002.

<sup>245</sup> National Information, Southam Medical Database, Canadian Institute for Health Information, 2002.

<sup>246</sup> "Australian Social Trends, Health — Health Services: Distribution of General Practitioners," Australian Bureau of Statistics, 1994. This is the most recent count by the Australian Bureau of Statistics; a new count is scheduled to be released late in 2002.

<sup>247</sup> New Zealand Workforce Statistics, 2000.

In general, Canadians have little trouble seeing a GP. But specialist services and sophisticated equipment are increasingly rationed. In 2000, for example, Canadians often waited as long as 28 weeks to see a specialist.<sup>248</sup> GP visits, the services that are less expensive, are the ones that are more accessible to the public. For similar reasons, Canadians have difficulty getting access to high-tech treatments or diagnostic services. As noted above, although the United States has seen a major expansion of outpatient surgery, Canada has actively discouraged this trend — presumably to control spending. All over Canada, CT scanners and other equipment are generally restricted to hospitals.

**MYTH NO. 12: A single-payer system would lower health costs because preventive health services would be more widely available.**

A common argument for national health insurance is that when care is “free” at the point of service, people will seek preventive services more readily. Consequently, it is argued, money will be saved when doctors catch conditions in their early stages — before they develop into more costly-to-treat diseases.

**Do Preventive Services Save Money?** Careful studies show that, in general, preventive medicine raises rather than lowers overall health care costs. As one observer put it, “nearly every aspect of preventive care has crashed upon the rocky shore of added costs.”<sup>249</sup> Very few medical procedures — including preventive or diagnostic procedures — pay for themselves in terms of a net lifetime reduction in total health care costs.<sup>250</sup> Some exceptions to the general rule include immunization for childhood diseases, smoking cessation advice and prenatal care for at-risk mothers.<sup>251</sup>

Despite the popular mythology, checkups for children or adults do not save the health care system money. Nor do Pap smears. Nor do mammograms.

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<sup>248</sup> Michael Walker and Greg Wilson, “Waiting Your Turn: Hospital Waiting Lists in Canada, 11th Edition,” Fraser Institute, Critical Issues Bulletin, September 2001.

<sup>249</sup> Scott Gottlieb, “For HMOs, Preventive Medicine Doesn’t Pay,” *American Medical News*, Vol. 44, No. 30, August 13, 2001.

<sup>250</sup> Ashley B. Coffield et al., “Priorities Among Recommended Clinical Preventive Services,” *American Journal of Preventive Medicine*, Vol. 21, No.1, 2001. For a comprehensive list of life-saving interventions and their costs, see Tammy O. Tengs, “Dying Too Soon: How Cost-Effectiveness Analysis Can Save Lives,” National Center for Policy Analysis, NCPA Policy Report No. 204, May 1997; and T. O. Tengs et al., “Five Hundred Life-Saving Interventions and Their Cost-Effectiveness,” *Risk Analysis*, Vol. 15, No. 3, June 1995, pp. 369-390.

<sup>251</sup> T. O. Tengs et al., “Five Hundred Life-Saving Interventions and Their Cost-Effectiveness,” *Risk Analysis*, Vol. 15, No. 3, June 1995, pp. 369-390.

<sup>253</sup> See “Is Preventive Medical Care Cost-Effective?” National Center for Policy Analysis, Brief Analysis No. 188, November 9, 1995. The Office of Technology Assessment (OTA) studied the cost-effectiveness of adding coverage for several preventive measures — including flu and pneumonia vaccines and screening tests for cervical and colon cancer — to the federal Medicare insurance program for the elderly. None of the preventive measures was found to cut costs. See U.S. Congress, Office of Technology Assessment, *Preventive Health Services for Medicare Beneficiaries: Policy and Research Issues*, (Washington, D.C.: U.S. Government Printing Office, February 1990); and U.S. Congress, Office of Technology Assessment, *The Cost and Effectiveness of Colorectal Screening in the Elderly — Background Paper*, (Washington, D.C.: U.S. Government Printing Office, September 1990). A separate study by the OTA found that only three kinds of preventive care save money: prenatal care for poor women, tests in newborns for certain congenital disorders and most childhood immunizations. See U.S. Congress, Office of

Nor do most other tests.<sup>253</sup> It is true that diagnosing cancer early lowers treatment costs for the patient found to have the disease. But in order to find that patient through screening, the diagnostic test must be given to thousands of healthy patients. When all costs are considered, the extra costs of screening the healthy swamp the reduced costs of treating the few found to have the disease.<sup>254</sup>

That preventive care usually adds to overall health care costs does not mean that it is not valuable. But we need to compare the money spent with the benefits received. Take breast cancer for example. Figure 12-1 shows the cost of screening (including the costs of treatment for those discovered to have cancer) per year of life saved as a result of the screening and subsequent treatment for breast cancer. As the figure shows:

- Giving regular mammograms to women age 55 to 64 costs about \$110,000 for every year of life saved as a result of the screening, when all costs are considered.
- For women in their forties, however, the costs jump considerably — to \$190,000 for each year of life saved.

This does not mean that mammograms are wasteful. To the contrary, they are a very reasonable investment for many women. Economists have studied the price people will pay to avoid various risks and found them willing to pay \$75,000 to \$150,000 for each year of life saved.<sup>255</sup> Note: this is not the amount of money people are willing to pay to purchase an extra year of life. These numbers are *implied* by the amounts people are willing to pay to avoid risk, when the risks are small and the amount of money is also small, such as the extra wages required to induce people to work in riskier jobs. Since the trade-off for mammograms shown in the figure are close to or within this range, regular mammograms probably would appear worthwhile to most women.

Similar considerations apply to Pap smear exams for cervical cancer. As Figure 12-2 shows:

- Screening young women every four years for cervical cancer costs less than \$12,000 for each year of life saved.

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Technology Assessment, *Benefit Design in Health Care Reform: Report #1-Clinical Preventive Services*, (Washington, D.C.: U.S. Government Printing Office, September 1993).

<sup>254</sup> Also see “Is Preventive Medical Care Cost-Effective?” National Center for Policy Analysis, Brief Analysis No. 188, November 15, 1995; and Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, D.C.: Brookings Institution, 1986).

<sup>255</sup> W. Kip Viscusi, “The Value of Risks to Life and Health,” *Journal of Economic Literature*, Vol. 31, No. 4, December 1993, pp. 1912-46; and George Tolley, Donald Kendel and Robert Fabian, eds., *Valuing Health for Policy: An Economic Approach* (Chicago: University of Chicago Press, 1994).

- More frequent screening, however, causes the costs to soar: from about \$220,000 per year of life saved at three year intervals (as opposed to four year intervals) to about \$310,000 at two year intervals (as opposed to three).
- Giving Pap smears every year (as opposed to every other year) is really expensive: almost \$1.5 million per year of life saved.

Pap smear screening — even screening every fourth year — costs money; it doesn't save money. However, four-year cervical cancer tests are a very good buy" in the business of risk avoidance. To put this figure in perspective, note that the payoff is not as good as the payoff from wearing seatbelts in automobiles. But it is a better buy than air bags. More frequent screenings, however, make the costs rise rapidly in relation to the benefits. Despite the preference of many doctors for annual screening, the trade-off is well outside the range of choices people make to avoid risk in other walks of life.

Now suppose we ignore costs and ask: what is the right number of Pap smears from a purely medical point of view? There is no right answer. Four-year Pap smears produce a medical benefit. Annual Pap smears produce a bigger benefit. One presumes that monthly Pap smears would further enhance the benefit. Medical science alone cannot justify one frequency over any other, unless one adopts the untenable position that people should obtain any and all diagnostic tests as long as there is any possibility of medical benefit.

**[Click here to see Figure 12-1 and Figure 12-2](#)**

**Prevention vs. Preventive Care.** A distinction should be made between the broadly understood "prevention" and the narrowly defined "preventive medical care." Anything that can prevent a disease can be labeled prevention. Eating a proper diet, getting adequate exercise, losing excess weight, abstaining from smoking, drinking only in moderation and practicing proper sanitation are all examples of prevention. The medical literature has conclusively demonstrated that many individuals can avoid disease and premature death by choosing healthful eating and living habits.

In addition, public health efforts to provide clean drinking water and improve sanitation have been shown to prevent disease and promote longevity. In fact, according to public health experts, most of the increases in life expectancy over the last 100 years have resulted from improvements in public health rather than advances in medicine. Only a few of the ten greatest public health triumphs in the 20<sup>th</sup> century related to medicine.<sup>256</sup>

Vaccination still ranks as one of the few cost effective medical interventions that save more money than they cost. Yet, the greatest way to improve health outcomes is to educate patients about a healthy lifestyle.<sup>257</sup> Decline in deaths from coronary heart disease and strokes,

<sup>256</sup> 10 Public Health Triumphs, *Nursing Library*, page 1, March 2000; "Ten Great Public Health Achievements — United States, 1900-1999," *Morbidity and Mortality Weekly Report*, Vol. 48, No.12 April 02, 1999 pp. 241-243. For an in-dept review of each achievement, see the CDC's Web site at [www.cdc.gov/od/oc/media/tengpha.htm](http://www.cdc.gov/od/oc/media/tengpha.htm).

<sup>257</sup> For a discussion of lifestyle changes that increase health and life expectancy, see NB Belloc and L Breslow, "Relationship of Physical Health Status and Health Practice," *Preventive Medicine*, Vol. 1, 1972, pp. 409-421, 1972; Jack A. Meyer and Marion E. Lewin, "Introduction," in Meyer and Lewin, eds., *Charting The Future of Health Care* (Washington, DC: American Enterprise Institute, 1987), p. 5; Bruce Bower, "Health Aging May Depend on Past Habits," *Science News*, Vol. 159, No. 24, June 16, 2001; G.E. Vaillant, K. Mukamal, "Successful Aging," *American Journal of Psychiatry*, Vol. 158, June 2001, p. 839; Patricia Andersen-Parrado, "6 Strategies to Help You Live

and recognition of tobacco use as a health hazard, two of the top ten items are better treated early through lifestyle changes. These conditions, if not caught early, require highly advanced technology, treatments and medication.

**The Role of Preventive Care.** Preventive medical care, on the other hand, is a narrowly defined concept. It includes regular exams and screening tests designed to catch a disease or a health problem before it has a chance to spread. It also covers medical interventions, such as treatments, designed to prevent problems before they become severe.

The fact that preventive medicine adds to overall health care costs should not be taken to suggest preventive medical care is bad. Diagnostic tests showing that no disease is present benefits patients by relieving anxiety and creating reassurance of health. Most of the time, preventive care is like a *consumer good* that creates benefits in return for a cost; it is not like an *investment good* that promises a positive economic rate of return.

**Preventive Care Under Single-Payer Health Insurance.** There is evidence that the amount of preventive care people get under single-payer systems is based more on socioeconomic status and education than on whether medical care is free or not. For example, studies comparing women in Ontario and women in two areas of the United States found that in both countries a woman's chances of receiving a Pap smear or clinical breast cancer screening increased consistently with education and income. Rates were similar in both countries across socioeconomic levels, regardless of whether a woman had health insurance.<sup>258</sup>

Furthermore, preventive care may actually be less available under a single-payer system, precisely because care *is* free. A comparison of American and British physicians in the 1990s found that the British saw a physician almost as often as Americans (about six times a year).<sup>259</sup> Yet when Americans did see a doctor, as Figure 12-3 shows, the consultation was six times as likely to last more than 20 minutes.<sup>260</sup> It is doubtful that time-constrained doctors from countries with national health insurance give more preventive services to their patients than their American counterparts.

Because the services of GPs are “free” to Britons, an inordinate number of their visits are for trivial complaints. To handle the caseload, British doctors have responded by spending less time with each patient. Moreover, because of the British government's desire to control costs,

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Longer and Better.” *Better Nutrition*, April, 2000; Hirofumi Shigeta, “Lifestyle, Obesity, and Insulin Resistance,” *Diabetes Care*, March, 2001; Andrew Baum, “HEALTH PSYCHOLOGY: Mapping Biobehavioral Contributions to Health and Illness,” *Annual Review of Psychology*, 1999.

<sup>258</sup> See S.J. Katz and T.P. Hofer, “Socioeconomic Disparities in Preventive Care Persist Despite Universal Coverage: Breast and Cervical Cancer Screening in Ontario and the United States,” *Journal of the American Medical Association*. Vol. 272, August 17, 1994, pp. 530-34.

<sup>259</sup> Anderson and Poullier, “Health Spending, Access, and Outcomes: Trends in Industrialized Countries.”

<sup>260</sup> See Edward W. Campion, “A Symptom of Discontent,” *New England Journal of Medicine*, Vol. 344, No. 3, January 18, 2001, pp. 223-225; and John G. R. Howie et al., “Quality at General Practice Consultations: Cross Sectional Survey,” *British Medical Journal*, Vol. 319, No. 7212, September 18, 1999, pp. 738-743. Note: the average general practitioner (GP) consultation was eight minutes in Britain, whereas the average consultation across all specialties in the United States was 18.3 minutes. See also David Mechanic, Donna D. McAlpine and Marsha Rosenthal, “Are Patients’ Office Visits with Physicians Getting Shorter?” *New England Journal of Medicine*, Vol. 344, No. 3, January 18, 2001, pp. 198-204.

British physicians have much less access to diagnostic equipment, and most send their patients to a hospital even for chest x-rays and simple blood tests. As a result, preventive medical care is slighted in the NHS system. For example, a recent survey of 200 British general practitioners and more than 2,000 consumers found that:<sup>261</sup>

- Around 87 percent of smokers want more advice and help from their GPs.
- But 93 percent of GPs say they lack the time to give such advice.

Physician time constraints are also a problem in Canada. On a per capita basis, Canadians visit physicians 10 percent more often than people in the United States, but it is not clear that they receive more services. Apparently, more Canadian physician time is spent on (arguably) trivial conditions such as colds, sore throats or upset stomachs.<sup>262</sup> The average length of a physician visit is longer in the United States than in Canada. There are indications that the care provided by American doctors is more intense, since it is more specialized and American doctors perform more procedures in their offices. As noted above, two-thirds of care in Canada is delivered by general practitioners or family physicians; whereas in the United States two-thirds of care is delivered by specialists.<sup>263</sup>

**[Click here to see Figure 12-3](#)**

Note that the United States does not necessarily do a better job of delivering preventive medicine. As in the case of Britain, it is believed that one out of every two U.S. diabetics is undiagnosed.<sup>264</sup> However, socializing the health care system by no means guarantees that these problems will be solved.

**MYTH NO. 13: Single-Payer health insurance is the solution to the problems of managed care.**

Although the term “managed care” means different things to different people, in all its guises it involves interference in the doctor-patient relationship by third-party bureaucracies — employers, insurance companies and government — whose primary interest is in controlling costs.

There is evidence that managed care succeeded in controlling costs throughout the 1990s but began to experience a consumer backlash by the end of the decade.<sup>265</sup> Moreover, people appear to dislike the idea of managed care more than they dislike managed care itself. Polls show that, even though 80 percent of people are satisfied with the care received from their HMO,

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<sup>261</sup> “Challenging Nicotine Addiction,” Smoking Cessation in Primary Care (SCRAPE), August 2001, reported in “U.K. Physicians Lack Time to Help Patients Quit Smoking,” Reuters Health, August 23, 2001.

<sup>262</sup> Ibid.

<sup>263</sup> Victor R. Fuchs and James S. Hahn, “How Does Canada do it? A Comparison of Expenditures for Physicians’ Service in the United States and Canada,” *New England Journal of Medicine*, September 27, 1990, pp. 884-890.

<sup>264</sup> “Diabetes: A Growing Public Health Problem,” Centers for Disease Control, Diabetes Public Health Resource, 2001. Available at: <http://www.cdc.gov/diabetes/pubs/glance.htm>

<sup>265</sup> Alain C. Enthoven and Sara J. Singer, “The Managed Care Backlash and the Task Force in California,” *Health Affairs*, Vol. 17, No. 4, July/August 1998, pp. 95-110. Also see Robert J. Blendon, et al., “Understanding the Managed Care Backlash,” *Health Affairs*, Vol. 17, No. 4, July/August 1998, pp. 80-94.

45 percent say they possess negative opinions about HMOs in general.<sup>266</sup> Another recent survey uniquely tracked people who were unaware of their true insurance status. People who thought they were HMO members (even if they were not) were more likely to say they were dissatisfied than those who thought they were not in an HMO (even though they were).<sup>267</sup>

**The Managed Care Revolution in the United States.** In 1980 fewer than 10 million people were enrolled in HMOs. Today almost 70 million are – approximately one in four Americans.<sup>268</sup> And three-fourths of all employees with health insurance are covered by some type of managed care. What difference does this change make?

For starters, it means fewer choices for patients and doctors. Only a few years ago, a person with private health insurance could see any doctor, enter any hospital or (with a prescription) obtain any drug. Today things are different. In general, patients must choose from a list of approved doctors covered their health plan. Yet, employers switch health plans and, even if they don't, employees routinely switch jobs. So long-term relationships between patients and physicians are harder to form. Moreover, many people cannot see a specialist without a referral from a "gatekeeper" family physician and or even get treatment at a hospital emergency room without prior (telephone) approval from their managed care organization. Patients who fail to follow the rules may have to pay part or all of the bill out of their own pockets.

Under managed care freedom of choice has been curtailed even more for doctors than for patients. Not long ago, most doctors ordered tests, prescribed drugs, admitted patients to hospitals or referred them to specialists and performed procedures based on their own experience and professional judgment. No longer. Now doctors who want to be on the "approved" list must agree to practice medicine based on a health plan's guidelines. For most doctors, the guidelines mean fewer tests, fewer referrals and fewer hospital admissions. Furthermore, many U.S. physicians also say they spend too much time and effort on billing, negotiating fees and interpreting numerous insurance contracts. Since the advent of managed care, many also complain that they are under pressure to spend less time with each patient.

**Is Single-Payer Health Insurance a Solution?** American advocates of a single-payer system of health insurance say that such a system would, resolve virtually all of the major abuses of managed care.<sup>269</sup> In particular, single-payer advocates would:<sup>270</sup>

- Eliminate HMOs and most other forms of managed care;

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<sup>266</sup> Gary Langer, "Conflicting Views on HMOs," ABCNEWS.com, January 22, 1999.

<sup>267</sup> James D. Reschovsky and J. Lee Hargraves, "Health Care Perceptions and Experiences: It's Not Whether You are in an HMO, It's Whether You Think You Are," Center for Studying Health System Changes, Issue Brief #30, September 2000.

<sup>268</sup> Ibid.

<sup>269</sup> Don R. McCanne, "Would Single-Payer Health Insurance Be Good for America?" Physicians for a National Health Program, March 27, 2000.

<sup>270</sup> For one single-payer proposal, see Physicians' Working Group on Single-Payer National Health Insurance, Proposal for Health Care Reform presented to the Congressional Black Caucus and the Congressional Progressive Caucus.

- Have all health care financed by the government, with no premiums or copayments from those covered;
- Control costs by assigning global budgets to hospitals and setting fees and salaries for physicians; and
- Prohibit private insurance or personal payment for any service covered by a single-payer system of national health insurance.

Prima fascia, there is no reason to believe patients would be better off. As noted above, a recent study in the prestigious *British Medical Journal* compared medical service delivery by the British National Health Service with that of the California HMO, Kaiser Permanente. The study found the NHS provides far fewer services, less access to diagnostic tests and specialists than Kaiser for only slightly less money.<sup>271</sup> [See Myth No. 8]

Consider a few of the criticisms sometimes attributed to managed care: (1) you often can't see a specialist, (2) you can't always obtain expensive tests, (3) you may experience obstacles getting approval for surgery, and (4) you may have difficulty gaining admission into a hospital. These problems of HMO enrollees appear to be minor inconveniences when compared to the experiences of patients in other countries. In fact, these problems are common to all single-payer health insurance systems.

Almost all single-payer systems require patients to go through a gatekeeper who decides whether the patient gets a referral to a specialist. And, by limiting the number of specialists and access to expensive technology, single-payer systems place far greater obstacles in the way of patients than any managed care organization in the United States. However, single-payer health insurance differs from many private insurance companies in one important respect – no profit motive. But, far from being a burden, having no stockholders removes any incentive to operate efficiently. In fact, national health insurance provides all the wrong incentives for both the health care system itself and the patients in the system.

**Wrong Incentives for Providers: No Competition.** The primary source of problems in a single-payer system is the lack of competition. In countries with government-controlled medicine people have no alternative health insurer from which to buy. The same would be true of single-payer system implemented in the U.S. For example, a proposal by the group, Physicians for a National Health Insurance Program specifically states doctors would only be paid a negotiated fee for their work and the services of their support staff. As a cost-saving measure to reduce “medical inflation,” physicians would not be reimbursed for office-based procedures such as an MRI. The reason for this approach is to minimize “entrepreneurial incentives.”<sup>272</sup> However, “entrepreneurial incentives” is another word for “competition.” In

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<sup>271</sup> Feachem, Sekhri and White, “Getting More for Their Dollar: A Comparison of the NHS with California’s Kaiser Permanente.” Also see Alain Enthoven, “Commentary: Competition Made Them Do It,” *British Medical Journal*, Vol. 324, No. 7330, January 19, 2002, p. 143.

<sup>272</sup> See Physicians’ Working Group on Single-Payer National Health Insurance, Proposal for Health Care Reform presented to the Congressional Black Caucus and the Congressional Progressive Caucus.



Canada, fee structures are designed to discourage physicians from providing office-based procedures.<sup>273</sup> Physicians are often thought to provide too much “unnecessary” care if they can profit from the procedures and tests they recommend to patients. In other words, if your local hospital cannot give you the MRI you need on a timely basis, your physician isn’t allowed to “compete” with them to provide an alternative MRI service. Subsequently, if your local hospital chooses to skimp on capital equipment and buy too few MRI scanners, they lose no revenue for failing to provide these lifesaving services on a timely basis.

