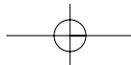
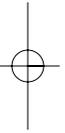
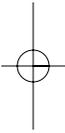
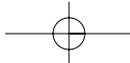
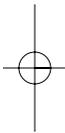
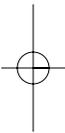


Part One

TWENTY MYTHS





Chapter One

Rights

MYTH NO. 1: IN COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH CARE SYSTEMS, PEOPLE HAVE A RIGHT TO HEALTH CARE

“Access to comprehensive health care is a human right,” according to the U.S. Physicians’ Working Group for Single-Payer National Health Insurance. “It is the responsibility of society, through its government, to ensure this right.”¹ Virtually every government that has established a system of national health insurance has proclaimed health care to be a basic human right.

In fact, there is no such right in any sense that people ordinarily understand the meaning of the term. What the right to care means almost everywhere is nothing more than the opportunity to get services for free (or at very little cost) as the government decides to make those services available. But government is under no obligation to provide any particular service. And if it fails to provide a service, people are not entitled to go to court and sue the way that Americans, for example, can sue an employer, a health maintenance organization (HMO) or even Medicaid.

Citizens of Canada, for example, have no right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue. In fact, in the 1980s some Canadian hospitals advertised in America in search of paying customers to help out with their cash-strapped budgets. Yet, it was illegal for Canadian citizens to pay for the same services. Canadian hospitals and doctors are not allowed to accept money

from patients for any medical services covered by their single-payer system, nor are insurers allowed to cover such services.²

Although the practice has since been discontinued, in part because of public embarrassment, for awhile one could maintain that Americans had more rights in the Canadian health care system than Canadians did. More recently, American members of Toronto professional sports teams were paying for care at Ontario hospitals, jumping the queue by paying for care. A new law outlaws this practice as well.³ One could even argue that Canadians have fewer rights than their pets. While Canadian pet owners can purchase an MRI scan for their cat or dog, purchasing a scan for themselves is illegal (although more and more human patients are finding legal loopholes, as we shall see below).⁴

Canada is not alone. We know of no country in the world that has established a universal right to any particular health care service. The one exception is the United States. Unlike countries with national health insurance, the United States grants every citizen a legally enforceable right (entitlement) to kidney dialysis treatment at government expense.

As noted in the introduction, countries with single-payer health insurance limit health care spending by limiting supply. They do so primarily by imposing global budgets on hospitals and area health authorities. Often there is a separate budget for high-tech equipment, to make doubly sure that high-cost procedures are curtailed.⁵ The consequence of making health care free, thus creating unconstrained demand, while limiting supply is that demand exceeds supply for virtually every service. That, in turn, leads to rationing, usually by forcing patients to wait for treatment.

By U.S. standards, rationing by waiting is one of the cruelest aspects of government-run health care systems.⁶ How much waiting is there? That is not an easy question to answer. Since waiting is viewed by most governments as an embarrassment, public officials are reluctant to collect and publish information about it. However, some facts are available:

- In England, with a population of almost sixty million, government statistics show more than one million are waiting to be admitted to hospitals at any one time.⁷
- In Canada, with a population of more than thirty-one million, the independent Fraser Institute found that more than 876,584 are waiting for treatment of all types.⁸
- In Norway, with a population of almost 4.5 million, 270,000 are waiting in queues on any given day for various types of medical treatments, including hospital admission.⁹
- In New Zealand, with a population of about 3.6 million, the government reports the number of people on waiting lists for surgery and other treatments is more than 90,000.¹⁰

On the surface, the number of people waiting may seem small relative to the total population, ranging from 0.5 percent in Canada to around 2.5 percent in New Zealand. However, considering that only 16 percent of the population enters a hospital each year in developed countries and that only a small percent requires serious (and expensive) procedures, these numbers are quite high.¹¹ In New Zealand, if 11 percent (496,000) are admitted to a hospital each year, a waiting list of 90,000 would represent a ratio of almost one person waiting for every five who receive treatment.