**Wrong Incentives for Patients: “Free” Care.** Because national health insurance uses tax money and patients usually pay little or nothing for a doctor visit, there is a tendency to think of health care as free. Numerous studies have shown that the less people have to pay out-of-pocket, the more medical care they consume.<sup>275</sup> Despite consuming more, these patients do not experience better health outcomes.<sup>276</sup> This is because, in order to limit demand, single-payer systems limit access to equipment and specialists. For the most part, medical care is available for routine ailments like a cold or for emergencies like a ruptured appendix. But those with chronic serious illnesses and those needing non-emergency procedures or diagnostic tests are consigned to waiting lists.

**Physicians Under National health Insurance.** Because of doctors’ frustrations with managed care, a single-payer system of national health insurance might seem appealing to them. Some believe a single-payer system would reduce administration, paperwork and overhead and allow physicians to spend more time doing what they are trained for: treating patients. However, physicians in countries with (single-payer) national health insurances also express frustration, as they are able to spend even less time than U.S. physicians with each patient, face more obstacles to providing care for their patients, and receive even less compensation.

**Limiting the Number of Physicians.** Patients in most industrialized countries access the health care system through the use of a primary care physician. Consequently, in countries with national health insurance, governments often attempt to limit demand for medical services by having fewer physicians.<sup>277</sup> [See Figure 13-1] Dr. Lorne Tyrrell, president of the Association of Canadian Medical Colleges, says Canada needs about 540 new physicians each year to account

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<sup>273</sup> Patricia M. Danzon, “Hidden Overhead Costs: is Canada’s System Really Less Expensive?” *Health Affairs*, Vol. 11, No. 1, Spring 1992.

<sup>275</sup> See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, Calif.: Rand, 1984); and Willard Manning et al., “Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment,” *American Economic Review*, June 1987. The Rand study was conducted from 1974 to 1982. A \$1,000 deductible over that period would be equivalent to a deductible between \$1,870 and \$3,830 today.

<sup>276</sup> The one exception was vision care, which is not surprising since eyeglasses are often viewed as a marginal health care expenditure.

<sup>277</sup> This theory is sometimes referred to as “physician-induced demand” whereby an increase in the number of physicians is thought to increase demand for medical care since physicians are supposedly in a position to provide unknowledgeable patients with more care than is necessary.

for population growth and 1,950 to counter attrition. However, since 1980 Canada has as a matter of policy reduced the number of students accepted by its 16 medical schools by 18 percent, to 1,577 per year. There are approximately five qualified applicants for every acceptance to Canadian medical schools.

Some students, unable to gain admission, have opted to study medicine abroad in such places as Ireland. Despite the shortage of physicians, few of these foreign-trained Canadian doctors will ever be allowed to practice in Canada. Medical students are required to complete a Canadian residency program in order to practice there. But health authorities limit the number of residency program slots to 100 for each 100 graduates of Canadian medical schools. In most cases, the only way a foreign-trained Canadian physician can gain admission to a residency program is by promising to practice for a number of years in an under-served area.

**More Patients, Less Time.** As a result of having fewer physicians, doctors that practice medicine under single-payer systems of national health insurance must see larger numbers of patients for shorter periods of time. As Figure 13-2 shows, U.S. physicians see an average of 2,222 patients per year, but physicians in Canada and Britain see an average of 3,143 and 3,176, respectively.<sup>278</sup> Thus it is not surprising that 30 percent of American patients spend more than 20 minutes with their doctor on a visit, compared to 20 percent in Canada and only 5 percent in Britain.<sup>279</sup>

**[Click here to see Figure 13-1 and Figure 13-2](#)**

In a recent survey, 30 percent of Canadians reported having difficulty finding a family doctor. The survey also found:<sup>280</sup>

- Most family doctors' practices are full, and about two-thirds of all family physicians are no longer routinely accepting new patients.
- More than two-thirds were spending time battling moderate to severe problems in obtaining services for their existing patients.
- Family doctors are now working an average of 73 hours a week.

The College of Family Physicians of Canada, which conducted the survey, concluded that the country needs 3,000 more family physicians now, and predicted the shortage would worsen.

**Discontent in Britain.** Physicians working in Britain's National Health Service have expressed growing dissatisfaction.<sup>281</sup> For example:

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<sup>278</sup> Gerard Anderson and Peter Sotir Hussey, "Comparing Health System Performance In OECD Countries," Health Affairs, Vol. 20, No. 3, May/June 2001, pp. 219-232.

<sup>279</sup> See Figure 11-1 in Myth 11.

<sup>280</sup> "2001 National Family Physician Workforce Survey," College of Family Physicians of Canada, October 25, 2001.

- Last year, hundreds of family doctors announced plans to close their offices for a day of protest over working conditions.<sup>282</sup>
- Between 20 percent and 25 percent of new doctors leave the NHS within five years of qualification; these often migrate to other countries or leave the medical profession altogether.<sup>283</sup>
- A study of medical graduates in the North West of England found that almost one-fifth had become disillusioned with the NHS and left over a 10-year period.<sup>284</sup>
- A survey of Scottish GPs found that 60 percent were considering leaving medicine for other careers because of working conditions.<sup>285</sup>

Dr. Michael Gross, a prominent neurologist, reported that he worked 4,000 consecutive days on call at the Surrey & Sussex Healthcare Trust before resigning in frustration.<sup>286</sup>

**Physician Compensation.** Like managed care, one way single-payer systems reduces health expenditures is by squeezing the compensation of doctors, nurses and other health care workers. But a single-payer system can squeeze physicians' compensation much more effectively because it is a monopsony — that is, a single buyer of a given good or service. Just as a monopoly seller can raise prices above the market level, a monopsony can reduce the compensation and treatment fees it pays physicians, thanks to the lack of competing payers.<sup>287</sup> As the Physicians' Working Group for Single-Payer National Health Insurance has written in its Proposal for Health Care Reform in the United States, "Such single source (monopsony) payment has been the cornerstone of cost containment and health planning in Canada and other nations with universal coverage." [See Figure 13-3]

A Commonwealth Fund analysis compared physician incomes, across countries, often adjusting for differences in the cost of living. The finding: doctors in other industrialized countries earn much less than those in the United States. On the average, doctors in Canada and

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<sup>281</sup> For more on physician morale see M. McBride and D. Metcalfe, "General Practitioners' Low Morale: Reasons and Solutions," *British Journal of General Practice*, Vol. 45, 1995, pp. 227-29; R. Petchey, "Exploratory Study of General Practitioners' Orientations to General Practice and Responses to Change," *British Journal of General Practice*, Vol. 44, 1994, pp. 551-55; B. Leese and N. Bosanquet, "Changes in General Practice Organization: Survey of General Practitioners' Views on the 1990 Contract and Fundholding," *British Journal of General Practice*, Vol. 46, 1996, pp. 95-99.

<sup>282</sup> "GPs Plan Day of Protest Over Working Conditions," *Ananova.com*, May 1, 2001.

<sup>283</sup> John Crace, "Health Scare: As a Medical Career Becomes Less Popular, Where Will New Doctors Come From?" *Guardian Unlimited*, December 4, 2001.

<sup>284</sup> "Poor Working Conditions Force Doctors Out of NHS," *BBC News*, June 10, 1998.

<sup>285</sup> Gaby Hinsliff, "Young GPs Will Get Golden Hello," *Guardian Unlimited*, March 11, 2001.

<sup>286</sup> Jeevan Vasagar, "NHS in Chaos From Top Down, Says Consultant," *Guardian Unlimited*, July 5, 2001, p. 5.

<sup>287</sup> Mark V. Pauly, "Managed Care, Market Power, and Monopsony," *Health Services Research*, Vol. 33, No. 5, December 1998, pp. 1439-1460.

Germany earn about half as much; those in Austria, France and Britain earn less than one-third as much; and those in Finland, Norway and Sweden earn one-fourth as much.<sup>288</sup>

**[Click here to see Figure 13-3](#)**

Despite American physicians' frustration with uninsured patients and managed care, these problems seem to pale in comparison with the lack of resources and bureaucratic hassles experienced by their national health service counterparts locked in their countries' single-payer systems.

**MYTH NO. 14. A single-payer system of health insurance would improve the United States' ability to compete in international markets and benefit American labor.**

Some critics have argued that high U.S. health care costs make U.S. products less competitive in the international marketplace and ultimately harm American labor.<sup>289</sup> Those holding this view assert that health care costs add to the price of American products and that a single-payer health insurance system would make American manufacturers more competitive by removing from employers, the cost of providing their employees with health insurance. However, both assertions are wrong.

There is no evidence that the cost of private health insurance adds anything to the price of a good.<sup>290</sup> Health insurance is simply one element in a workers' total compensation package. For many American workers, health insurance is a (non-taxable) fringe benefit provided in lieu of money wages. Fringe benefits for most American workers have grown from less than 19 percent of payroll in 1951 to nearly 42 percent today.<sup>291</sup> This reflects the fact that workers, faced with taxes on wage income, have increasingly preferred to receive a larger portion of their compensation in the form of non-taxed benefits.<sup>292</sup>

However, what workers are paid in terms of total compensation depends on what they produce, not what they consume. The fact that Americans spend a greater proportion of their income on health care and a smaller proportion on other goods and services does not put us at a

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<sup>288</sup> Gerard F. Anderson, "Multinational Comparisons of Health Care: Expenditure, Coverage and Outcomes," Commonwealth Fund, October 1998. Also see Gerard F. Anderson and Jean-Pierre Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs*, Vol. 18, No. 3, May/June 1999, pp. 178-192.

<sup>289</sup> This argument is often based upon the fact that most workers obtain their health insurance through their employer and the American health care system is relatively expensive. For example, see Noam Chomsky, *Secrets, Lies and Democracy*, (Tucson: Odonian Press, 1994)

<sup>290</sup> John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance, National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

<sup>291</sup> U.S. Chamber of Commerce, "Employee Benefits Historical Data 1951-1979" and "1996 Employee Benefits Report."

<sup>292</sup> W. Michael Cox and Richard Alm, "The Economy's Good News: The Upside of Downsizing," National Center for Policy Analysis, NCPA Policy Backgrounder No. 145, February 25, 1998.

competitive disadvantage relative to other countries.<sup>293</sup> This same principle applies to other countries. For example:

- The Japanese spend a greater proportion of their income on food, but that doesn't mean that food consumption adds to the price of a Japanese car.
- The Canadians spend a greater proportion of their income on education, but that doesn't mean that education adds to the price of Canadian lumber.

These international differences merely reflect consumer preferences and consumer product prices.

However, single-payer health insurance system *would* affect our ability to compete in international markets. That is because such insurance involves not only the purchase of health care but also a redistribution of income among producers in different industries. On the whole:<sup>294</sup>

- A single-payer health insurance system would impose extra taxes on U.S. exporting industries and use the proceeds of those taxes to subsidize other industries.
- The industries that would receive subsidies contribute mostly to domestic rather than international markets.
- The industries that would be penalized are the manufacturers that provide most of our exports.

Consider, for example, the impact national health insurance programs have had on international competitiveness among European countries. In these countries, national health insurance has not improved the ability to compete in international markets. Instead, it has reduced that ability in some countries and contributed to high unemployment by increasing the cost of labor. For example, in addition to all taxes levied to finance non-health care expenditures:

- Germany's sickness insurance funds are financed by compulsory contributions of 13.5 percent of payroll, shared equally by employers and employees.<sup>295</sup>
- In France, in addition to a payroll tax on wages of 12.8 percent for employers and 0.75 percent for employees for health insurance, employees pay an additional 7.5

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<sup>293</sup> For a discussion of health care spending and competitiveness, see Uwe Reinhardt, "Health Care Spending and American Competitiveness," *Health Affairs*, Vol. 8, No.4, Winter 1989, pp. 5-21.

<sup>294</sup> See the discussion in John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

<sup>295</sup> Volker Ulrich, "Health Care in Germany: Structure, Expenditure and Prospects," Fraser Institute, October 10, 1999.

percent of all income, including interest, dividends and other earnings, as a general social contribution, most of which goes to health insurance.<sup>296</sup>

If a single-payer system were introduced in the United States, we can assume that it would impose similar tax burdens on U.S. industries. Far from making U.S. producers more competitive, a single-payer health insurance system would likely raise production costs relative to foreign rivals and make industries less competitive by increasing our tax burden to levels found in European countries such as Britain and Germany. The U.S. prosperity and competitiveness in international markets is in large measure attributable to this country's comparatively lower tax rates — on both employees and employers.

Despite the fact that almost a quarter of our federal budget goes to defense spending, a burden not equaled by our trading partners, taxes are lower in the United States than in most other developed countries. As Figure 14-1 shows, only Japan currently has a tax burden as low as ours.<sup>297</sup> In those countries that rely on single-payer national health insurance schemes, high taxation can be directly linked to the financial burdens of public-financed health care. If the United States were to adopt a program of single-payer health insurance system, our tax burden would approach that of these countries. That additional burden would have a major impact on our ability to compete.

**[Click here to see Figure 14-1](#)**

#### **MYTH NO. 15: Single-payer health insurance would benefit America's elderly.**

If the experience of other countries is any guide, the elderly have the most to lose under a national health insurance system. In general, when life-saving care is rationed, the young get preferential treatment over the old.

**Age Discrimination in Britain.** For the most part, the elderly are able to schedule appointments with GPs and can usually gain access to medical facilities, albeit with difficulty. However, many find it difficult to receive the treatment and specialized care that many conditions associated with advanced age require. Access to surgery, both emergency and non-emergency, is limited, as younger, healthier patients are given priority and allowed to pass the seniors in queue. In Britain, what is termed "ageism" has been discussed extensively in medical circles and in the popular media.<sup>298</sup>

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<sup>296</sup> Robert E. Moffit et al., "Perspectives on the European Health Care Systems: Some Lessons for America," Heritage Foundation, Lecture No. 711, July 9, 2001. In Germany's two-tiered system, about 90 percent of the population pay the tax for insurance through sickness funds. But those whose income is above a certain level are allowed to opt out of the sickness funds and, instead of paying the tax, use the money to buy private insurance; about 10 percent have done so.

<sup>297</sup> "Revenue Statistics of OECD Member Countries: 2002 Edition," Organization for Economic Cooperation and Development, 2002.

<sup>298</sup> See, for example, J. Grimley Evans, "The Rationing Debate: Rationing Health Care by Age: The Case Against," *British Medical Journal*, Vol. 314, No. 7083, March 15, 1997, pp. 822-825; Ann Bowling, "Ageism in Cardiology," *British Medical Journal*, Vol. 319, No. 7221, November 20, 1999, pp. 1353-1355; Graham C. Sutton, "Will You

- Extrapolating from a Gallup survey, the U.K. charity Age Concern estimates that one in 10 people (nearly 2 million) notice a difference in their treatment from the NHS after their 50th birthday.<sup>299</sup>
- One in 20 people over age 65 said they had been refused treatment; many said their doctors told them the money would be better spent on treating younger patients.<sup>300</sup>
- According to article published in the *British Medical Journal*, in many coronary care units, age rather than medical considerations often determines whether a patient will be treated.<sup>301</sup>
- Although more than one-third of all diagnosed cancers occur in patients 75 years of age or older, most cancer-screening programs in the NHS do not include people over age 65.<sup>302</sup>
- A report by the British Thoracic Society and the Society of Cardiothoracic Surgeons of Great Britain and Ireland said only one in 50 lung cancer patients over age 75 receives surgery.<sup>303</sup>
- In one particularly disturbing case, BBC News alleged that 60 seniors died after being deprived of food and water by hospital staff in an effort to relieve the pressure on the hospital for beds.<sup>304</sup>

Age discrimination is not just an action of individual doctors or hospital staff. In countries with single-payer health insurance systems, denial of care to the elderly also occurs as a result of institutional obstacles.<sup>305</sup> For example, in Britain:

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Still Need Me, Will You Still Screen Me, When I'm Past 64?" *British Medical Journal*, Vol. 315, No. 7115, October 25, 1997, pp. 1032-1033; and Michael Rivlin, "Should Age Based Rationing of Health Care be Illegal?" *British Medical Journal*, Vol. 319, No. 7221, November 20, 1999, p.1379.

<sup>299</sup> Linda Beecham, "Patients Say the NHS Is Ageist." *British Medical Journal*, Vol. 318, No. 7191, April 24, 1999, p. 1095; Celia Hall, "Campaign to Halt Ageism in NHS," *The Daily Telegraph*, November 8, 1999.

<sup>300</sup> Ibid.

<sup>301</sup> Michael M Rivlin, "Protecting Elderly People: Flaws in Ageist Arguments," *British Medical Journal*, Vol. 310, No. 6988, May 6, 1995, pp. 1179-1182.

<sup>302</sup> Turner et al., "Cancer In Old Age-Is It Inadequately Investigated And Treated?," *British Medical Journal*, Vol. 319, No. 7205, July 31, 1999, pp. 309-312.

<sup>303</sup> Martyn R. Partridge, "Thoracic Surgery in a Crisis," *British Medical Journal*, Vol. 324, No. 7334, February 16, 2001, pp. 376-377.

<sup>304</sup> "NHS Euthanasia Claims 'Nonsense'," BBC News, December 6, 1999.

<sup>305</sup> Jammi N. Rao, "Rationing. Politicians, Not Doctors, Must Make the Decisions About Rationing," *British Medical Journal*, Vol. 318, No. 7188, April 3, 1999, p. 940.

- Guidelines issued by the British Medical Association allow NHS doctors to withdraw food and water given by tube to elderly patients suffering from severe stroke and dementia even if they are not facing imminent death.<sup>306</sup>
- In an effort to curb costs, the NHS has cut the number of geriatric beds in British hospitals by 50 percent over the past 20 years.<sup>307</sup>

Some critics of the NHS claim that its policies toward the elderly are deliberately aimed at eliminating a burden on the system, and amount to a strategy of conducting involuntary euthanasia with older patients.

**Age Discrimination in New Zealand.** The same sort of discrimination against the elderly exists in other countries with national health insurance. New Zealand’s guidelines for end state renal failure programs say that age should not be the *sole* factor in determining eligibility, but that “in usual circumstances people over 75 should not be accepted.” Since there is no private dialysis service in New Zealand, this amounts to a death sentence for the elderly with kidney failure.<sup>308</sup>

**International Comparisons.** A recent Commonwealth Foundation survey asked seniors in several countries to rate the performance of their nation’s health care system. As Figure 15-1 shows:<sup>309</sup>

- Seven percent reported long waits for non-emergency surgery in the United States, compared to 40 percent in Canada and 51 percent in the United Kingdom.
- Fourteen percent reported difficulty in gaining access to a specialist in the United States, compared to 23 percent in both Canada and the U.K.
- Four percent reported long waits for serious surgery in the United States, compared to 11 percent in Canada and 13 percent in the U.K.
- Four percent reported they received inadequate outpatient services in the United States, compared to 10 percent in Canada and 14 percent in the U.K.

**[Click here to see Figure 15-1](#)**

The survey found that the United States is the only country of the three in which the elderly are more satisfied with their health care system than the non-elderly.

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<sup>306</sup> “British Hospitals Deprive Elderly, Doctors Say,” BBC News, December 6, 1999.

<sup>307</sup> See report by the Counsel and Care Charity as reported in “Pensioners a Burden to NHS,” BBC News, April 3, 1998.

<sup>308</sup> Colin M. Feek et al., “Experience With Rationing Health Care in New Zealand.,” *British Medical Journal*, Vol. 318, No. 7194, May 15, 1999, pp. 1346-1348.

<sup>309</sup> “The Elderly’s Experiences with Health Care in Five Nations,” Commonwealth Fund, International Health Policy Survey, 1999.



How serious is the problem of restricted access to life-saving care and medical technology for elderly patients in countries with single-payer systems? Lacking hard data, one can only speculate. As noted above, health economists are reluctant to take population mortality rates as an indicator of health care quality. Whether a person lives or dies in any given year is more likely a result of that person's lifestyle and environment than anything hospitals or doctors do.<sup>310</sup> Despite these caveats, if the life expectancy of any population group is significantly affected by the health care system, it is likely to be that of the elderly. And international statistics on population mortality are consistent with the proposition that the elderly have the most to lose by non-price rationing of medical care. According to one study:<sup>311</sup>

- Although there is very little relationship between health care spending and life expectancy at birth, in OECD countries, among 80-year-olds there is a statistically significant correlation.
- An 80-year-old U.S. female can expect to live almost a year longer than her British counterpart.
- An 80-year-old U.S. male can expect to live a half-year longer than his British counterpart.

As the proportion of the population that is elderly continues to grow in most developed countries, seniors' access to health care in countries with single-payer health insurance system is likely to deteriorate even further. These countries will increasingly be faced with the unpleasant choice of raising taxes or more rationing of care.

#### **MYTH NO. 16: Single-payer health insurance would benefit racial minorities.**

Critics of the U.S. health care system often point to the disadvantages faced by minorities. On the average, African-Americans and Hispanic-Americans are less likely to have health insurance, see a physician or enter a hospital. But is single-payer health insurance the answer? Empirical studies show that minorities also face discrimination in medicine including under systems of non-price rationing.<sup>312</sup> In fact, they often fare worse.

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<sup>310</sup> For a discussion of lifestyle and life expectancy, see Gary E. Fraser and David J. Shavlik, "Ten Years of Life: Is It a Matter of Choice?" *Archives of Internal Medicine*, Vol. 161, No. 13, July 9, 2001, pp.1645-1652; Damaris Christensen, "Making Sense of Centenarians: Genes and Lifestyle Help People Live Through a Century," *Science News*, Vol. 159, No. 10, March 10, 2001; Jack A. Meyer and Marion E. Lewin, "Introduction," in Meyer and Lewin, eds., *Charting The Future of Health Care* (Washington, DC: American Enterprise Institute, 1987), p. 5; Patricia Andersen-Parrado, "6 Strategies to Help You Live Longer and Better," *Better Nutrition*, April 2000; and Hirofumi Shigeta, "Lifestyle, Obesity and Insulin Resistance," *Diabetes Care*, March 2001.

<sup>311</sup> Gerard F. Anderson and Peter S. Hussey, "Health and Population Aging: A Multinational Comparison," Commonwealth Fund, October 1999.

<sup>312</sup> For discussion, see Michael Lowe, Ian H Kerridge and Kenneth R Mitchell, "'These Sorts of People Don't Do Very Well': Race and Allocation of Health Care Resources," *Journal of Medical Ethics*, Vol. 21, No. 6, December 1995.

In a market where prices are used to allocate resources, goods and services are rationed by price. Willingness to pay determines which individuals utilize resources, rather than race or political connections. In a nonmarket system, things are very different. Unable to discriminate on the basis of price, suppliers of services must discriminate among potential customers based on other factors. Race and ethnic background are invariably among those factors.

Take the (non-price) rationing of organ transplants, for example. Currently, in the United States no “market” exists for transplant organs. Donated organs are supposedly available on the basis of need rather than the ability-to-pay. Yet, despite the existence of a non-profit organ donor system that supposedly doesn’t discriminate on “ability to pay,” the rate of transplanted organs for minorities is proportionally lower than in whites. According to the United Network for Organ Sharing:<sup>313</sup>

- Blacks received only 3.7 percent of pancreases despite comprising eight percent of those waiting.
- Blacks received only 14.9 percent of living donor kidneys and 27 percent of cadaveric kidneys despite comprising 34.8 percent of the people on the waiting list.

These disparities in levels of care are confirmed by a study in the *Journal of the American Medical Association*, which found that both blacks – together with the poor – receive a lower percentage of needed transplants than whites and higher income individuals.<sup>314</sup> There have been very few studies of how racial minorities fare under national health insurance in other countries. However, the few studies that exist, together with surveys and anecdotal evidence, are consistent with what economic theory would predict and show that minorities receive sub-standard care.

**Racial Discrimination in Britain.** In Britain, uneven levels of access and treatment for the country’s growing minority population (mostly South Asian) has fueled claims of racism within the NHS. For example:

- According to the British newspaper *The Guardian*, a confidential government report as well as that of an independent think tank found racism flourishing in the NHS.<sup>315</sup>

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<sup>313</sup> “2001 Annual Report of the U.S. Organ Procurement and Transplantation Network and the Scientific Registry for Transplant Recipients: Transplant Data 1991-2000,” U.S. Department of Health and Human Services, 2001. In 2000, blacks comprised 36 percent of those waiting for kidneys, eight percent of those waiting for a pancreas. However, Blacks, do receive a proportionate amount of donor hearts (13.4%) while comprising an identical proportion of those waiting (13.4%). Report available at [www.ustransplant.org](http://www.ustransplant.org).

<sup>314</sup> G. Caleb Alexander and Ashwini R. Sehgal, “Barriers to Cadaveric Renal Transplantation Among Blacks, Women and the Poor,” *Journal of the American Medical Association*, Vol. 280, No. 13, October 7, 1998, pp. 1148-1152.

<sup>315</sup> John Carvel, “Secret Government Report Finds Racism Flourishing in NHS,” *Guardian Unlimited*, June 25, 2001; John Carvel, “NHS Staff Tell of Morale-Sapping Racism,” *Guardian Unlimited*, June 25, 2001; John Carvel, “Racism is Rife in NHS, Says Study,” *Guardian Unlimited*, June 19, 2001.

- In one case, NHS had accepted an organ donation that was reserved for *white-only* patients.<sup>316</sup>
- A survey of general practices practitioners in England found diabetes and asthma programs were more common in the mostly-white affluent areas than in inner-city London, which is characterized by a high minority population.<sup>317</sup>
- The NHS was also less likely to equip hospitals in London’s minority areas with cervical cancer testing and childhood immunization.<sup>318</sup>

**Racial Discrimination in Canada.** Similar problems have been identified with respect to the indigenous minorities in Canada.<sup>319</sup> In a recent study of Canadian Indian groups, researchers found that all the groups sampled had much less access to health care than Caucasians — despite their much greater health needs. For example:

- The infant death rate during the study period was 13.8 per 1000 live births for Indian infants and 16.3 per 1000 for Inuit infants, approximately twice the rate (7.3 per 1000) for all Canadian infants during the same period.<sup>320</sup>
- Overall, Canadian aboriginal people “die earlier than their fellow Canadians and sustain a disproportionate share of the burden of physical disease and mental illness.”<sup>321</sup>

**Racial Discrimination in New Zealand.** In New Zealand indigenous Maori population, the average life expectancy for Maori men (68 years) is 5.5 years less than for non-Maori men,

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<sup>316</sup> The incident took place in July 1998. Sarah Boseley, David Brindle and Vikram Dodd, “NHS Took Organs Donated for Whites Only,” *Guardian Unlimited*, July 7, 1999; and Sarah Boseley, “Transplant Chief Loses Job Over Racism Row,” *Guardian Unlimited*, February 23, 2000. For a report on this event and the NHS policy, see “An Investigation into Conditional Organ Donation — The Report of the Panel,” Department of Health, February 2000.

<sup>317</sup> Brenda Leese and Nick Bosanquet, “Change in General Practice and Its Effects on Service Provision in Areas with Different Socioeconomic Characteristics,” *British Medical Journal*, Vol. 311, No. 7004, August 26, 1995, pp. 546-550.

<sup>318</sup> *Ibid.*

<sup>319</sup> Aboriginal people have less access to health care services than other Canadians because of geographic location and a shortage of personnel trained to meet the needs of the native population. See Harriet L. MacMillan et al., “Aboriginal Health,” *Canadian Medical Association Journal*, Vol. 155, No. 11, December 1, 1996, pp. 1569-1578. See also “CMA’s Submission to the Royal Commission on Aboriginal Peoples” in *Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada* (Ottawa: Canadian Medical Association, 1994), pp. 9-17; *Aboriginal Health in Canada* (Ottawa: Medical Services Branch, Health Canada, 1994); and Vincent F. Tookenay, “Improving the Health Status of Aboriginal People in Canada: New Directions, New Responsibilities,” *Canadian Medical Association Journal*, Vol. 155, No. 11, December 1, 1996, pp. 1581-1583.

<sup>320</sup> Harriet L. MacMillan et al., “Aboriginal Health,” *Canadian Medical Association Journal*, Vol. 155, No. 11, December 1, 1996, pp. 1569-1578.

<sup>321</sup> *Ibid.*

and six years less for Maori women (73 years) than for non-Maori women.<sup>322</sup> Furthermore, those Maori who live in the least deprived areas live seven years longer than most deprived areas. The corresponding figure for women is eight years. The disparities do not stop with life expectancy, however.<sup>323</sup>

- Most diabetes is largely preventable (or manageable) through early diagnosis and intervention. However, the rate of incidence among 45-64 year old Maori is four times that of comparable non-Maori.
- The incidence of high blood pressure among young (25-44) Maori men and women, respectively, is almost twice the rate of non-Maori New Zealand men and women of European ancestry.

**Racial Discrimination in Australia.** Australia also has both a significant minority population (the Aborigines).

Various studies have reported that:<sup>324</sup>

- Aborigines are three times more likely to die in infancy than white Australians and about half of the survivors will die before they reach age 50.
- Of all Aborigines who died between 1995 and 1997, 53 percent of men and 41 percent of women were under age 50. By comparison, 13 percent of all other Australian men and 7 percent of all other Australian women who died were under age 50. The disparities are a direct result of health care access inequalities.
- Death rates are higher for Aborigines in all age groups. In infancy, Aborigines are 3.1 to 3.5 times more likely to die than other Australians. In the 35-54 age group, they are six to seven times more likely to die than other Australians.

Despite the greater overall health needs of these populations, minorities in countries with single-payer systems of national health insurance are routinely marginalized by systems that focus resources and services on the more affluent, white, urban majority.

**MYTH NO. 17: Single-payer health insurance would benefit residents of rural areas.**

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<sup>322</sup> Lisa Macdonald, "Maori/Non-Maori Lives: the Widening Gap," *Green Left Weekly*, Issue No. 326, July 29, 1998, p23, available at <http://jinx.sistm.unsw.edu.au/~greenlft/1998/326/326p23b.htm>; and Tikanga Oranga Hauora (Health Trends), Ministry of Maori Development, Whakapakari, No 4., 2000, available at <http://www.tpk.govt.nz/maori/education/tohtrend.pdf>.

<sup>323</sup> Tikanga Oranga Hauora (Health Trends), Ministry of Maori Development, Whakapakari, No 4., 2000.

<sup>324</sup> "The Health and Welfare of Australia's Aboriginal and Torres Strait Island Peoples," Australian Bureau of Statistics, 2000. For similar trends in health care for New Zealand's Maori population, see "Our Health, Our Future: The Health of New Zealanders 1999," New Zealand Ministry of Health, 1999; and "Maori Health," *Healthcare Review — Online*, Vol. 2, No. 4, December 1997.

What we know about who gets care and who does not under non-price rationing schemes is very incomplete. However, geographical variations in health care and outcomes exist.<sup>325</sup> Despite extensive reform efforts to combat geographic disparities in access to medical services, Canada, Britain, New Zealand and Australia all struggle with medically under-served areas.<sup>326</sup>

Waiting times are longer in rural areas, principally because advanced medical equipment is in short supply there. Such technology, which is expensive, is often only available at major hospitals in large cities. In addition, since care is given only to patients who are available when an opening occurs in the surgery schedule, rural patients are at a considerable logistical disadvantage. Urban patients, who live close to medical facilities, benefit most from public provision. Their rural counterparts often have to travel hundreds of miles just to get treated. So, by using waiting as a rationing device, public systems indirectly discriminate against rural patients.

Even in urban areas, as we have seen, success in obtaining care often depends on the politics of bureaucracy. A patient who is treated by a physician in a rural area will tend to be at a disadvantage vis-à-vis a patient represented by a physician who lives nearby and is a colleague of the hospital staff. Urban patients also have access to political and personal relationships that may be important in dealing with bureaucratic obstacles — opportunities not generally available to rural patients.

**Rural Patients in Britain.** Britain is one of the few countries that even publishes hospital waiting lists by region and for the country as a whole. Yet in Britain, as in other countries with a single-payer systems, rationing decisions are made by doctors and hospital personnel at the local level. There is no national procedure to guarantee that those in greater need move to the front of the waiting lines.

The most important philosophical principle set forth by those who established the British National Health Service was equal access to health care. Yet as we noted above, inequalities across England persist and may even have grown worse since the NHS was founded in 1948. The British government tends to spend the most in metropolitan areas — especially the wealthier urban districts — where private sector alternatives are most abundant. For example, the NHS spends 20 percent of its annual budget on the greater London area, although only 15 percent of the population lives there and they have access to the most private sector services. Nonetheless, there are persistent pleas to allocate even more resources to the London area.<sup>327</sup> Overall, there are vast differences in the amount of resources allocated to different regions of the country:<sup>328</sup>

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<sup>325</sup> Nigel Rice and Peter C. Smith, “Ethics and Geographical Equity in Health Care,” *Journal of Medical Ethics*, Vol. 27, No. 4, August 2001.

<sup>326</sup> Morris L. Barer, Laura Wood and David G. Schneider, “Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons,” Centre for Health Services and Policy Research, University of British Columbia, May 1999.

<sup>327</sup> Mike Pringle, “Primary Care: Opportunities and Threats. An Opportunity to Improve Primary Care,” *British Medical Journal*, Vol. 314, No. 7080, February 22, 1997, pp. 595-97.

<sup>328</sup> “Good Hospital Guide for Britain and Ireland,” Dr. Foster, 2001 cited in *The Sunday Times*, January 2001.

- The North East Thames region (near London) has 27 percent more doctors and dentists per person, 15 percent more hospital beds and 12 percent more total health spending than the Trent region (in the more rural northern part of the country).
- There are 63 doctors per 100 beds at University College Hospital Trust in London, compared to 11 doctors per 100 beds at the hospital in Northern Devon, a rural area in southern England.
- At Chelsea and Westminster Healthcare Trust, located in one of London's most prosperous districts, there are 64 doctors per 100 beds, compared to only 18 doctors per 100 beds at Pinderfields Hospital in rural West Yorkshire.

These differences in resources reinforce regional disparities in the levels of care that patients receive. To be sure, government reforms of the past two decades have brought some noticeable declines in the waiting list numbers. However, it is significant to note that some areas have seen greater improvement than others. Table 17-1 shows changes in the waiting lists for the three best and three worst-performing health authorities in England. As the table shows:

- Between March 1997 and 1999, the total number of patients waiting for medical treatment in the three London health authorities fell by between 23 and 31 percent.<sup>329</sup>
- Over the same period, the total number of patients waiting for medical treatment in the three rural health authorities increased by between 12 and 19 percent.

**[Click here to see Table 17-1](#)**

For individual hospital trusts within London and rural health authorities, the differences in levels of treatment and health outcomes are even more striking.<sup>330</sup>

- At Hamerton Hospital in London, 96 percent of inpatients are admitted within six months, compared to 51 percent of patients at Surrey and Sussex Healthcare Trust in the rural southeast.
- Similarly, at Whittington Hospital in London, 90 percent of inpatients are admitted within six months, compared to 54 percent of patients at Royal Surrey County Hospital in the rural southeast.

Importantly, these inequalities do not reflect differences in need. Northerners die younger and are less healthy than southerners.<sup>331</sup> Similarly, people from poor urban areas live shorter lives and die more frequently from common, treatable illnesses than their wealthier

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<sup>329</sup> "Hospital Waiting List Statistics: England," National Health Service, NHS Executive, 2000.

<sup>330</sup> "Good Hospital Guide for Britain and Ireland," Dr. Foster, 2001.

<sup>331</sup> "Dying of Inequality," *The Economist*, April 4, 1987, p. 52; see also "UK Death Rate Echoes North-South Divide," Reuters Health, 2000.

neighbors living only blocks away. This is because inequalities in levels of service lead to unequal health outcomes. For example:<sup>332</sup>

- A person with colon cancer in Herefordshire has a 52.4 percent chance of survival, while a person in the rural northeastern town of Tees has a 24.9 percent chance.
- A woman with breast cancer living in Hillingdon, London has an 80.3 percent chance of surviving five years, compared to a 64.5 percent chance for a woman in rural North Staffordshire.

Clearly, a person's chances of surviving major illnesses or procedures depend very much on where he or she lives. Although some of the differences in outcomes may be attributable to regional differences in lifestyle, differences in medical resources must surely matter. The difference in cancer mortality and survival rates, for example, has been attributed to the general shortage of specialists and relative lack of investment in cancer drugs and radiotherapy equipment in under-served health regions.<sup>333</sup>

**Rural Patients in Canada.** Canada, too, has proclaimed equal access to health care a national goal. However, across Canada wide differences exist between the level of care available to citizens who live in the sparsely populated countryside and those who live in metropolitan areas. Although rural residents pay the same high taxes as urban dwellers, they are routinely faced with more limited care. Hospital closings are becoming a serious problem for rural patients for example. According to the *Canadian Journal of Rural Medicine*, "in Alberta, Saskatchewan and Manitoba rural hospitals have been closed by the dozens."<sup>334</sup>

Not surprisingly, the number of family physicians — as well as the number of specialists — varies widely across the rural and urban centers. In British Columbia, the average family physician in the rural Peace Liard region has 1,316 patients whereas in urban Vancouver the average family physician has only 606 patients. If specialists are included, there are 1,099 patients per physician in the Peace Liard region compared to 268 patients per physician in Vancouver.<sup>335</sup> There are also inequalities among the provinces:

- Among Canadian provinces, the number of physicians per 100,000 population varies from a high of 211 in Quebec to a low of 92 in the Northwest Territories — a difference of more than two to one.<sup>336</sup>

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<sup>332</sup> "Cancer Rates Reveal Regional Divide," BBC News, July 13, 2000; "NHS Postcode Lottery Revealed," BBC News, November 7, 2001; "Quality and Performance in the NHS. Performance Indicators: July 2000," National Health Service, NHS Executive, July 2000.

<sup>333</sup> Ibid.

<sup>334</sup> John Wootton, "Rural Hospitals: We Can't Do without Them!," *Canadian Journal of Rural Medicine*, Vol. 2, No. 2, Spring 1997, p. 59.

<sup>335</sup> Harvey V. Thommasen et al., "Physician: Population Ratios in British Columbia," *Canadian Journal of Rural Medicine*, Vol. 4, No. 3, Summer 1999, pp. 139-145.

<sup>336</sup> Southam Medical Database, Canadian Institute for Health Information, 2001.

- The number of patient beds varies from a high of 22.3 per 1,000 population in Prince Edward Island to 10.6 per 1,000 in Yukon — a difference of more than two to one.<sup>337</sup>

As noted above, health care in Canada tends to be hospital-based, with modern technology restricted to teaching hospitals and outpatient surgery discouraged. Moreover, specialists and major hospitals tend to be in major cities. As in other countries, rural residents often travel to the larger cities for medical care. A major study produced at the University of British Columbia has determined the impact this has on the amount of care urban and rural patients receive. As previously noted, this study is unique in that it identified patients based on where they lived and thus was able to accurately determine how much care was delivered to the population of the different health regions. As Table 17-2 and Figure 17-1 show:<sup>338</sup>

- Overall, people living in British Columbia's two largest cities (Vancouver and Victoria) receive about 63 percent more physician services per capita than those living in the 27 rural districts of the province.
- Urban residents receive 91 percent more services from specialists per capita than rural residents, and for specific specialties some discrepancies are even greater.
- On the average, urban residents are about seven times more likely to receive services from a thoracic surgeon, almost four times more likely to receive the services of a psychiatrist, almost three times more likely to receive services from a dermatologist and twice as likely to receive services from a neurologist.

**[Click here to see Table 17-2 and Figure 17-1](#)**

#### **MYTH NO. 18 Single-payer health insurance systems would reduce the cost of prescription drugs for Americans.**

Advocates of single-payer insurance maintain that it would “simultaneously address two pressing needs: (1) providing all Americans with full coverage for necessary drugs and supplies, and (2) containing drug costs.”<sup>339</sup> It would accomplish this by establishing a national formulary (a list of approved drugs) and negotiating prices of those drugs with manufacturers “based on their costs (excluding marketing or lobbying).”<sup>340</sup>

The idea has appeal to many Americans faced with high prescription drug costs. However, people in countries with single-payer systems of national health insurance do not have

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<sup>337</sup> Statistics Canada, Canadian Institute for Health Information, 1996-97, available at <http://www.statcan.ca/english/Pgdb/People/Health/health32a.htm>

<sup>338</sup> Arminée Kazanjian et al., “Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94,” University of British Columbia, 1995. Physicians in Canada are paid by the province on a fee-for-service basis. Income data are available by specialty for each region. Consequently, fee-for-service income is a good measure of the value of services actually rendered to patients. By using physician billing data, the researchers determined the regional hospital district in which each patient lived — even if the service was provided in some other district.

<sup>339</sup> Proposal for Health Care Reform by the Physicians’ Working Group on Single-Payer National Health Insurance.

<sup>340</sup> Ibid.



the free access to a wide range of drugs, increasingly, many new, more effective drugs. Further, although some drugs cost less in other countries, others cost far more than in the United States. On the whole, prescription drug prices in countries with national health insurance are comparable to U.S. prices despite stringent rationing of availability in the other countries.

**Do Britons and Canadians Get the Same Drugs for Less Money?** Some drugs cost less in Canada, but others do not. For example, the anti-hypertensive drug atenolol costs four times as much in Canada as in the United States.<sup>341</sup> Although many patented drugs are less expensive in Canada, the average retail price for generic drugs is higher.<sup>342</sup> Large numbers of Americans cross the border to Canada to buy drugs that cost less there. But large numbers of Canadians travel to the United States to buy drugs because so many drugs are not available at any price in Canada.

Canada tries to control costs through a lengthy approval process for pharmaceuticals. From 1994 through 1998, the federal government approved only 24 of 400 drugs considered, ruling that the rest were not substantial improvements over their predecessors. In addition, each of Canada's 10 provinces has a review committee that must approve the drug for that province's formulary.

When a prescription drug is approved, the Patented Medicines Price Review Board negotiates a price with the pharmaceutical company. As a rule, the board will not approve a price for a new drug that is any higher than the most expensive existing drug used to treat the same condition. Still, price controls have had questionable success. A University of Toronto study concluded that their main effect had been to limit patients' choices, causing them to rely more on hospitals and surgery.<sup>343</sup>

Many drugs found in the United States are simply not available in Britain. Each local health authority often decides which drugs are placed on their formulary based upon funds available in a limited budget. Those drugs thought to expensive are often left off the list. Budget restrictions created by the NHS have denied patients the best drug therapy in many cases. For example:

- Dr. Edward Newlands, the British doctor who co-developed the brain cancer drug Temodal, cannot prescribe it to his own patients.<sup>344</sup>
- Taxol, a drug that is widely prescribed in the United States for the treatment of breast cancer, and Gemzar, a drug used to treat pancreatic cancer, are unavailable in some regions of the U.K.<sup>345</sup>

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<sup>341</sup> William McArthur, "Prescription Drug Costs: Has Canada Found the Answer?" National Center for Policy Analysis, Brief Analysis No. 323, May 19, 2000.

<sup>342</sup> John R. Graham, "Prescription Drug Prices in Canada and the United States — Part 3: Retail Price Distribution," Fraser Institute, August 30, 2001.

<sup>343</sup> McArthur, "Prescription Drug Costs: Has Canada Found the Answer?"

<sup>344</sup> Grace-Marie Turner, "Foreign Countries Limit Access to Prescription Drugs," Galen Institute, Galen Reports, May 27, 2000. <http://www.galen.org/news/052700.html>.

- Fewer than one-third of British patients who suffered a heart attack had access to beta-blockers (used by 75 percent of patients in the United States) despite the fact that post-heart attack use of the drug has been documented to reduce death by 20 percent.<sup>346</sup>

**Are Prescription Drug Prices Lower in Other Countries?** Comparing prices across countries is complicated. Pharmaceutical companies, like makers of other products, charge different prices in different countries. In the United States, the list prices of drugs are generally used as reference points for calculating discounts, so the list price is not usually the price actually charged. The top-selling drugs in one country are not the top sellers in others, so one cannot simply compare top sellers. Further, generic drugs often have higher volumes and lower prices than brand-name drugs.