Patients may wait for months or even years for treatment.¹² For example:

- Canadian patients waited an average of 8.3 weeks in 2003 from the time they were referred to a specialist until the actual consultation, and another 9.5 weeks before treatment, including surgery.¹³
- 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 much longer.¹⁴
- Of the 90,000 people waiting for surgery or treatment in New Zealand in 1997, more than 20,000 were waiting for a period of more than two years.¹⁵
- In Britain, 43,900 patients, many of them needing hip or knee replacements, had been waiting for more than a year at the end of 2001.¹⁶
- The London-based Adam Smith Institute estimates the people currently on the NHS waiting lists will collectively wait about one million years longer to receive treatment than doctors deem acceptable.¹⁷

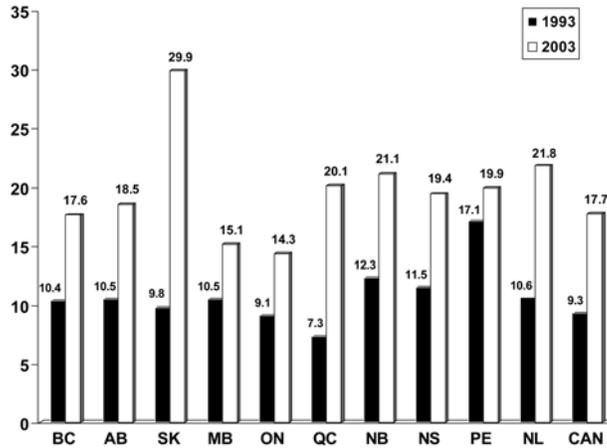
Official lists often understate the length of the wait because a given treatment might require waiting in more than one queue. For instance, a Canadian patient must initially see a general practitioner (GP) for a referral to a specialist. The patient may then wait weeks or months to see that specialist. After the specialist's examination, a patient usually faces another wait for treatment. In many cases, a given treatment involves several waits—a wait for a diagnostic test and another for surgery, for example.¹⁸

Figure 1.1 shows the average length of time Canadian patients wait from the time they are referred by a GP to the time of actual treatment. As the figure shows, waiting times are long all across Canada and they vary considerably from province to province. They range, for example, from a low of 14.3 weeks in Ontario, on the average, to almost seven months in Saskatchewan. Figure 1.2 shows waiting times by specialty. Again, the waits are long for all treatments, and they range from 6.1 weeks, on the average, for cancer treatment to more than seven months for orthopedic surgery.

Note also that waiting times increased during the 1990s in every province and for every type of procedure. As we shall see below, advocates of single-payer health insurance claim that Canada has been more successful than the

FIGURE I-1

Numbers of Weeks Patients Wait between Referral by GP and Treatment, by Province, 1993 and 2003

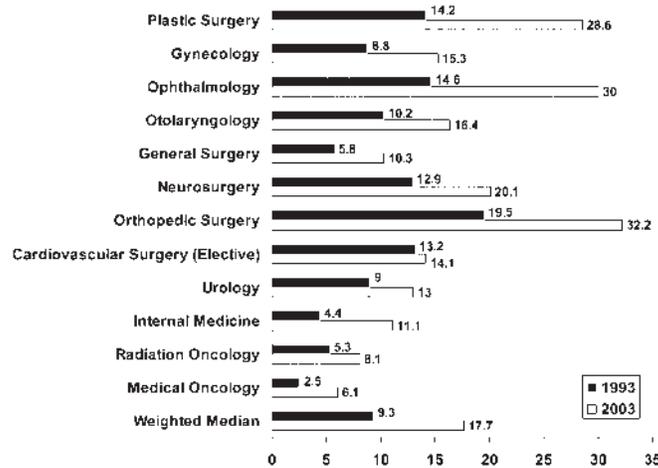


Note: Median waiting times. The Canadian provinces are: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland.