Economist Patricia Danzon of the Wharton School at the University of Pennsylvania examined some well-publicized studies of international price comparisons of pharmaceuticals and concluded that their findings of very large price differences between the United States and other industrial countries were based on flawed methodology. Among the errors: using small, non-random samples of products, excluding generic drugs (which make up 42 percent of U.S. purchases), ignoring differences in prescription and consumption patterns from country to country, and ignoring manufacturer discounts and rebates in the United States.<sup>347</sup>

Prof. Danzon conducted her own comparison, attempting to control for all these complicating factors. She determined manufacturers' prices of drugs, including generic drugs, in the United States and eight other countries, and converted the weights of each product to U.S. measures. Depending on the country and the drugs available, she compared from 187 to 484 products. She found that average prices of prescription drugs were comparable to or higher than U.S. prices in Canada, Germany, Sweden and Switzerland, and lower in France, Italy, Japan and the U.K.<sup>348</sup>

**How Successful Are Controls at Holding Down Drug Spending?** Apparently not very, despite the fact that countries with single-payer systems try to limit both price and availability. As Figure 18-1 shows, when per capita spending is adjusted for differences in the value of currency from country to country (what economists call "purchasing power parity"):

- Germany spends \$335 and France \$309 per capita on prescription drugs each year, compared to the United States' \$291.

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<sup>345</sup> D. Taylor and J. Mossman, "Living with Ovarian Cancer," Cancer BACUP, Care Survey, 1999; and "Is NICE removing postcode prescribing?" CancerBACUP, November 2000.

<sup>346</sup> Grace-Marie Turner, "Foreign Countries Limit Access to Prescription Drugs," Galen Institute, Galen Reports, May 27, 2000; Neil C. Campbell et al., "Secondary Prevention in Coronary Heart Disease: Baseline Survey of Provision in General Practice," *British Medical Journal*, Vol. 316, Issue 7142, May 9, 1998, pp. 1430-34; also see K.W. Clarke, D. Gray and J.R. Hampton, "Evidence of Inadequate Investigation and Treatment of Patients with Heart Failure," *British Heart Journal*, Vol. 71, No. 6, June 1994, pp. 584-87.

<sup>347</sup> See Patricia Danzon, "The Uses and Abuses of International Price Comparisons," in R. B. Helms, ed., *Competitive Strategies in the Pharmaceutical Industry* (Washington, D.C.: AEI Press, 1996); Patricia Danzon, *Pharmaceutical Price Regulation: National Policies Versus Global Interests* (Washington, D.C.: AEI Press, 1997); and Patricia Danzon and J.D. Kim, "The Life Cycle of Pharmaceuticals: A Cross-National Perspective," Wharton School, Wharton Working Paper, 1997.

<sup>348</sup> Danzon, "The Uses and Abuses of International Price Comparisons."

- Spending in Italy (\$271) and Canada (\$255) is only slightly less than in the United States.

**[Click here to see Figure 18-1](#)**

Although price controls and cost containment programs are generally ineffective in holding down drug spending, they do have a substantive impact on research and development spending. Countries with less money to reinvest in R&D have seen their pharmaceutical industries decline or go abroad. The United States, which has no widespread price controls on drugs, produces by far the most innovative drugs.

**MYTH NO. 19: Single-payer health insurance would be popular in the United States.**

This notion is based largely on the assumption that it is popular in other countries. However, although there is hardly a clamoring in other countries to implement an American-style system, there appears to be a growing concern that the basic public health care model is failing. For example, between 1987 and 1997 the proportion of Canadians who were satisfied with their health care system dropped from 56 percent to 20 percent.<sup>349</sup> [See Figure 19-1.] In Britain, the sad state of the National Health Service has been a major campaign issue — with reports of long waits, low standards of care and even outright abuse appearing often in the British press.

**[Click here to see Figure 19-1](#)**

However, even if socialized medicine were as popular elsewhere as its advocates assert, it would be unlikely to gain wide acceptance in the United States for one important reason: Americans are accustomed to a level of health care that socialized medical systems cannot provide.

Precisely because the U.S. medical market is largely private, Americans of every social rank are aware of the advanced state of medical technology that exists and have come to expect access to life-saving equipment and procedures. Having witnessed the efficacy of private medicine in improving lives, Americans are conditioned to expect immediate delivery of all that medical science has to offer if life or limb is threatened. When Americans were asked to agree or disagree with the statement “system needs completely rebuilt,” almost three of four insured individuals disagreed. More shocking is forty-one percent of uninsured individuals also disagreed with the statement.

Only a small percentage of Americans are dissatisfied with their family’s care. Moreover, satisfaction often has much to do with perceptions, even if erroneous. A recent survey was unique because it tracked those people who were unaware of their true insurance status. People who thought they were HMO members (even if they were not) were more likely to list

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<sup>349</sup> “Health Care in Canada 2000: A First Annual Report,” Canadian Institute for Health Information, April 2000.

themselves as dissatisfied than those who thought they were not in an HMO (even though they were).<sup>350</sup> [See Figure 19-2]

**[Click here to see Figure 19-2](#)**

“Don’t push me around” is a distinctively American phrase. In the United States we have widespread access to information about modern medical technology. In the age of the Internet, people are demanding far greater say in their treatment decisions.<sup>351</sup> We also have a legal system that protects the rights of those without political power or money, and a strong devotion to basic rights of due process. Single-payer systems of national health insurance, as it operates in other countries, simply would not survive in the U.S. cultural and legal system.

**MYTH NO. 20: The defects of single-payer health insurance schemes in other countries could be remedied by a few reforms.**

The rationale behind this argument is simple. Since health care services in countries with single-payer health insurance are government-administered public goods, any problems that arise in their delivery can be alleviated by some adjustment at the government level. However, as the years of failed reform efforts in Britain and has shown, the structural defects of single-payer system of national health insurance are not effectively remedied at the governmental level.

The characteristics described above are not accidental byproducts of government-run health care systems. They are the natural and inevitable consequences of placing the market for health under the control of politicians.<sup>352</sup> It is not true that health care policy in countries with single-payer health insurance just happens to be as it is.

Why are low-income patients so frequently discriminated against under national health insurance? Because such insurance is almost always a middle-class phenomenon. Prior to its introduction, every country had some government-funded program to meet the health care needs of the poor. The middle-class working population not only paid for its own health care but also paid taxes to fund health care for the poor. Single-payer health insurance extends the “free ride” to those who pay taxes to support it. Such systems respond to the political demands of the middle-class population, and they serve the interests of this population.

Why do single-payer health insurance schemes skimp on expensive services to the seriously ill while providing so many inexpensive services to those who are only marginally ill? Because the latter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small

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<sup>350</sup> James D. Reschovsky and J. Lee Hargraves, “Health Care Perceptions and Experiences: It’s Not Whether You are in an HMO, It’s Whether You Think You Are,” Center for Studying Health System Changes, Issue Brief #30, September 2000.

<sup>351</sup> See Devon M. Herrick, “Managing Health Care with the Internet,” National Center for Policy Analysis, Brief Analysis No. 330, July 27, 2000; and Devon M. Herrick, “Patient Power and the Internet,” National Center for Policy Analysis, Brief Analysis No. 317, March 31, 2000.

<sup>352</sup> John C. Goodman and Philip K. Porter, “Political Equilibrium and The Provision of Public Goods,” *Public Choice*, forthcoming.

number of voters). Democratic political pressures in this case dictate the redistribution of resources from the few to the many.

Why are sensitive rationing decisions and other issues of hospital management left to hospital bureaucracies? Because the alternative is politically impossible. As a practical matter, no government can make it a national policy that 25,000 of its citizens die from lack of the best cancer treatment every year.<sup>353</sup> A substantial number of these will die because of a lack of government-provided resources. Nor can any government announce that some people must wait for surgery so that the elderly can use hospitals as nursing homes, or that elderly patients must be moved so that surgery can proceed.

These decisions are so emotionally loaded that no elected official could afford to claim responsibility for them. Important decisions on who will and will not receive care and on how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.

## The Politics of Medicine

“Public choice” is the name of a relatively new discipline that attempts to integrate economics and political science.<sup>354</sup> Its chief goal is to explain political phenomena with fundamental principles, in much the same way that economists explain purely economic phenomena. The name, however, is potentially misleading. The new discipline could just as accurately be called “modern political science.”

A fascinating discovery of this discipline is that economic principles, if carefully applied, explain much of what happens in politics. Take the concept of competition. Just as producers of goods and services compete for consumer dollars, so politicians in a democracy compete for votes. Moreover, the process of competition leads to certain well-defined results.

In the economic marketplace, competition inevitably forces producers to choose the most efficient method of production. Those who fail to do so either go out of business or mend their ways. The ultimate outcome — efficient production — is independent of any particular producer’s wishes or desires.

In a similar way, political competition inexorably leads candidates to adopt a specific position called the winning platform. The idea of a winning platform is a fairly simple one. It is

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<sup>353</sup> Karol Sikora, “Cancer Survival in Britain,” *British Medical Journal*, Vol. 319, No. 7208, August 21, 1999, pp. 461-462.

<sup>354</sup> The two seminal works on public choice theory are Anthony Downs, *An Economic Theory of Democracy* (New York: Harper Row, 1957); and James Buchanan and Gordon Tullock, *The Calculus of Consent* (Ann Arbor: University of Michigan Press, 1962). For a different approach to the theory, especially as it applies to government regulation, see George Stigler, *The Citizen and The State: Essays on Regulation* (Chicago: University of Chicago Press, 1975). See also John C. Goodman and Philip K. Porter, “Theory of Competitive Regulatory Equilibrium,” *Public Choice*, Vol. 59, pp. 51-66, 1988; and Gary S. Becker, “A Theory of Competition Among Pressure Groups for Political Influence,” *The Quarterly Journal of Economics*, Vol. 48, pp. 371-400.

a set of political policies that can defeat any other set of policies in an election. A politician who wants to be elected or reelected has every incentive to endorse the winning platform. If he does not, he becomes vulnerable; for if his opponent adopts the winning platform, the opponent will win.

Of course in the real world, things are rarely so simple. Many factors influence voters other than substantive political issues — a candidate’s religion, general appearance, speaking ability, party affiliation, etc. Even when voters are influenced by real political issues, politicians don’t always know what the winning platform is. Often they must guess at it. Nonetheless, public choice theory holds that, other things equal, a candidate always improves his chances of winning by endorsing the winning platform. Hence, all candidates have an incentive to identify and endorse this platform. Candidates who do not are unlikely to survive the political competition.

This line of reasoning leads to a remarkable conclusion: In democratic systems with two major political parties, both parties tend to adopt the same policies. They do so not because the party leaders think alike or share the same ideological preferences, but because their top priority is to win elections and hold office.

Two corollaries follow from this conclusion. The first is that it is absurd to complain about the fact that “major candidates all sound alike,” or that “it doesn’t seem to make any difference who wins.” The complaints are merely evidence that political competition is working precisely as the theory predicts it will work. Indeed, the more accurate information political candidates receive through better polling techniques and computerization, the more similar they will become. The theory predicts that, in a world of perfect information, the policies of the two major parties would be identical.

The second corollary is more relevant for our purposes. In its extreme form, the corollary asserts that “politicians don’t matter.” Over the long haul, if we want to explain why we have the political policies we have, it is futile to investigate the motives, personalities and characters of those who hold office. Instead, we must focus on those factors which determine the nature of the winning platform.

This corollary is crucial to an understanding of single-payer health insurance. A great many British health economists who support socialized medicine are quick to concede that the British National Health Service has defects. But these defects, in their view, are not those of socialism; they merely represent a failure of political will, or the fact that the wrong politicians were in office. The ultimate goal, they hold, is to retain the system of socialized medicine and make it work better.

By contrast, we argue that the defects of the policies which govern single-payer health insurance programs are natural and inevitable consequences of placing the market for health under the control of politicians. It is not true that British health care policy just happens to be as it is. Enoch Powell, a former Minister of Health who ran the British National Health Service, seems to have appreciated this fact. Powell wrote that “whatever is entrusted to politicians becomes political even if it is not political anyhow,”<sup>355</sup> and he goes on to say that

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<sup>355</sup> Powell, *Medicine and Politics, 1975 and After*, p. 5.

“The phenomena of Medicine and Politics ... result automatically and necessarily from the nationalization of medical care and its provision gratis at the point of consumption .... These phenomena are implicit in such an organization and are not the accidental or incidental results of blemishes which can be ‘reformed’ away while leaving the system as such intact.”<sup>356</sup>

An extensive analysis of the British health care system shows that all of the major features of national health insurance can be explained in terms of public choice theory.<sup>357</sup> That is, far from being the consequence of preferences of politicians (who could be replaced by different politicians with different preferences in the next election), the major features of single-payer systems of national health insurance follow inevitably from the fact that politicians have the authority to allocate health care resources, and from that fact alone. The following is a brief summary.

**The Total Amount of Spending on Health Services.** One argument used to justify socialized medicine is that, left to their own devices, individuals will not spend as much as they ought to spend on health care. This was a major reason why many middle- and upper-middle-class British citizens supported national health insurance for the working class. It was also a major reason why they supported formation of the NHS in 1948.<sup>358</sup> Many expected that, under socialized medical care, more total dollars would be spent on health care than would otherwise have been the case.

In fact, it is not clear that socialized medicine in Britain has increased overall spending on health care. It may have even led to the opposite result. This is the contention of Dennis Lees, Professor of Economics at the University of Nottingham, who wrote that “the British people, left free to do so, would almost certainly have chosen to spend more on health services themselves than governments have chosen to spend on their behalf.”<sup>359</sup> The same may be true of the single-payer systems of national health insurance programs in other countries.

To see why this is true, let us first imagine a situation in which a politician is trying to win over a single voter. To keep the example simple, let us suppose the politician has access to \$10 to spend on the voter’s behalf. To maximize his chance of winning, the politician should spend the \$10 precisely as the voter wants it spent. If the voter’s choice is \$5 in medical care, \$3 in a retirement pension and \$2 in a rent subsidy, that should also be the choice of the vote-maximizing politician. If the politician does not choose to spend the \$10 in this way, he risks losing this voter to a clever opponent.

Now it might seem that if the voter wants \$5 spent on medical care, we can conclude that he would have spent the \$5 on medical care himself if he were spending \$10 of his own money. But this is not quite true. State-provided medical care has one feature that is generally missing from private medical markets, and from other government spending programs as well — non-

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<sup>356</sup> Ibid., p. 67.

<sup>357</sup> John C. Goodman, *National Health Care in Great Britain: Lessons for the U.S. A.* (Dallas: Fisher Institute, 1980), ch. 10.

<sup>358</sup> Dennis Lees, “An Economist Considers Other Alternatives,” in Helmut Schoeck, ed., *Financing Medical Care: An Appraisal of Foreign Programs* (Caldwell, Idaho: Caxton Printers, Ltd., 1963), p. 80.

<sup>359</sup> Dennis Lees, “Economics and Non-economics of Health Services,” *Three Banks Review*, No. 110, June 1976, p. 9.

price rationing. Non-price rationing, as we have seen, imposes heavy costs on patients (the cost of waiting and other inconveniences), leads to deterioration in the quality of services rendered and creates various forms of waste and inefficiency.

Thus, other things equal, \$5 of spending on government health care will be less valuable to the average voter than \$5 of spending in a private medical marketplace. It also means that, under socialized medicine, spending for health care will be less attractive to voters relative to spending programs which do not involve non-price rationing.

Public choice theory, then, predicts that the average voter will desire less spending on health care, relative to other goods and services, when health care is rationed by non-market devices. Moreover, the greater the rationing problems, the less attractive health care spending will be. So, we would expect even less spending on health care in a completely “free” service like the NHS than in a health service that charged patients more user fees.

In the real world, politicians rarely have the opportunity to tailor their spending purely to the desires of a specific voter. Generally they must allocate spending among programs that affect thousands of voters at the same time. New spending for a hospital, for example, provides benefits for every one in the surrounding community. No matter what level of spending is chosen, some voters will have preferred more, and others less. Often in such cases, the vote-maximizing level of spending will be the level of spending preferred by the average voter.

**Inequalities in Health Care.** Decisions on where to spend health dollars are also inherently political. A major argument in favor of national health insurance is that private medical care allows geographical inequalities in levels of provision. Yet, as we have seen, those inequalities continue and many argue that levels of provision among geographical areas of Britain, Canada and New Zealand today are just as unequal as they would have been in the absence of national health insurance.

In theory, creating regional equality is a relatively simple task. All governments have to do is spend more in areas that are relatively deprived and less in areas that are relatively well-endowed. But most governments have not done this. Why? Public choice theory supplies a possible answer.

Policymakers must make two choices about spending in a particular area or region. First, they must decide how many total dollars are to be spent there. Second, they must decide how to allocate those dollars. In a democracy, there is no particular reason why per capita spending will be the same in all areas.

Per capita spending may differ across voting districts for numerous reasons. Voter turnout may be higher in some districts than in others, which suggests that those districts are willing to “pay” more (in terms of votes) for political largesse. Voters in some districts may be more aware of, and more sensitive to, changes in per capita spending than voters in other districts.

Given that a certain amount of money is going to be spent in a certain area or region, competition for votes dictates that the money be allocated in accordance with the preference of the voters in that area or region. To return to the hypothetical example of the previous section, suppose that, say, \$10 is going to be spent in the city of Merseyside, England. If a majority of residents want \$2 spent on health services and \$8 spent on other programs, political competition will tend to produce that result. Yet if the residents of some other city want \$8 spent on health



services and \$2 spent on other programs, political competition will also tend to produce that result.

Prior to the establishment of single-payer systems in most developed countries, geographical inequalities reflected community preferences. In general, the citizens of wealthier and more densely populated areas chose to spend a larger fraction of their income on medical care. There is no reason to suppose that their preferences were radically altered by national health insurance, and thus no reason to suppose that in allocating public spending, vote-maximizing politicians are doing anything other than responding to voter preferences.

**Spending Priorities: “Caring” vs. “Curing.”** The British National Health Service’s emphasis on “caring” rather than “curing” marks a radical difference between British and American health care.

There can be no doubt that Britain’s choices are the result of conscious political decisions. American economist Mary-Ann Rozbicki asked a number of British health planners the following question: “If you suddenly enjoyed a sharp increase in available resources, how would you allocate it?” The response was invariably the same. They would put the additional resources into services for the aged, the chronically ill and the mentally handicapped.<sup>360</sup> Commenting on this response, Rozbicki writes:<sup>361</sup>

It is difficult for an American observer to comprehend that view. He has been impressed by the support services already afforded the non-acute patient (and the well consumer) — the doctor, nurse and social worker attendance at homes, clinics and hospitals for the purpose of improving the comfort and well-being of the recipients involved. He has also been impressed (and sometimes shocked) by the relative lack of capability to diagnose, cure and/or treat life-threatening conditions. The U.S. patient, while having forgone the home ministrations of the family doctor and learned to endure the antiseptic quality of the hospital, also confidently expects immediate delivery of all that medical science has to offer if life or health is under immediate threat.

What political pressures lead decision makers to prefer caring over curing? Rozbicki believes it is a matter of numbers — numbers of votes. Money spent on caring is spread out over far more people than money spent on curing. Rozbicki writes:<sup>362</sup>

In weighing the choice between a more comfortable life for the millions of aged or early detection and treatment of the far fewer victims of dread diseases, [the British health authorities] have favored the former. In choosing between a fully equipped hospital therapy and rehabilitation center or nuclear medicine technology, they have favored the former. *The sheer numbers involved on each side of the equation would tend to dictate these choices by government officials in a democratic society.*

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<sup>360</sup> Mary-Ann Rozbicki, “Rationing British Health Care: The Cost/Benefit Approach,” Executive Seminar in National and International Affairs, U.S. Department of State, April, 1978, p. 17.

<sup>361</sup> Ibid.

<sup>362</sup> Ibid., p. 18. (Emphasis added.)

While Rozbicki's explanation may be correct, it cannot be complete. It is true that the number of potential beneficiaries of home visits far exceeds those of radiation therapy. But all Britons are potentially ill, so all have an interest in NHS spending priorities. To understand these priorities, we must understand why the average citizen would approve of them.

Like the citizens of other countries, most Britons know little about medical technology. This ignorance, moreover, is quite "rational." Information is costly. The rational person has an incentive to expand his knowledge about any subject only to the point at which the cost of an additional bit of information is equal to its benefit. This is the economic explanation for the commonly observed fact that the average person does not become an expert in medical science.

In Britain, however, the average citizen has much less incentive to become knowledgeable about medicine than his counterpart in the United States. Precisely because the medical market in the United States is largely private, a better-informed person becomes a better consumer.

But within the confines of the NHS, medical services are not "purchased." Suppose a British citizen invests time and money to learn more about medical matters and discovers that the NHS is not offering the kinds of services it should. This knowledge is of almost no value unless the citizen can inform millions of other voters, persuade them to "throw the rascals out" and achieve a change of policy. Such a campaign would be enormously expensive, undoubtedly costing the citizen far more than he could expect to recover from any potential personal benefit.

Undoubtedly part of the reason Europeans, Canadians and citizens from many OECD countries are happy with single-payer health insurance systems has to do with a simple fact. Most of them are not sick and in need of care. At the point of service, national health insurance makes care virtually free. The politics of medicine dictates that much of the expenditure takes place where consumed by the bulk of the population. Where the flaws of single-payer health insurance systems are most apparent is where expensive intervention is needed by the few who are very ill.

For example, almost three quarters of health expenditure is consumed by only ten percent of the population. Experts say as much as 41 percent of health expenditure is consumed by the two percent of the population that is most in need of care. [See Figure 21-1]

**[Click here to see Figure 21-1](#)**

Socialized medicine affects the level of knowledge that patients have in yet another way. In a free market for medical care, suppliers of medical services have an incentive to inform potential customers about new developments. Such information increases the demand for new services and, thus, promises to enhance the income of those who supply them. In the NHS, however, the suppliers of medical care have no such incentives. Doctors, nurses and hospital administrators increase their income chiefly by persuading the government to pay them more. They increase their comfort, leisure time and other forms of satisfaction by encouraging patients to demand not more but less.

Economic theory, then, would predict that in a socialized medical scheme, people will acquire less knowledge about medical care than they would have acquired in a private system. The evidence confirms this prediction. Numerous commentators have observed that British

patients know far less about medical care than American patients. Rozbicki, for example, writes that “the British populace appears much less sophisticated in its medical demands than the American populace.”<sup>363</sup>

The general ignorance about medical science which prevails among British voters has a profound impact on NHS policies. Other things equal, people will always place a higher value on those services with which they are familiar and on benefits about which they are certain. The known is preferred to the unknown and certainty to uncertainty. The average British voter is familiar with, and fairly certain about, the personal value of the non-acute services provided by the NHS. He or she is probably unfamiliar with, and uncertain about, the personal value of advanced services for acute ailments. Thus, the voter will tend to approve of NHS spending priorities.

Another reason why voters will tend to prefer caring to curing services stems from a characteristic of non-price rationing. All of the services of the NHS require rationing. But in some sectors, the rationing problems are far greater than in others because quality can sometimes be sacrificed to quantity. We have seen that, in comparison with American doctors, British GPs have greatly reduced the time spent with each patient and the quality of service rendered. Nonetheless, this type of adjustment allows the typical patient to actually visit his GP within two or three days of making an appointment. The quality of treatment may have deteriorated, but patients are at least certain that they will receive *some* treatment. Presumably, given the overall rationing problem, patients prefer this type of adjustment.

Such adjustments cannot be made with most acute services. It is not feasible to sacrifice quality for quantity in, for example, CT scans, organ transplants and renal dialysis. Patients either receive full treatment or no treatment, and very few patient-pleasing adjustments can be made.

These characteristics of health care rationing have an important effect on the preferences of potential patients — even those who are knowledgeable about medicine. The existence of non-price rationing tends to make all health care services less valuable than those services would be in the free market. But because non-acute services can be adjusted to increase the certainty of some treatment, whereas acute services generally cannot, the former tend to become more valuable relative to the latter. Thus, to a certain extent, the priority given to non-acute treatment is perfectly rational.

**Administrative Controls.** One of the most remarkable features of national health insurance is the enormous amount of decision-making power left in the hands of doctors. By and large, the medical communities in Britain, Canada and New Zealand have escaped the disciplines of both the free market and government regulation. In the view of Michael Cooper,<sup>364</sup> Anthony Culyer<sup>365</sup> and many others, this discretion is the principal reason for many of the gross inefficiencies found in the British National Health Service.

In addition to the power of GPs and consultants, other producer interest groups also have obtained power and influence. Within the NHS, these include hospital administrators, junior

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<sup>363</sup> Ibid., p. 17.

<sup>364</sup> Michael Cooper, *Rationing Health Care* (London: Croom Helm, Ltd., 1975), p. 73.

<sup>365</sup> Anthony Culyer, “Health: the Social Cost of Doctors’ Discretion,” *New Society*, February 27, 1975.

doctors and nonmedical hospital staff. The complaint made again and again is that the NHS is primarily organized and administered to benefit such special interest groups rather than patients. As Dennis Lees puts it,<sup>366</sup>

The British health industry exists for its own sake, in the interest of the producer groups that make it up. The welfare of patients is a random by-product, depending on how conflicts between the groups and between them and government happen to shake down at any particular time.

Government production of goods and services always tends to be less efficient than private production. Nonetheless, the NHS could be run more efficiently than it actually is. Its administrators could adopt well-defined goals and assert more control over the various sectors to ensure that the goals are pursued. They could create incentives for NHS employees to provide better, more efficient patient care.

That these things are not done is hardly surprising. Over 200 years ago, Adam Smith observed that government regulation in the marketplace inevitably seemed to benefit producer interest groups at the expense of consumers. Things have changed very little with the passage of time. Economic studies of virtually every major regulatory commission in the United States have come to the same conclusion: the welfare of producers is regularly favored over the welfare of consumers.<sup>367</sup> Why should we expect the NHS to be different?

Are these phenomena consistent with public choice theory? At first glance it may seem that they are not. Since consumers outnumber producers, it might seem that, with democratic voting, consumers would always have the upper hand. If sheer voting power were the only power, this might be so. But two additional factors put consumers at a disadvantage: costs of information and costs of political organization.

To achieve any fundamental change of policy, voters must be informed about what kinds of changes they specifically seek. They must also be organized — at least to the extent that they can communicate to politicians their willingness to withhold electoral support unless their desires are satisfied. But as we have seen, information is costly. Organizing a political coalition is also costly. And the incentives for any single individual to bear these costs are extremely weak.

Producers are in a different position. Since they are working in the industry, they already possess a great deal of information about which policies are consistent with their self-interest and which are not. Their costs of political organizing also are much lower because they are relatively few in number and share common interests. In addition, because the personal stake of each producer in regulatory issues is far greater than that of a representative consumer, each producer has a much greater *personal incentive* to contribute to political efforts that protect the interests of producers as a group.

Producer interest groups, then, ordinarily have enormous advantages over consumer groups in issues involving government regulation of their industry. These advantages appear to

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<sup>366</sup> Lees, “Economics and Non-economics of Health Services,” p. 12.

<sup>367</sup> A representative sample of such studies is contained in Paul W. MacAvoy, ed., *Crisis of the Regulatory Commissions* (New York: Norton, 1970).

be more than sufficient to overcome their relative vulnerability in terms of sheer voting power. This insight was provided by Professor Milton Friedman 40 years ago.<sup>368</sup>

Each of us is a producer and also a consumer. However, we are much more specialized and devote a much larger fraction of our attention to our activity as a producer than as a consumer. We consume literally thousands if not millions of items. The result is that people in the same trade, like barbers or physicians, all have an intense interest in the specific problems of this trade and are willing to devote considerable energy to doing something about them. On the other hand, those of us who use barbers at all get barbered infrequently and spend only a minor fraction of our income in barber shops. Our interest is casual. Hardly any of us are willing to devote much time going to the legislature in order to testify against the inequity of restricting the practice of barbering. The same point holds for tariffs. The groups that think they have a special interest in particular tariffs are concentrated groups to whom the issue makes a great deal of difference. The public interest is widely dispersed. In consequence, in the absence of any general arrangements to offset the pressure of special interests, producer groups will invariably have a much stronger influence on legislative action and the powers that be than will the diverse, widely spread consumer interest.

Public choice theory, then, predicts that administrative inefficiencies caused by producer interest groups within health care bureaucracies will continue to be a permanent feature of socialized medicine. There is no reason to believe that this defect can be “reformed” away.

**Why the NHS Continues to Exist.** In 1978, an article appeared in *Medical Economics* with the heading, “If Britain’s Health Care Is So Bad, Why Do Patients Like It?”<sup>369</sup> That British patients *do* like the NHS had been confirmed repeatedly by public opinion polls. The same can be said of Canadians.

Why are British patients so satisfied with the NHS? There appear to be two major reasons: (1) the typical British patient has far lower expectations and much less knowledge about medicine than the typical American patient; and (2) most British patients apparently believe that they are “getting something for nothing.”

Comparing British and American patients, one doctor wrote that British patients “have fewer expectations” and are “more ready to cooperate unhesitatingly with the authoritarian figure of the doctor or nurse.”<sup>370</sup> An American economist noted with surprise that British hospital patients, “far from complaining about specialists’ inattention, a lack of laboratory tests or the ineffectiveness of medical treatment, more often than not display an attitude of gratefulness for

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<sup>368</sup> Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), p. 143.

<sup>369</sup> John J. Fisher, “If Britain’s Health Care Is So Bad, Why Do Patients Like It?” *Medical Economics*, August 21, 1978.

<sup>370</sup> Derek Robinson, “Primary Medical Practice in the United Kingdom and the United States,” *New England Journal of Medicine*, Vol. 297, No. 4, July 28, 1977, p. 189.

whatever is done.”<sup>371</sup> Another doctor summarized the difference in British and American attitudes this way.<sup>372</sup>

The British people — whether as a result of different life philosophy or generally lower level of affluence — have a much lower level of expectation from medical intervention in general. In fact they verge on the stoical as compared with the American patient, and, of course, this fact makes them, purely from a physician’s point of view, the most pleasant patients. The resulting service has evolved over the years into a service that would in my opinion be all but totally unacceptable to any American not depending on welfare for medical services.

The British public generally has little idea of how much they are paying for health care. Since it is financed through taxes, there tends to be a perception that it costs little. Just how the perception of getting something for nothing affects British attitudes toward what most Americans would regard as intolerable defects in the health service was vividly illustrated by the experience of an American congressman on a trip with a group to examine the NHS first hand. He met a young woman with substantial facial scars received in an accident. Although the woman wanted plastic surgery for her face, she said, “I’ve been waiting eight years for treatment, but they tell me I’m going to be able to have surgery within a year.” Yet when the congressman asked her what she thought of the NHS, her reply was, “Oh, it’s a wonderful system we have in Britain. You know, our medical care is all free.”<sup>373</sup>

It might seem that an enterprising politician or political party could win a British election by offering the British public a better deal. Why not tell voters what the NHS really costs them, then offer to return their tax dollars so they could purchase private health insurance and health services?

The average British voter would undoubtedly be better off as a result, but that doesn’t mean that most would approve of the plan. For one thing, even if voters knew what the NHS really costs, they might not be convinced that the private marketplace could offer a better deal. For years, British politicians have told voters that the NHS is the “envy of the world,” and the public has been deluged with stories in the socialist press indicating that only the rich get good medical care in the United States.<sup>374</sup>

For another thing, defenders of the NHS — including trade unions, thousands of NHS employees and many British doctors — would play on existing fears and suspicions. Surprising as it may seem, the sagging morale and continual frustrations of NHS doctors have not produced enormous numbers of converts to free enterprise medicine. Perhaps many prefer the “protection” of a government bureaucracy to the rigors of free market competition. Whatever the reason, most of Britain’s medical profession supports the idea of socialized medicine.<sup>375</sup> They not only support it, they also resisted Margaret Thatcher’s proposals to open it to minimal competition.

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<sup>371</sup> Rozbicki, *Rationing British Health Care*, p. 18.

<sup>372</sup> Quoted in Harry Swartz, “The Infirmity of British Medicine,” p. 31.

<sup>373</sup> Quoted by Lew Rockwell in *World Research INC*, March 1979, p. 5.

<sup>374</sup> *Ibid.*, p. 6.

<sup>375</sup> John Walsh, “Britain’s National Health Service: the Doctors’ Dilemmas,” *Science*, Vol. 201, July 28, 1979, p. 329.

In almost every country with single-payer health insurance systems, disinterested, knowledgeable observers agree on the need for substantial reform. As noted, even Sweden is searching for ways to introduce the disciplines of the competitive marketplace into its public system.

There have been successful attempts to privatize public health care programs (e.g., in Singapore and Chile), and among less-developed countries there will probably be more (e.g., in Colombia and Venezuela). But among developed countries, all serious attempts at fundamental reform have been blocked by the politics of medicine. Any continued public sector retreat in health care is likely to come about as people seek private sector alternatives rather than through changes at the ballot box.

## **Conclusion**

Our survey of national health insurance in countries around the world provides convincing evidence that government control of health care usually makes citizens worse off. When health care is made free at the point of consumption, rationing by waiting is inevitable. Government control of the health care system makes the rationing problem worse as governments attempt to slow the use of services by limiting access to modern medical technology. Under government management, both efficiency and quality of patient care steadily deteriorate.

The lesson from other countries is that America would not be served by an expansion of government bureaucracy or by greater governmental control over the U.S. health care system. Instead, what is needed is a limitation of the role of government and an expansion of the role played by the private sector and the individual in solving our health care problems.

TABLE 2-1

## Good Hospital Guide How London Hospitals Compare

Hospital	Mortality Index <sup>1</sup>	Drs per 100 Beds	Nurses per 100 Beds
1 Univ. Coll. London Hosp*	68	63	180
2 Bart's and the London*	70	53	129
3 Royal Free Hampstead*	79	48	131
4 Chelsea/Westm'ter H'care*	82	64	169
5 Guy's and St. Thomas's*	82	59	161
6 North West London Hosps	85	53	129
7 Hammersmith Hospitals	88	41	126
8 North Middlesex Hospital	88	49	119
9 Whittington Hospital*	90	43	150
10 St. George's Healthcare	91	49	123
11 St. Mary's Hospital*	91	59	132
12 Homerton Hospital*	92	33	116
13 King's College Hospital*	95	54	136
14 Bromley Hospitals	97	38	95
15 Kingston Hospital	101	57	169
16 Epsom and St. Helier	102	38	108
17 Queen Mary's Sidcup	103	37	109
18 Ealing Hospitals	103	42	122
19 Forest Healthcare	106	25	86
20 Lewisham Hospital*	106	37	131
21 Barnet and Chase Farm	106	43	150
22 Redbridge Healthcare	108	19	75
23 Mayday Healthcare	108	32	93
24 West Middox Univ Hospital	109	45	144
25 Newham Healthcare*	109	29	70
26 Hillingdon Hospital	111	33	108
27 Havering Hospitals	112	36	107
28 Greenwich Healthcare	112	17	131

<sup>1</sup> The mortality index is adjusted for severity of cases, and is ranked from low to high.  
Average index for London region: 96.

\* indicates Inner London boroughs (average mortality index: Inner London 85; Outer London 102).

Source: *Good Hospital Guide*, Dr. Foster, January 2001.

[http://www.drfooster.co.uk/hospital\\_guide/main/choosehospital.asp](http://www.drfooster.co.uk/hospital_guide/main/choosehospital.asp)



TABLE 2-2

**Services of All Specialists for  
Residents of Two Areas in Canada**  
(Spending per person, 1993-94)<sup>1</sup>

	<u>Vancouver</u> <sup>2</sup>	<u>Peace River</u> <sup>3</sup>
Child, Age 0-4:		
Male	\$727.4	\$242.5
Female	639.0	202.5
Adult, Age 5-9:		
Male	421.9	114.3
Female	361.4	105.2
Adult, Age 40-59:		
Male	579.4	163.3
Female	773.1	271.7
Adult, Age 70-79:		
Male	1302.0	452.4
Female	1044.1	484.8
All ages: <sup>4</sup>		
Allspecialits	609.5	231.6
Internists	50.5	11.6
OB/GYN	18.1	6.5
Psychiatrists	31.8	1.0

<sup>1</sup> Includes all physicians' fees for services rendered to residents living in the areas indicated, regardless of the area in which the service was received. Spending figures are age/sex standardized and are expressed in Canadian dollars.

<sup>2</sup> Greater Vancouver Regional Hospital District, British Columbia.

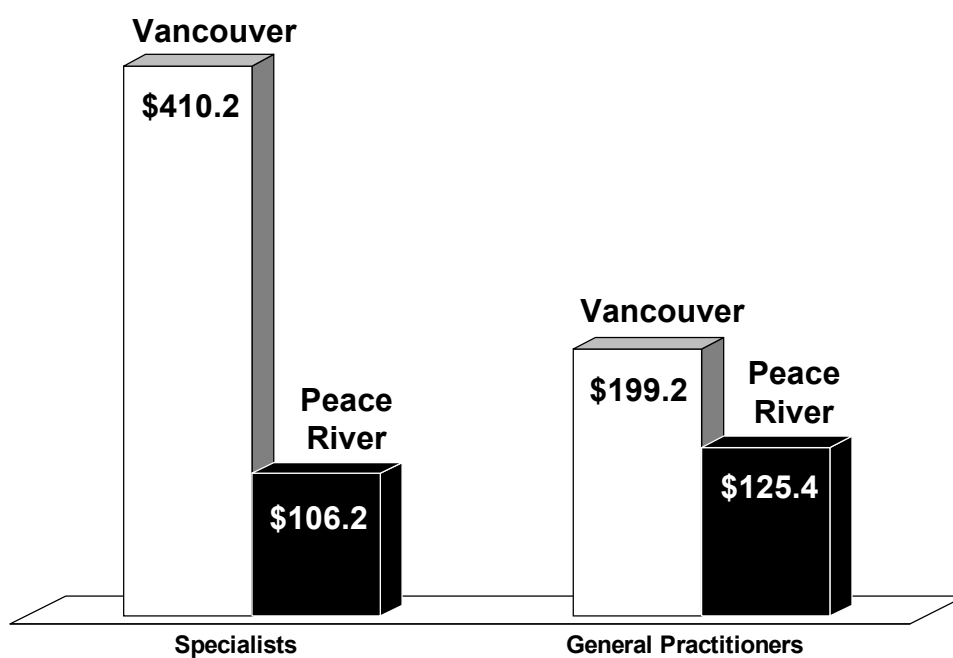
<sup>3</sup> Peace River Regional Hospital District, British Columbia.

<sup>4</sup> Sources: Arminée Kazanjian et al., "Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94," University of British Columbia, 1995, pp. 121-76.

FIGURE 2-1

## Amounts Spent on Physician Services for Residents of Two Canadian Hospital Districts<sup>1</sup>

(Per capita spending, 1993-94)



<sup>1</sup> Figures are expressed in Canadian dollars and are age/sex standardized.

Sources: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94*, (University of British Columbia, 1995) pp. 121-76.

TABLE 2-3

**Spending Per Person on Physician Services  
By Hospital Districts in British Columbia<sup>1</sup>  
(1993-1994)**

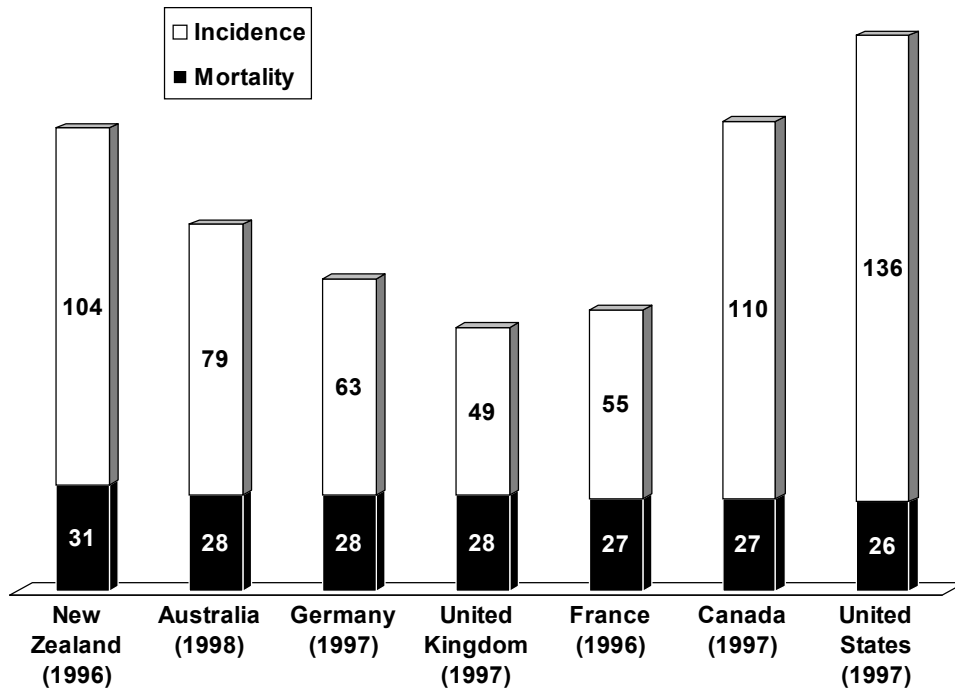
<b>Hospital Districts</b>	<b>Total Spending</b>	<b>Specialists</b>	<b>OB/GYN</b>	<b>Psychiatrists</b>	<b>Internists</b>
Urban districts:					
Vancouver	\$609.5	\$410.2	\$18.1	\$31.8	\$50.5
Victoria	379.5	242.4	8.9	13.3	28.0
Average	494.5				
Selected Rural District					
North Okanagan	290.8	153.8	7.9	4.1	16.3
Cariboo	265.3	125.5	7.8	2.5	17.0
Upper Fraser Valley	309.2	172.3	8.6	6.0	19.4
Central Kootenay	301.9	157.5	7.0	1.8	22.3
East Kootenay	267.0	119.8	3.5	0.8	10.2
South Okanagan	324.0	196.8	10.3	9.4	32.0
Simon Fraser	415.7	281.4	8.5	9.3	33.4
Peace River	231.6	106.2	6.5	1.5	11.6
Skeena-Queen	273.2	149.4	6.3	1.0	19.0
Burnaby	282.6	169.2	7.5	16.5	23.2
North Shore	338.6	206.7	7.6	13.2	27.9
Central Fraser Valley	278.8	151.9	8.4	7.1	20.5
Richmond	301.1	182.4	7.9	13.3	28.0
Average	289.5				

<sup>1</sup> Based on fees paid to physicians for rendering services to patients living in the areas indicated, regardless of the area in which the service was performed. All figures are age-sex standardized and expressed in Canadian dollars.

Sources: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94*  
University of British Columbia, 1995.