Source: Nadeem Esmail and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, 13th Edition," Fraser Institute, Critical Issues Bulletin, October 2003; Cynthia Ramsay and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, 7th Edition," Fraser Institute, Critical Issues Bulletin, 1997.

FIGURE I-2

Numbers of Weeks Patients Wait between Referral by GP and Treatment, by Specialty, 1993 and 2003



Note: Median waiting times.

Source: Nadeem Esmail and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, 13th Edition," Fraser Institute, Critical Issues Bulletin, October 2003; Cynthia Ramsay and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, 7th Edition," Fraser Institute, Critical Issues Bulletin, 1997.

United States at holding down health care costs. This success, however, has come at a very heavy price for patients.

In Britain, although the National Health Service (NHS) claims that more than 95 percent of patients are treated within twelve months, many are not.¹⁹ The most recent NHS records show that 22,182 patients had been waiting for treatment between twelve and seventeen months—less than half the 46,333 on waiting lists a mere nine months earlier.²⁰ However, the NHS is now gaming the system by identifying and treating patients up against the twelve-month limit to make its statistics look better, even though average waiting times for patients with serious conditions have not necessarily been reduced.²¹ Also, Britain's National Audit Office, which scrutinizes public spending on behalf of Parliament, reports that many health authorities have made "inappropriate adjustments" to make their waiting lists appear smaller.²² As one critic observed, "If a number becomes politically important, it becomes unreliable. The easier it is to manipulate the figures, the quicker this will be done. This is as true of the budget as of NHS waiting lists."²³

Patients queuing for treatment in single-payer countries are often waiting in pain. Many are risking their lives. An investigation by a British newspaper, *The Observer*, finds that delays in Britain for colon cancer treatment are so long that 20 percent of the cases considered curable at time of diagnosis are incurable by the time of treatment.²⁴ A study of cancer patients in Glasgow, Scotland, finds the same is true of lung cancer patients.²⁵ Twenty-five percent of British cardiac patients die while waiting their turn to receive treatment.²⁶ According to government reports, one in six people on NHS waiting lists for elective surgery are removed without ever being treated.²⁷

During one twelve-month period, 121 patients in Ontario, Canada, were removed from a waiting list for coronary bypass surgery because they had become too sick to undergo surgery with a reasonable risk of survival.²⁸ A study for Health Canada, the federal health agency that oversees the Health Canada Act, says government waiting lists may be inflated "20 percent to 30 percent" by the presence of patients "who have already received the procedure, have died, never knew they were on a list," and so on. The government defends these practices as evidence of efficiency, saying, "Waiting is widely associated with publicly funded health care systems; it indicates the absence of costly excess capacity."²⁹ That is an understatement.

Sometimes patients on waiting lists seek treatment in other countries. As we shall see below, Canadians occasionally cross the border into the United States to obtain care they cannot get in Canada. Sometimes Canadian provinces even pay for the treatment. Until recently, British patients were allowed to seek reimbursed treatment abroad under special circumstances. For example, in 2000, the NHS sent 1,100 Britons to continental European hospitals for treatment.

Many of the procedures were hip replacements and cataract surgeries for people who had waited for long periods.³⁰ An additional 200 Britons sought permission for treatment on the continent, but were turned down by their local health authorities.³¹

In a British Consumers' Association survey, more than half of those polled thought the NHS should pay for treatment abroad if it could be provided more quickly and more cheaply than in Britain.³² The British government has resisted that option.³³ Today, the Norwegian government sends patients who have been waiting for extended periods to other countries for treatment by doctors with private practices, in private hospitals.³⁴ European courts have twice ruled that refusing reimbursement for cross-border medical treatment violates the free movement of goods guaranteed by the Treaty of Rome, which governs the European Union. Due to these decisions, Britons, like other Europeans, will be more likely in the future to shop for health care in other EU countries to avoid long waiting lines at home.³⁵

Although crossing a border to obtain health care is not yet common in Europe,³⁶ many governments are justifiably worried that patients will seek care elsewhere due to perceived or real differences in quality. Also, spending on health care is limited in all European countries, but there are different degrees of rationing for different services in different countries. If patients were able to cross borders at will for treatment, they could potentially circumvent any waiting list. Mobility could create an artificial market for health care, one in which waiting times tend to equalize across countries—much as prices tend to equalize in competitive markets. Also, this type of patient migration would defeat many of the attempts by single-payer countries to control health spending.