FIGURE 4-1

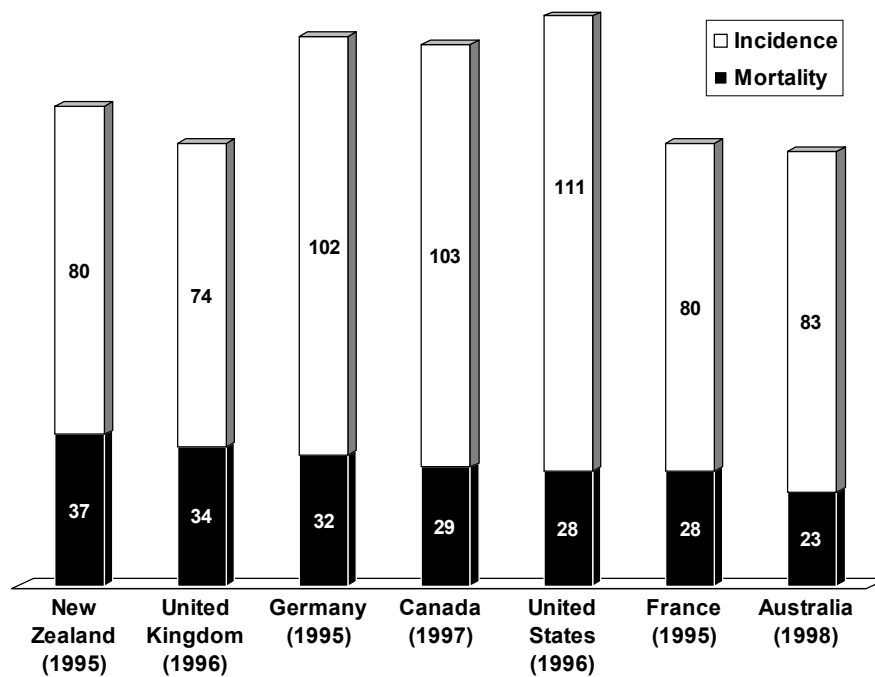
### Prostate Cancer Incidence and Mortality per 100,000 Males per Year



Sources: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

FIGURE 4-2

### Breast Cancer Incidence and Mortality per 100,000 Females per Year

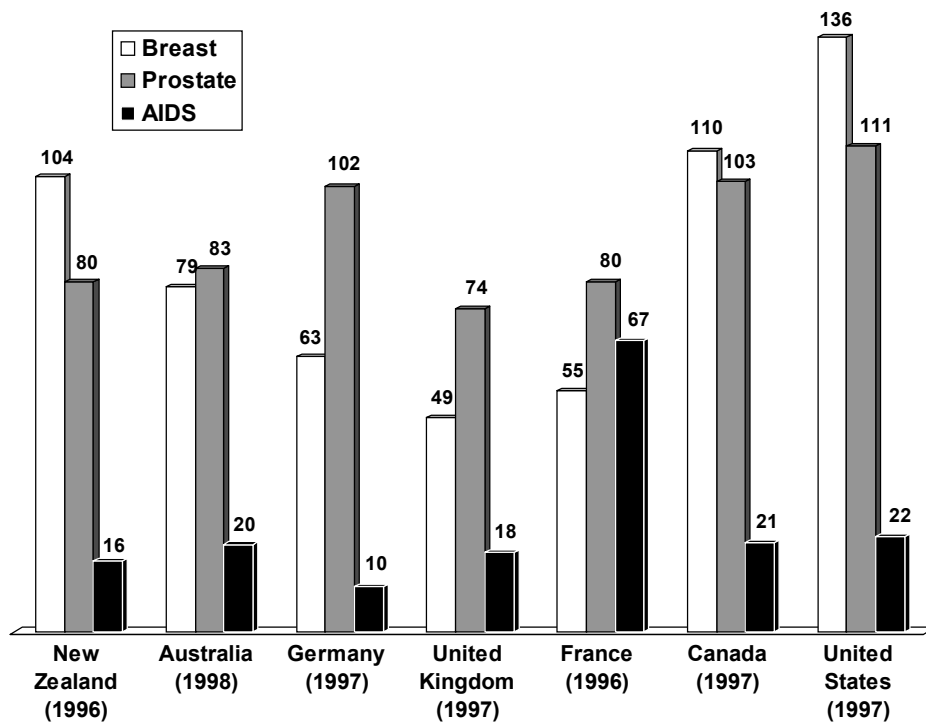


Sources: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data, 2000*, Commonwealth Fund, #431, October 2000.

FIGURE 5-1

## Incidence of Disease

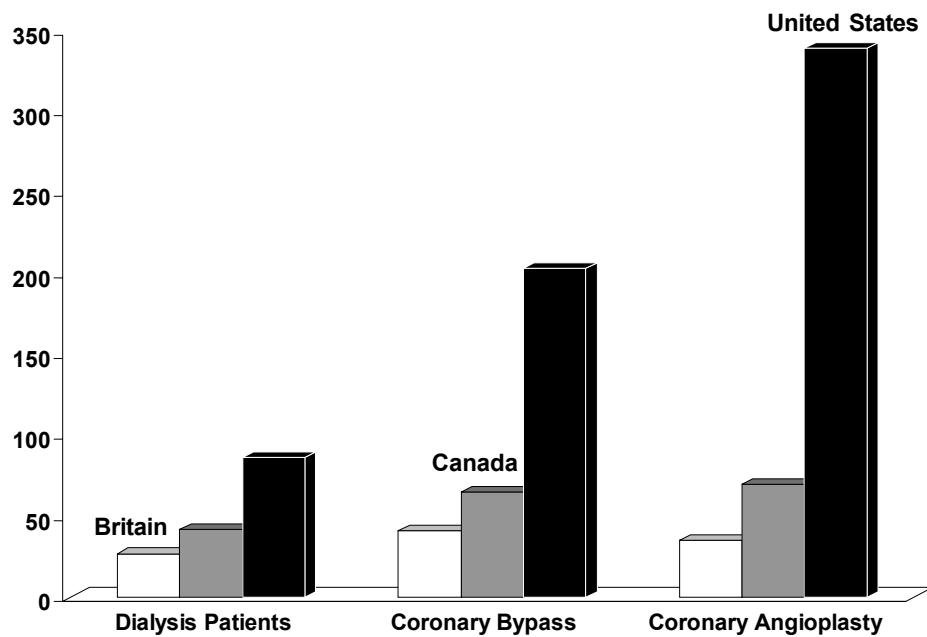
(per 100,000 per year)



Sources: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

FIGURE 5-2

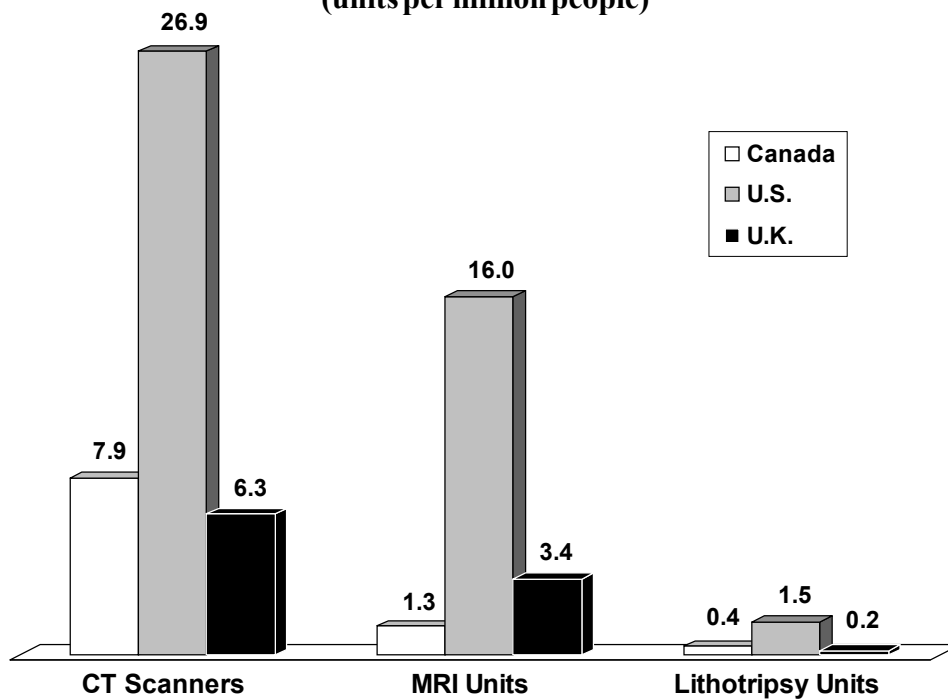
### Use of High-Tech Medical Procedures in Britain, Canada and the United States (Procedures per 100,000)



Sources: Uwe Reinhardt, Peter S. Hussey and Gerard F. Anderson, "Cross-National Comparison of Health System Using OECD Data, 1999, *Health Affairs*, Vol. 21, No. 3, May/June 2002, Exhibit 5.

FIGURE 5-3

### Access to Modern Medical Technology in the U.S., Britain and Canada (1996) (units per million people)

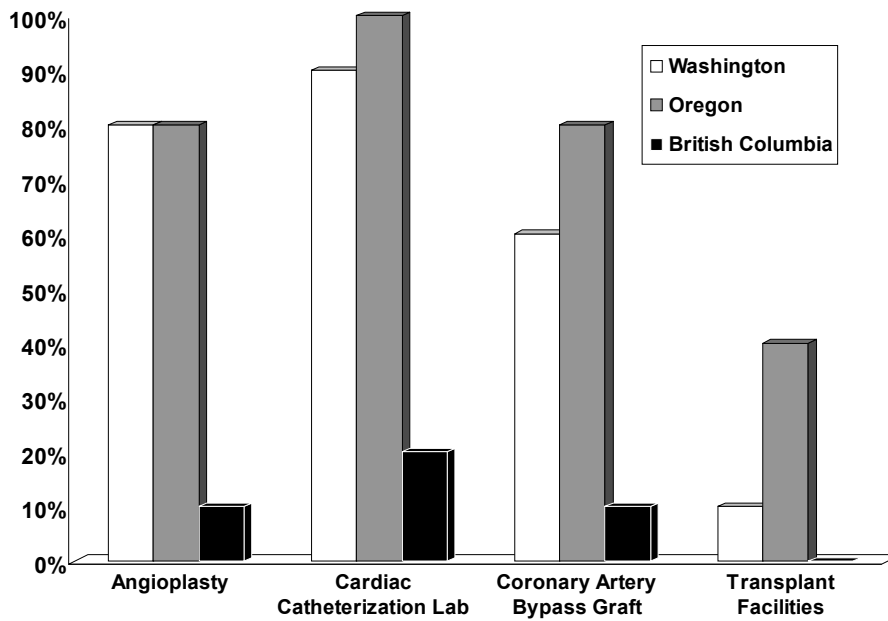


Source: Gerard F. Anderson and Jean Pierre Poullier, "Health Spending, Access and Outcomes: Trends in Industrialized Countries," *Health Affairs*, Vol. 18, No. 3, May/June 1999, p. 178-192; and Stephen Pollard, "European Health Care Consensus Group Paper," Centre for the New Europe, January 4, 2001.



FIGURE 5-4

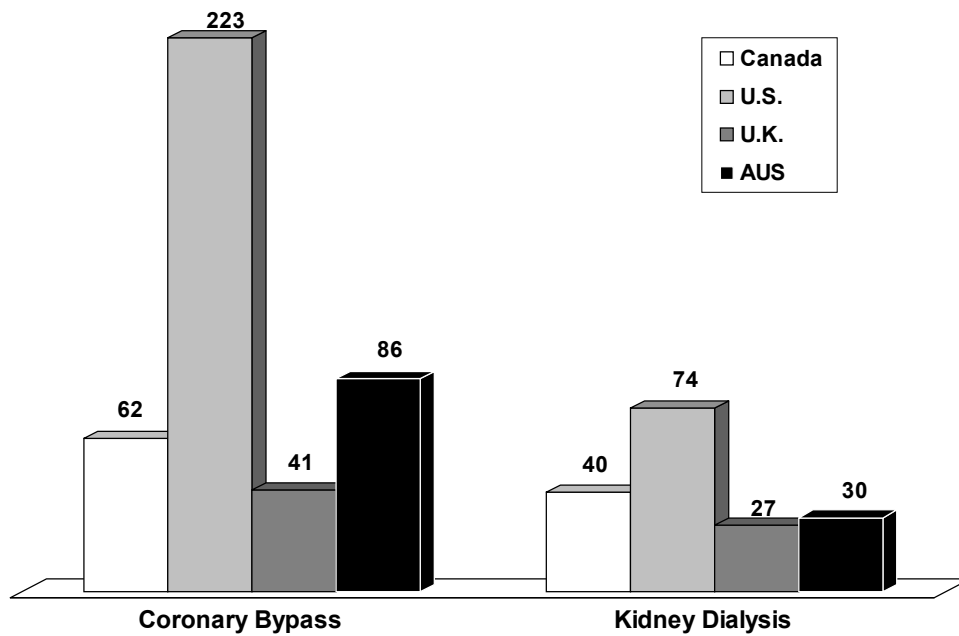
### Availability of Medical Technology in British Columbia, Washington, & Oregon Hospitals



Source: "The Availability of Medical Technology in Canada: An International Comparative Study," Fraser Institute, 1999.

FIGURE 6-1

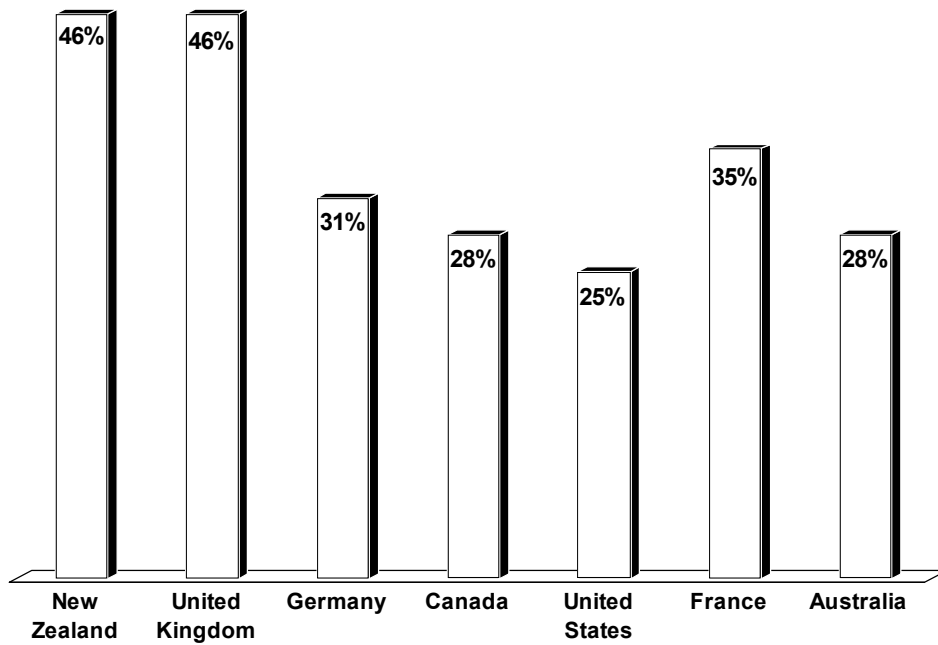
### Procedures per 100,000 Population 2000



Sources: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

FIGURE 6-2

## Breast Cancer Mortality Ratio

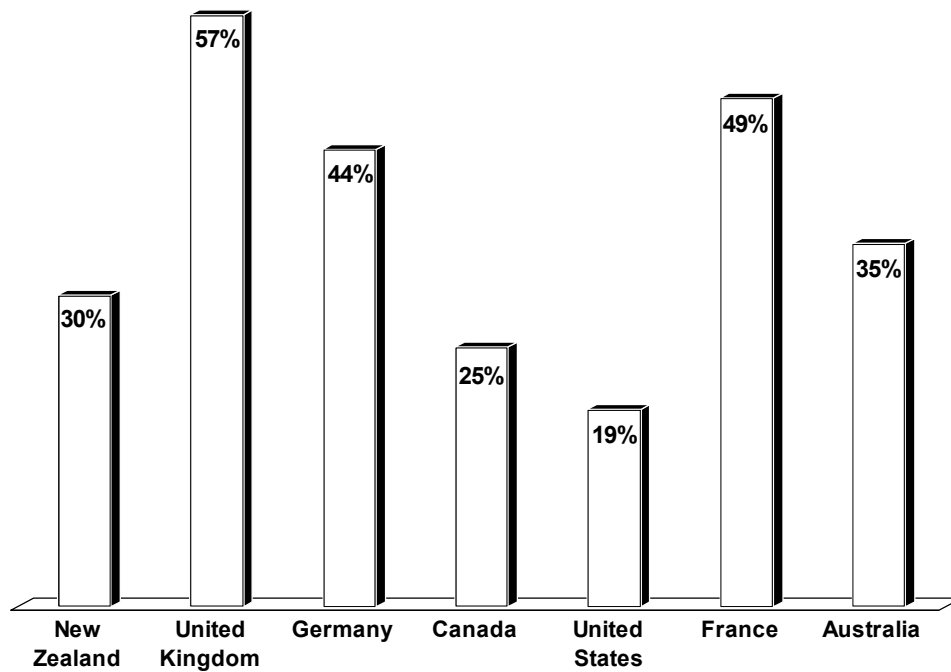


Note: The ratio is figured by dividing the death rate by the incidence of a disease.

Source: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

FIGURE 6-3

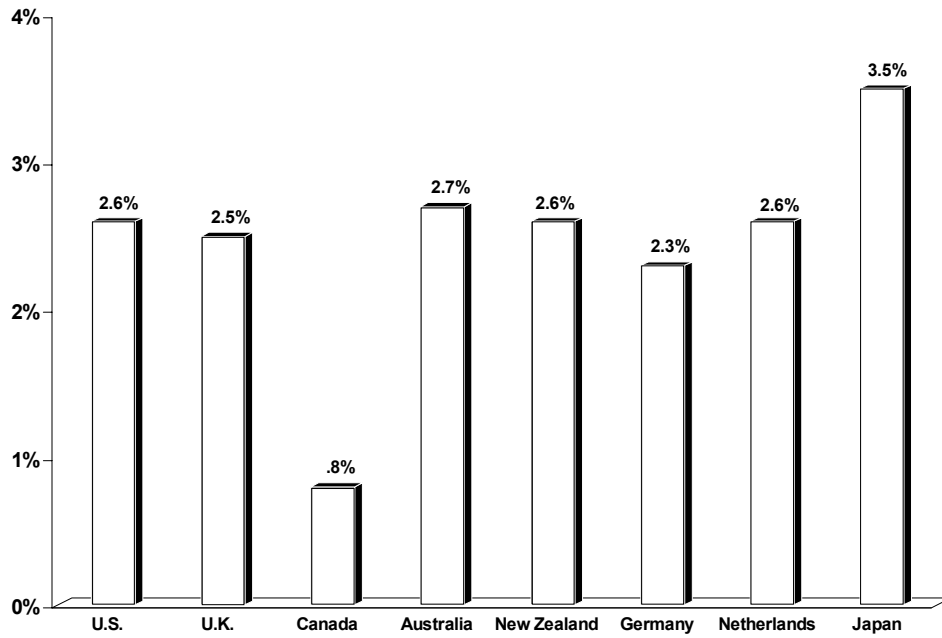
## Prostate Cancer Mortality Ratio



Sources: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

FIGURE 7-1

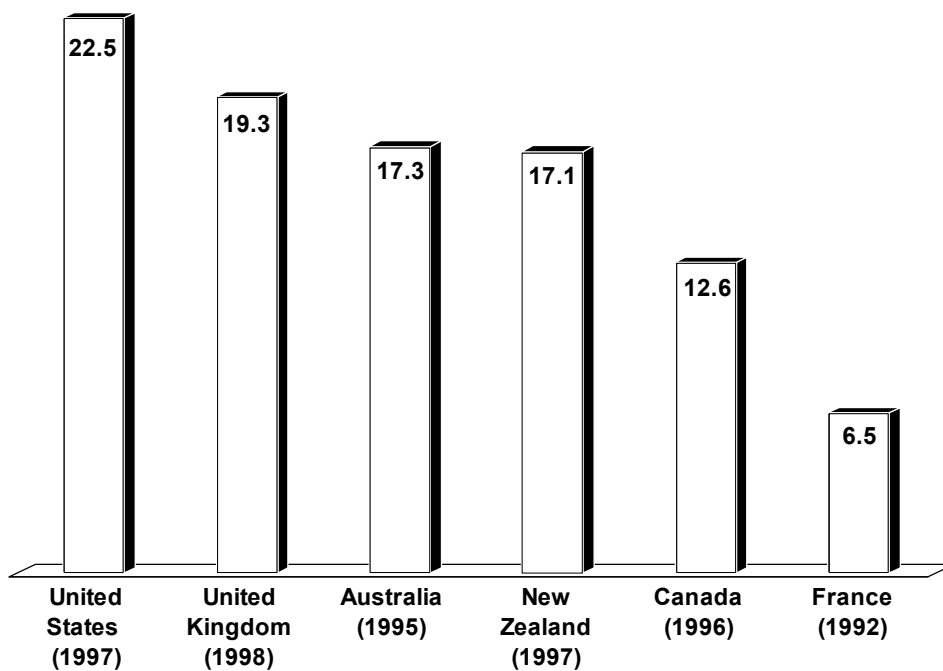
### Average Annual Real Growth in Per Capita Health Spending 1960-1998



Sources: Gerard Anderson, Jerney Hurst, Peter Hussey and Melissa Jee-Hughes, "Health Spending and Outcomes: Trends in OECD Countries: 1960-1998," *Health Affairs*, Vol. 19, No. 3, May/June 2000, p. 153 [Exhibit 3].

FIGURE 7-2

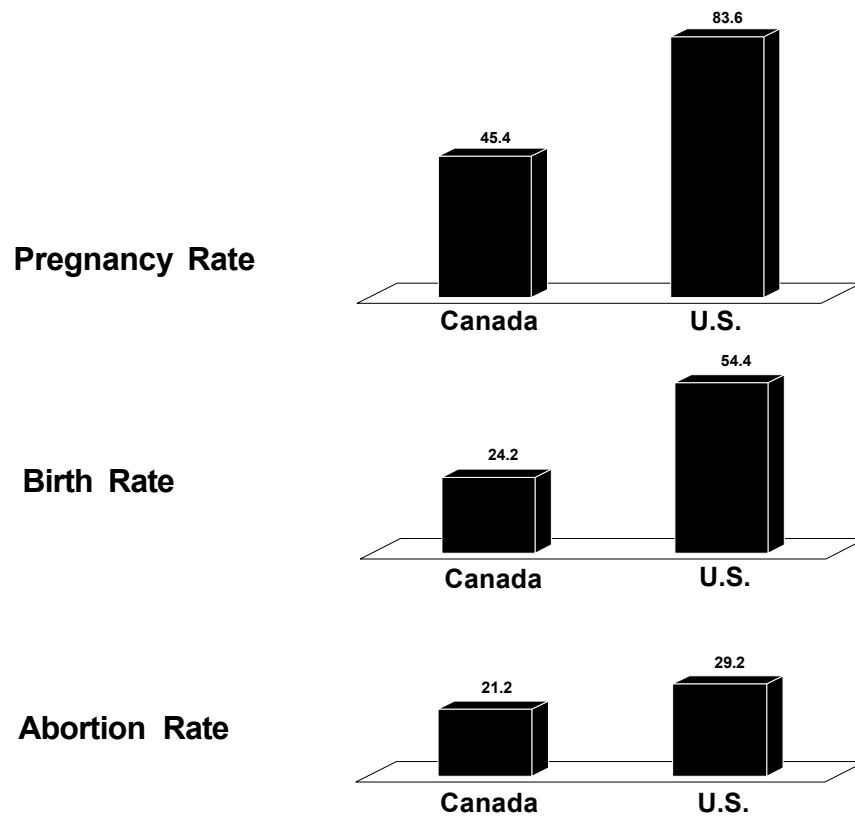
### Percent of the Population Age 15 and Older That Is Obese



Sources: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.

FIGURE 7-3

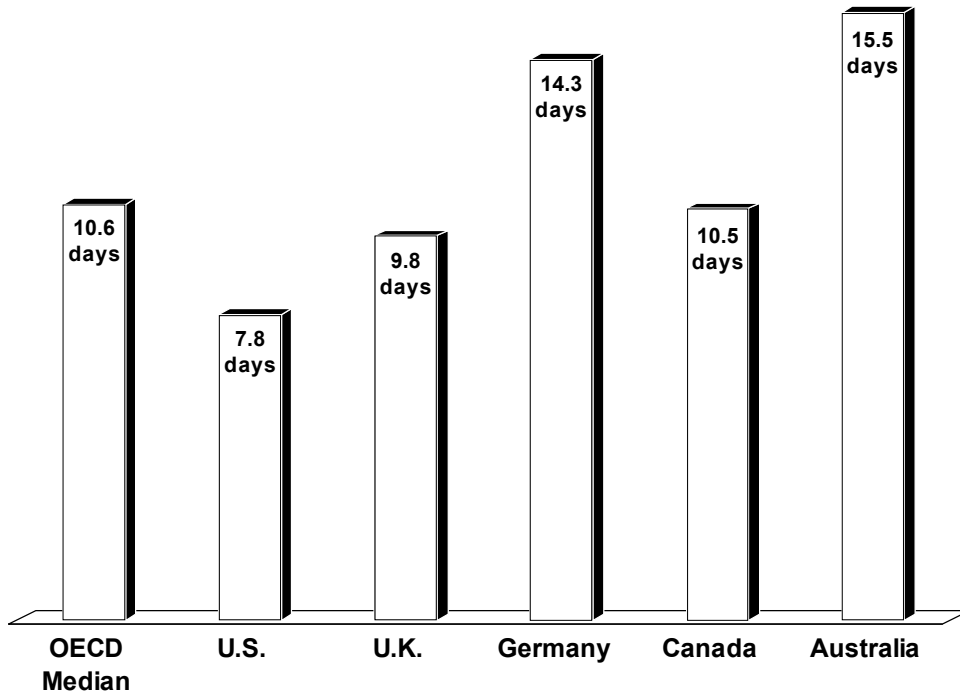
## Pregnancy, Childbearing and Abortions Among Girls Ages 15-19



Sources: Susheela Singh and Jacqueline E. Darroch, "Adolescent Pregnancy and Childbearing: Levels and Trends in Developing Countries," Alan Guttmacher Institute, *Family Planning Perspectives*, Vol. 32, No. 1, January/February 2000.

FIGURE 8-1

## Average Length of Stay

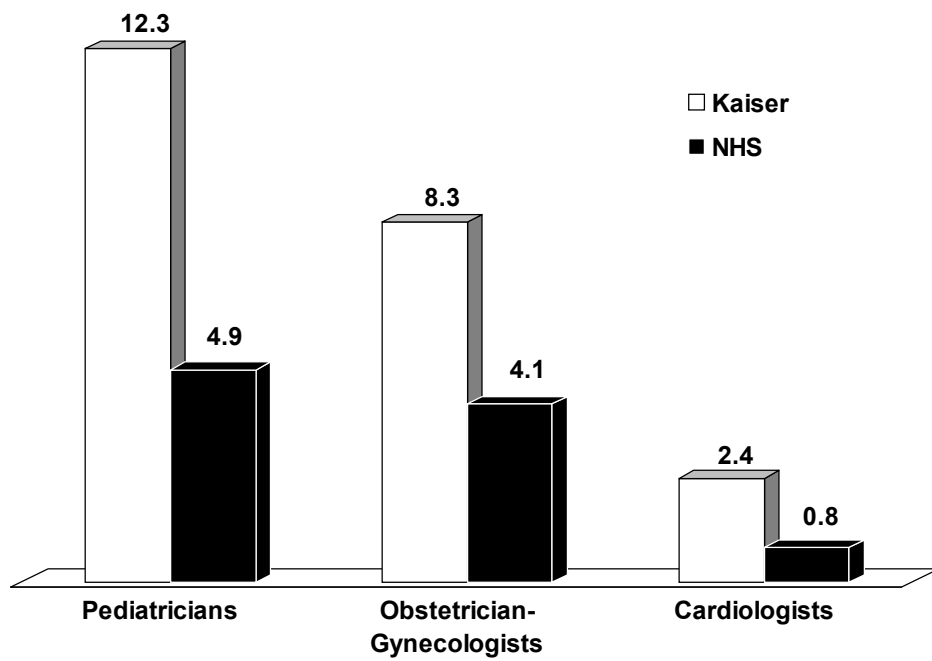


Sources: Gerard F. Anderson and Jean-Pierre Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs*, Vol. 18, No. 3, May/June 1999, [Exhibit 3] p. 183.



FIGURE 8-2

### Kaiser California vs. NHS Specialists per 100,000 People



Source: Richard G. A. Feachem, Neelam K. Sekhri and Karen L. White, "Getting More for Their Dollar: a Comparison of the NHS with California's Kaiser Permanente," *British Medical Journal*, Vol. 324, No. 7330, January 19, 2002, pp.135-141.

TABLE 9-1

**Rand Corporation Study on  
Unnecessary Medicine as Reported  
by the United States National Media**

	Panel's Assessment <sup>1</sup>		
	Appropriate	Equivocal	Inappropriate
Coronary angiography <sup>2</sup>	74%	9%	17%
Carotidendarterectomy <sup>3</sup>	35%	32%	32%
Uppergastiointestinal endoscopy <sup>4</sup>	72%	11%	17%
Overall	60%	18%	22%

<sup>1</sup> Based on medical records 5,000 Medicare patients.

<sup>2</sup> Use if x-rays and dye to expose obstructions of the heart.

<sup>3</sup> Surgical removal of obstructions in major arteries to the brain.

<sup>4</sup> Fiber optic examination of the exophague, stomach and upperimestine.

Source: Rand Corporation study results, reported in the *Wall Street Journal* March 22, 1990.

TABLE 9-2

## More Details on the Rand Study

	Percent of Time 7-9 Experts Agree that Procedure Is:	
	Appropriate	Inappropriate
Coronary angiography	50%	12%
Carotid endarterectomy	13%	17%
Uppergastrointestinal endoscopy	46%	7%
Overall	36%	12%

Source: Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?" *Journal of the American Medical Association*, Vol. 262, No. 21, December 1, 1989, p. 3021.

TABLE 9-3

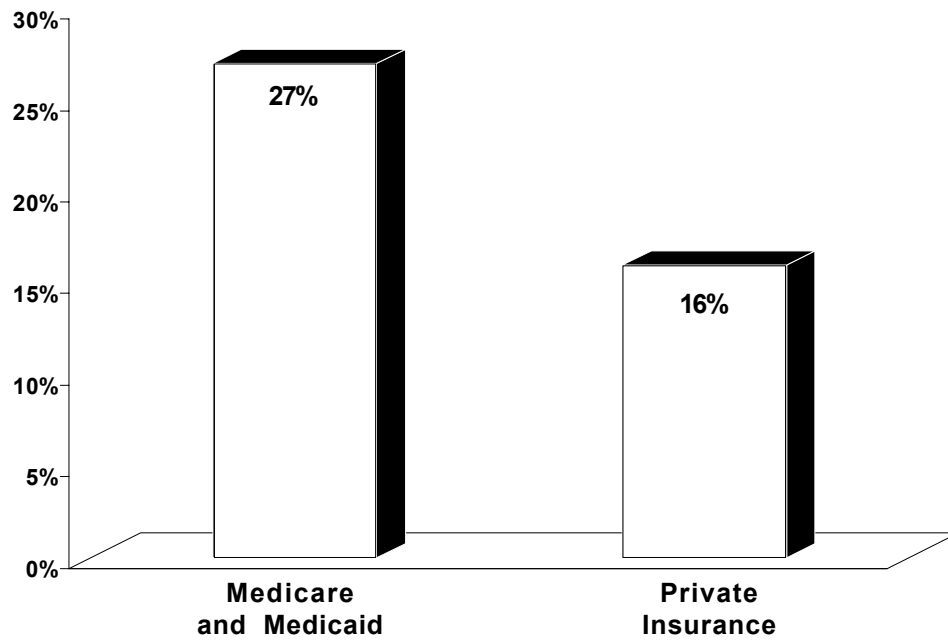
**Milliman & Robertson Estimate  
of Unnecessary Days in U.S. Hospitals**  
(Nonelderly Population)

<b>Market</b>	<b>Estimated Percentage of Days Unnecessary</b>
New York	72%
New Orleans	68
Pittsburgh	67
Philadelphia	67
Newark	67
National average	54
Seattle	41
San Diego	40
Salt Lake City	39
Phoenix	38
Portland	35

Source: David V. Axene, Richard L. Doyle and Dirk van der Burch, *Research Report: Analysis of Medically Unnecessary Inpatient Services* (Seattle: Milliman & Robertson, 1997); and Milliman & Robertson, *Length of Stay Efficiency Index for 1996* (Seattle: Milliman & Robertson, 1997).

FIGURE 10-1

## Administrative Costs as a Percent of Expenditure in the United States



Sources: Mark Litow and the Technical Committee of the Council for Affordable Health Insurance, "Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs," Council for Affordable Health Insurance, March 1994.

TABLE 11-1

## Non-Medical Spending by the British National Health Service

	Per Year
Non-emergency ambulance rides*	15,000,000
Missed Physician appointments**	10,000,000
Patients receiving non-medical services***	1,500,000

\* Only 4 million rides were classified as emergency or urgent.

\*\* The estimated cost of missed GP appointments is \$250 million dollars.

\*\*\* Community services includes such items as meals on wheels, homecare, daycare, home adaptations and professional support.

Source: *Community Care Statistics 2000/2001*, Referrals, Assessments and Package of Care for Adults, UK Department of Health, 2001, Table P2f.1.

TABLE 11-2

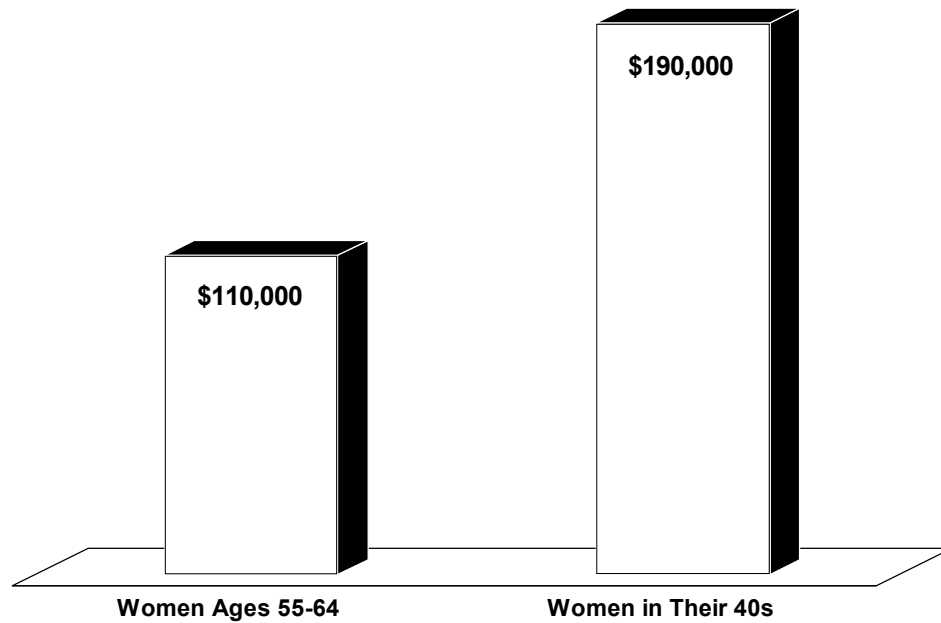
**Non-Medical Services by the  
British National Health Services**  
(Number of Community Services Performed)

Home alterations	375,000
Occupational therapy	456,000
Daycare services	260,000
Homecare/home help services	578,000

Source: *Community Care Statistics 2000/2001*, Referrals, Assessments and Package of Care for Adults, UK Department of Health, 2001, Table P2f.1.

FIGURE 12-1

## Yearly Mammograms: Cost per Year of Life Saved

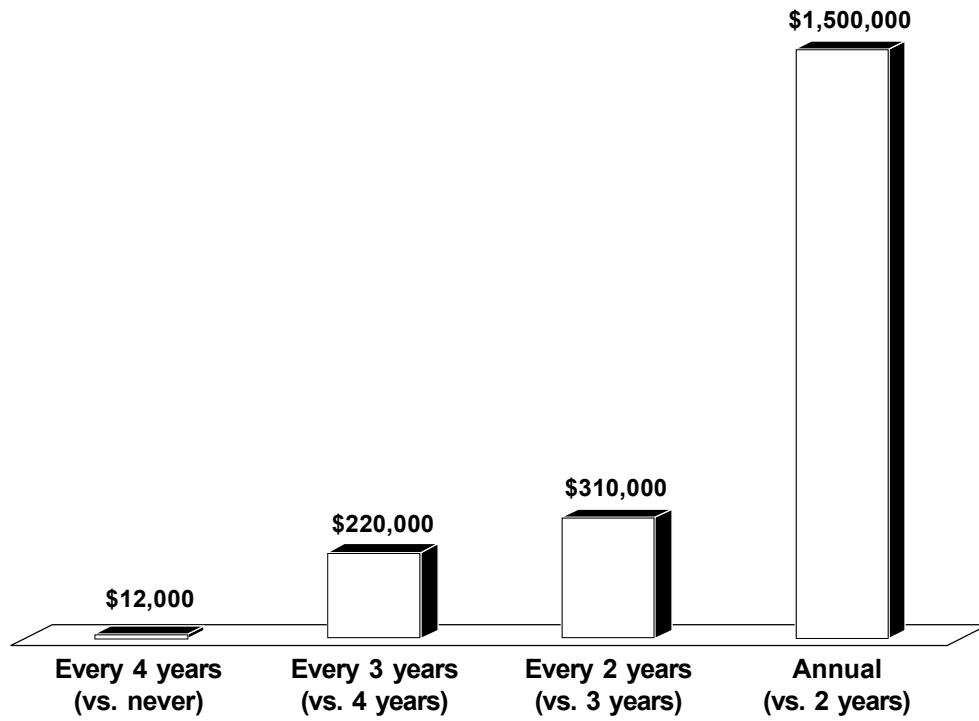


Source: Tammy O. Tengs et al., "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis*, Vol. 15, No. 3, June 1995.



FIGURE 12-2

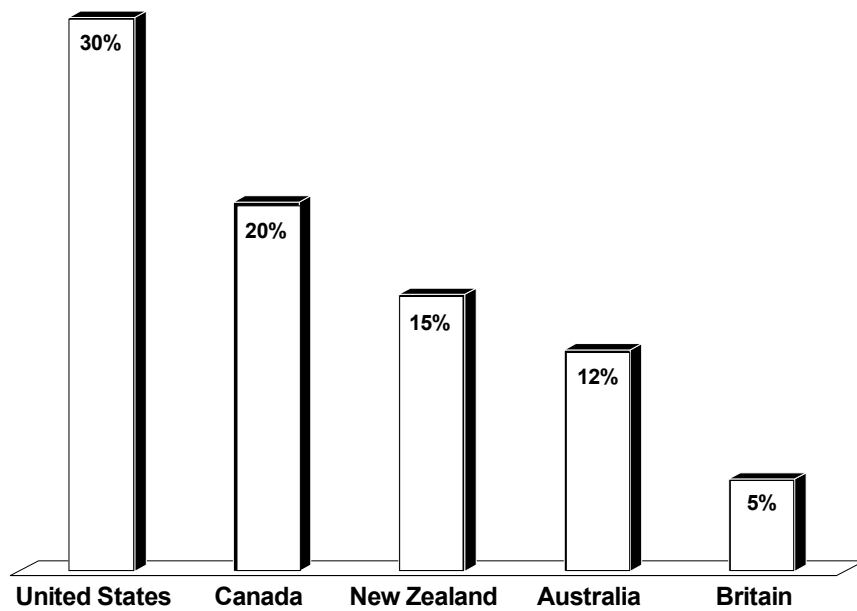
### Cervical Cancer Tests: Cost Per Life-Year Saved (women, age 20)



Source: Tammy O. Tengs et al., "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis*, Vol. 15, No. 3, June 1995.

FIGURE 12-3

## Patients Spending More Than 20 Minutes with Their Doctor

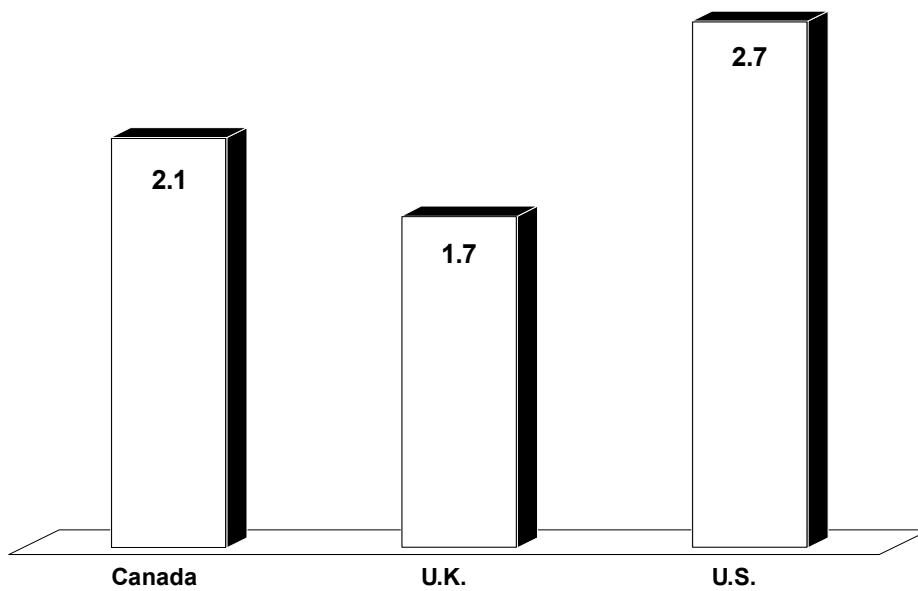


Source: Karen Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs*, Vol. 18, No. 3, May/June 1999, Exhibit 4, p. 212.

Note: Reflects most recent doctor visit.

FIGURE 13-1

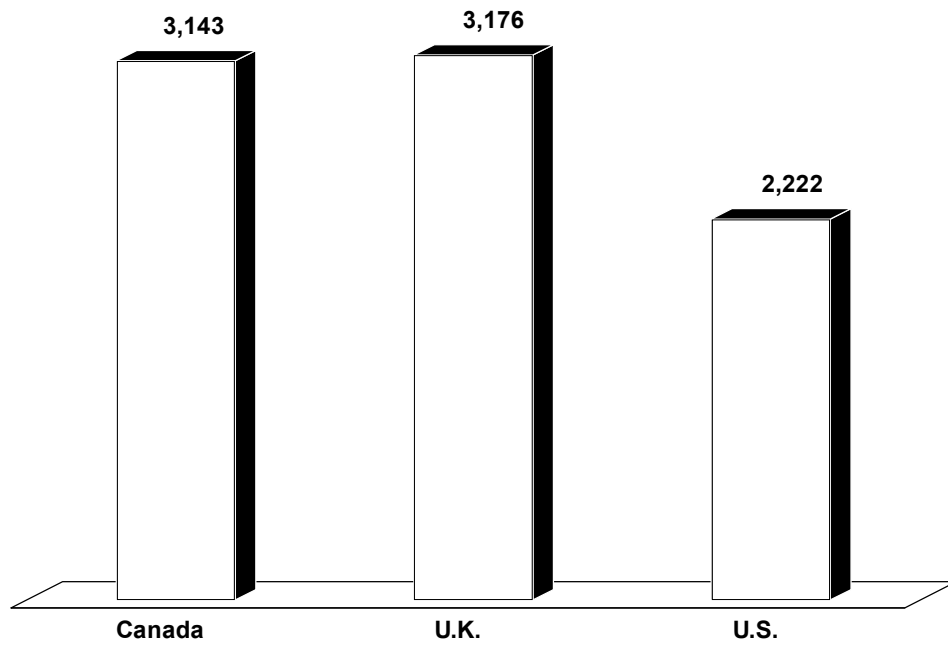
## Physicians per 1000 Population



Sources: Gerard F. Anderson, *Multinational Comparisons of Health Care*, the Commonwealth Fund, October 1998; Gerard Anderson and Peter Sotir Hussey, "Comparing Health System Performance In OECD Countries," *Health Affairs*, Vol. 20, No. 3, May/June 2001.

FIGURE 13-2

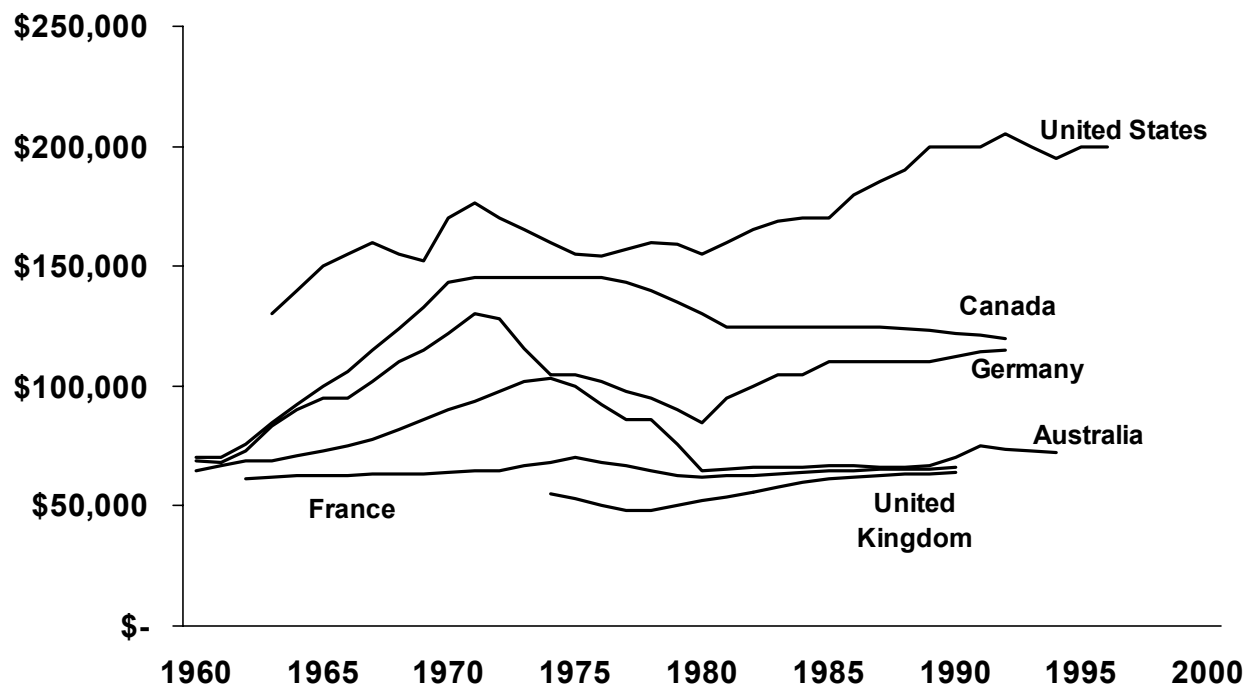
## Patients Seen Annually (Average per Physician)



Sources: Gerard Anderson and Peter Sotir Hussey, "Comparing Health System Performance In OECD Countries," *Health Affairs*, Vol. 20, No. 3, May/June 2001.

FIGURE 13-3

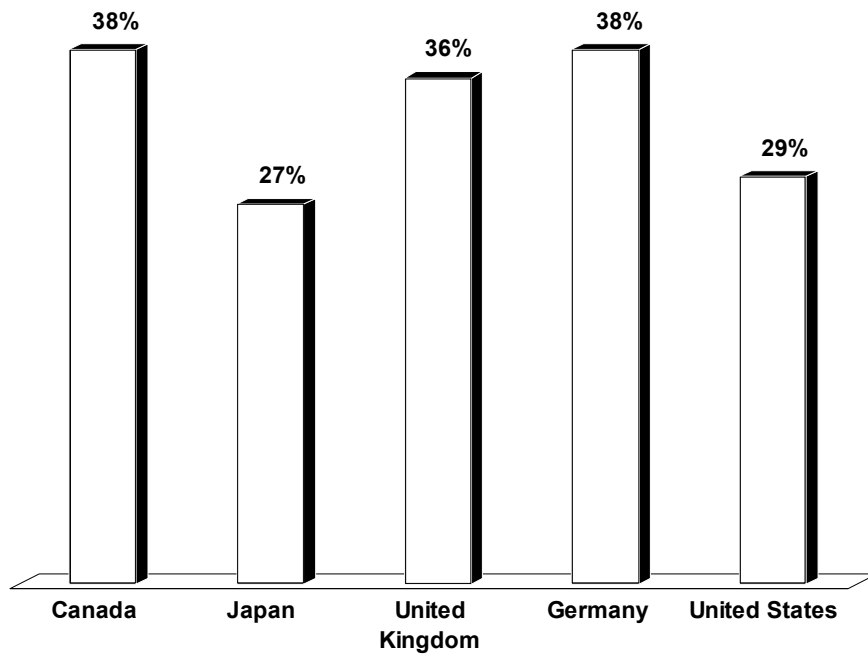
### Average Physician Income (Adjusted for cost-of-living differences and inflation)



Source: Gerard F. Anderson, "Multinational Comparison of Health Care: Expenditure, Coverage and Outcome," The Commonwealth Fund, Publication #299, October 1998, Chart IV-9, p. 43 and OECD Health Data 1998.

FIGURE 14-1

## Tax Burdens for Major U.S. Trading Partners<sup>1</sup>

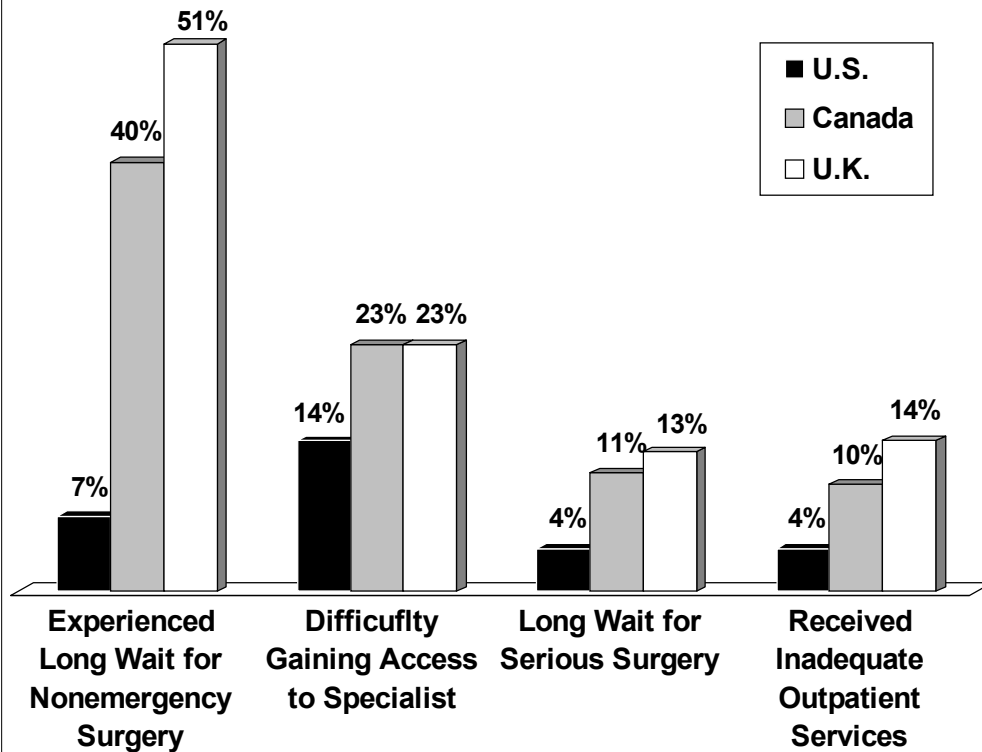


<sup>1</sup> As of 1999.

Sources: Organization for Economic Cooperation and Development,  
Revenue Statistics of OECD Member Countries: 2000 Edition.

FIGURE 15-1

## How The Elderly Evaluate Their Health Care: Responses to Survey Questions



Source: "The Elderly's Experiences with Health Care in Five Nations," Commonwealth Fund 1999 International Survey.

TABLE 17-1

**Percentage Change in Number of Patients  
on Waiting Lists Between March 1997 and  
March 1999 for London and Rural Areas**

<b>London Health Authorities</b>	<b>Percentage Change</b>
Brent and Harrow	-23.4%
Croydon	-24.1%
Camden and Islington	-31.6%

<b>Selected Rural Health Authorities</b>	<b>Percentage Change</b>
South Staffordshire	+19.9%
Worcestershire	+12.9%
Warwickshire	+12.8%

Sources: Hospital Waiting List Statistics: England, *NHS Executive*, 2000.



TABLE 17-2

## Spending on Physician Services Per Person in British Columbia<sup>1</sup> (1993-94)

<u>Speciality</u>	<u>Urban<sup>2</sup></u>	<u>Rural<sup>3</sup></u>	<u>Urban/Rural</u>
All Physician Services	\$494.5	\$303.0	163%
General Practice	173.2	142.3	122%
Specialists	321.3	168.5	191%
Anesthesia	30.0	9.6	313%
Dermatology	6.5	2.4	271%
General Surgery	15.9	13.8	115%
Internal Medicine	39.3	21.3	185%
Neurology	5.7	2.8	204%
Neurosurgery	2.5	1.3	192%
OB/GYN	13.5	8.6	157%
Ophthalmology	22.9	9.7	236%
Orthopedic Surgery	9.7	7.8	124%
Otolaryngology	7.7	3.9	197%
Pediatrics	11.5	4.7	245%
Pathology	59.8	39.0	153%
Plastic Surgery	4.85	2.3	211%
Psychiatry	22.6	5.7	396%
Radiology	44.5	26.9	165%
Thoracic Surgery	7.1	1.0	710%
Urology	7.0	4.4	159%

<sup>1</sup> Based on fees paid to physicians for rendering services to patients living in the areas indicated, regardless of the area in which the service was performed. All figures are age-sex standardized and expressed in Canadian dollars.

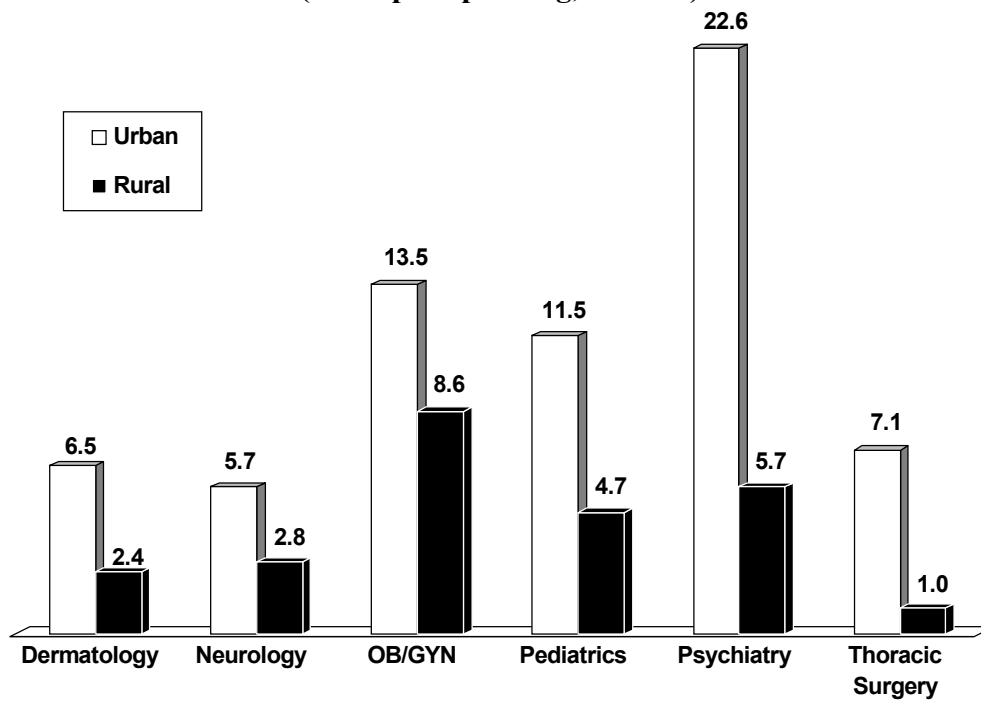
<sup>2</sup> Greater Vancouver and Victoria regional hospital districts.

<sup>3</sup> Twenty-seven non-metropolitan hospital districts.

Sources: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94*, University of British Columbia, 1995.

FIGURE 17-1

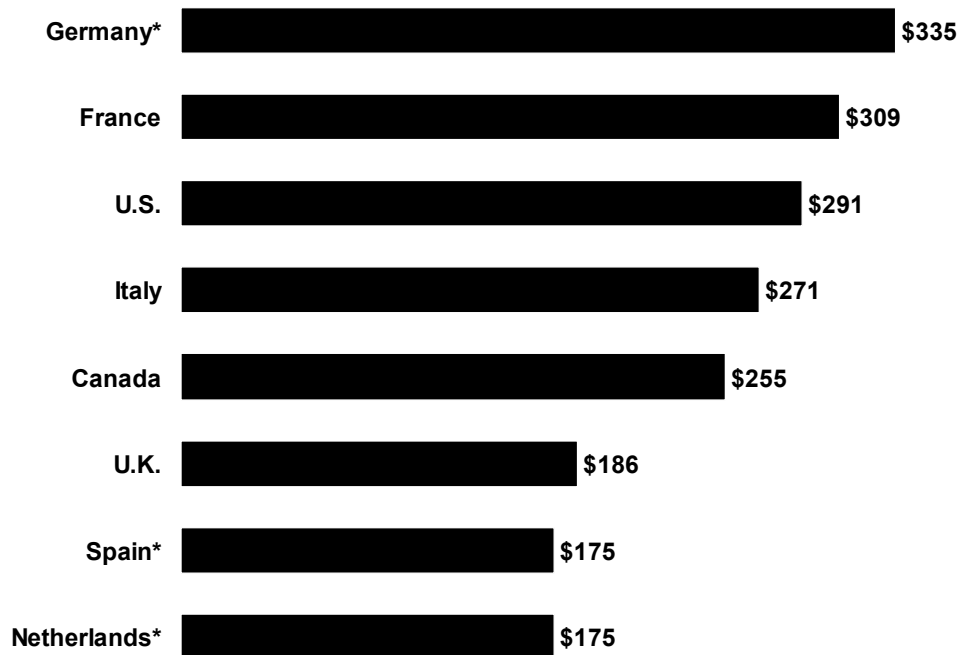
## Inequalities in the Use of Physician Services Among Urban and Rural Patients in British Columbia (Per capita spending, 1993-94)



Sources: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94*, University of British Columbia, 1995, pp. 121-76.

FIGURE 18-1

## A Comparison of Pharmaceutical Expenditures Per Capita



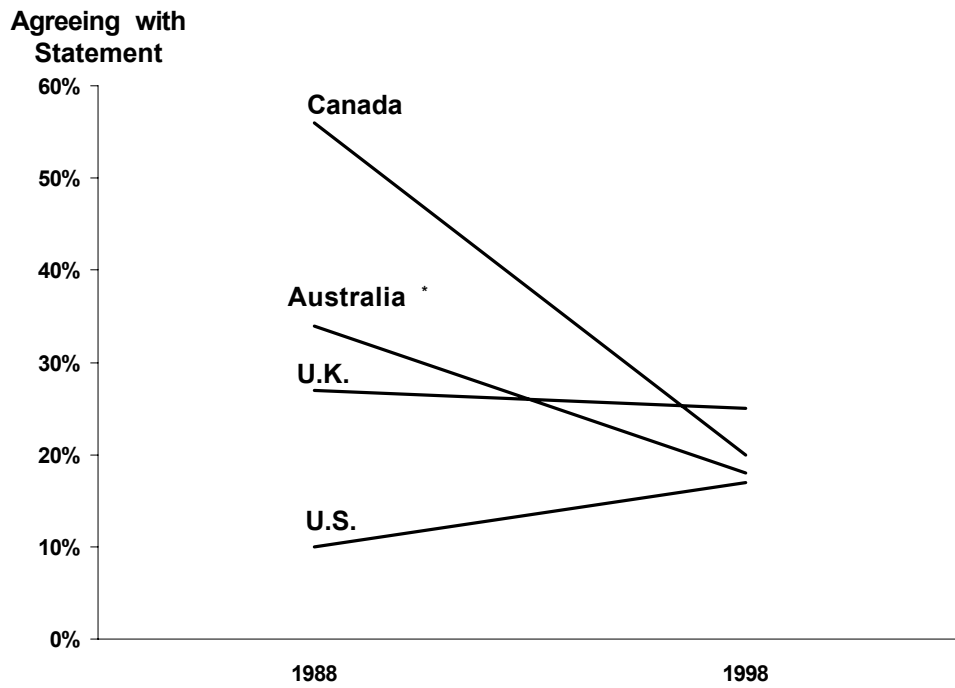
\* Based on purchasing power parity, U.S. dollars. Data are for 1993.

Note: Pharmaceuticals include nonprescription products.

Source: *OECD-OECD Health Data, 1996*.

FIGURE 19-1

## Only “Minor” Changes Needed

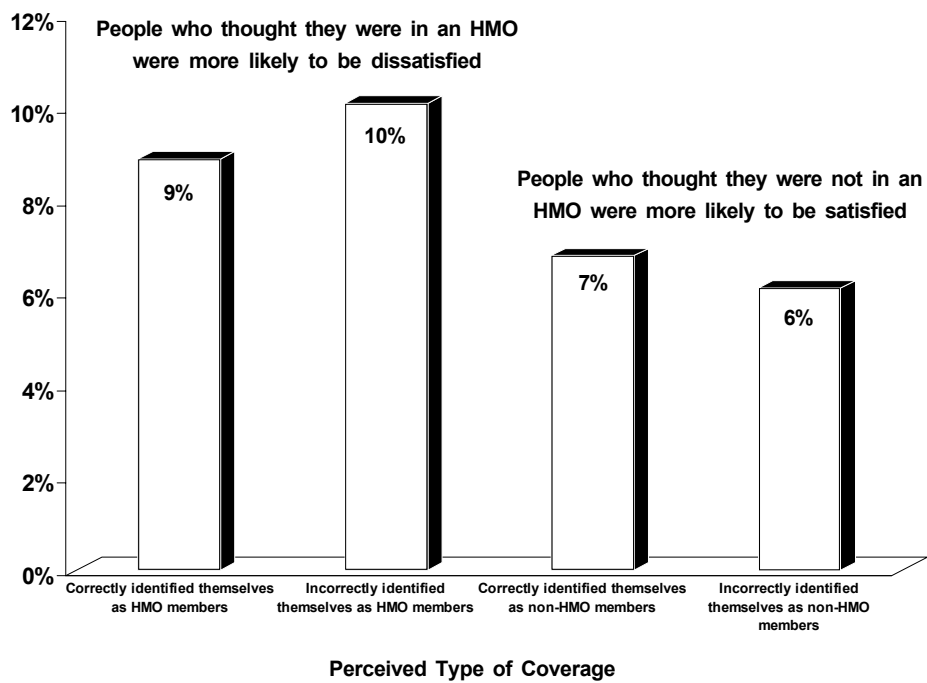


\* 1990 data

Sources: Harvard/Harris/Baxter Survey, 1988 (Canada, U.K., and U.S.); Harvard, Institute for the Future, 1990 (Australia); Commonwealth Fund 1998 International Health Policy Survey.

FIGURE 19-2

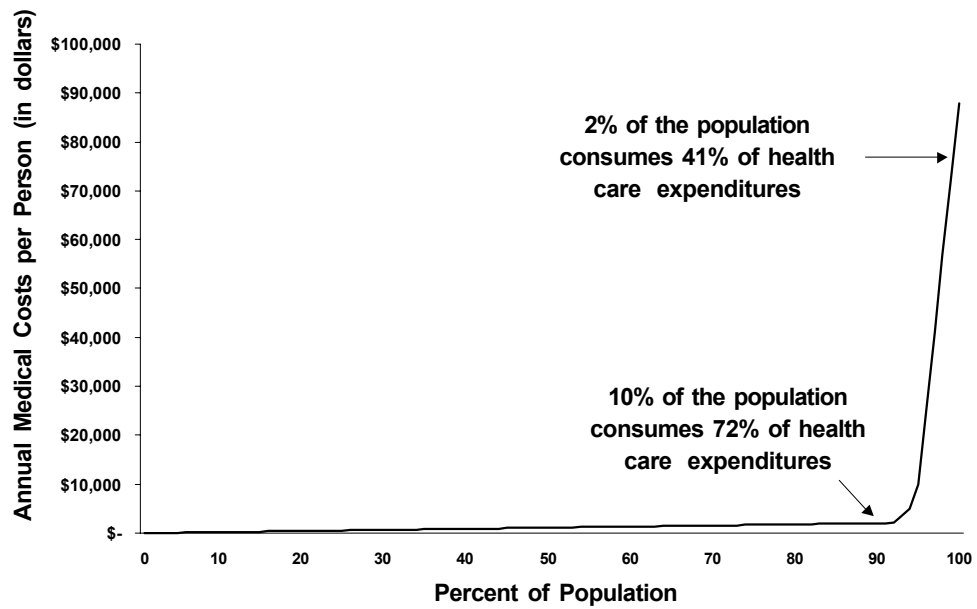
## Dissatisfied with Family Care



Sources: James D. Reschovsky and J. Lee Hargraves, "Health Care Perceptions and Experiences: It's Not Whether You Are in an HMO, It's Whether You Think You Are, Center for Studying Health System Change, Issue Brief #30, September 2000; Community Tracking Study Household Survey and Insurance Followback Survey, 1996-97.

FIGURE 21-1

## Distribution of Medical Costs Among the Population



Source: Donald W. Light, "Sociological Perspectives on Competition in Health Care," *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, October 2000.