RATIONING IN THE UNITED STATES

There is also rationing of care in the United States, more than many people may realize. This is especially true in public hospitals that provide care to the uninsured and in Medicare (for the elderly) and Medicaid (for the poor). These government programs face many of the same political pressures as national health insurance systems. For example:

- Doctors estimate that as many as half of the 300,000 people on dialysis in the United States might benefit from six-day-a-week treatment; but because Medicare covers a maximum of three days a week, only a few hundred patients receive the more extensive treatment.³⁷
- Only about one in fifteen patients who could benefit from it gets a new device called HeartMate because Medicare will not pay the full cost; by one

estimate, Medicare would have to pay \$15 to \$20 billion a year to furnish one to every patient who needs it.³⁸

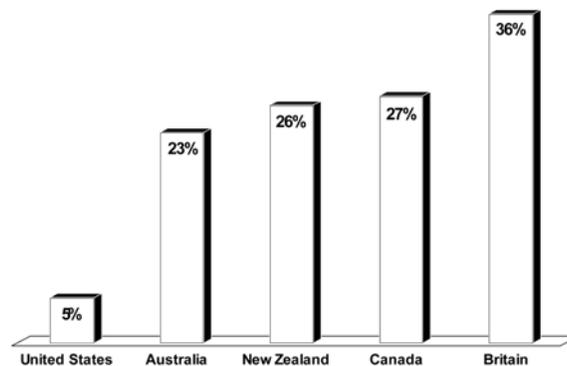
- Eli Lilly and Company makes the drug Xigris to treat severe sepsis, a disease that kills 250,000 people a year; but because Medicare balks at paying its steep cost—\$6,800 a treatment—doctors wrote fewer than 15,000 prescriptions for the drug in 2002, although 750,000 people suffer from sepsis each year.³⁹
- On the other hand, Medicare does pay for colonoscopies and because the procedure has enjoyed a surge in popularity, demand has far outstripped supply, causing patients in some parts of the country to wait for months.⁴⁰

In defense of its practices, Medicare claims that some of these expensive therapies are of unproven value. But the same claim is often made in defense of rationing by the governments of other countries.

In a recent survey of U.S. hospitals, 98 percent admitted to some rationing of MRI scans, 8 percent rationed PET imagining scans,⁴¹ 27 percent rationed the drug Xigris, and 35 percent admitted to some rationing of access to intensive care units.⁴² How does the U.S. experience compare to that of other countries? A study by the Commonwealth Fund and Harvard School of Public Health found that only about 5 percent of Americans undergoing surgery have to wait more than four months. As figure 1.3 shows, the comparable figure is

FIGURE 1-3

Patients Having to Wait More Than Four Months for Surgery¹



¹ Percent of all adults surgery patients receiving elective (nonemergency) surgery in last two years.

Source: Cathy Schoen, Robert J. Blendon, Catherine M. DesRoches, and Robin Osborn, "Comparison of Health Care System Views and Experiences in Five Nations, 2001," Commonwealth Fund, Issue Brief, May 2002.

26 percent or more in New Zealand and Canada and more than 36 percent in Britain.

Granted that rationing in the United States is not as bad as rationing in other countries, are the differences mere differences of degree, or are they also differences of kind? Our evidence will show that there are differences of kind.

NOTES

1. Steffie Woolhandler et al., "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," *Journal of the American Medical Association* (August 13, 2003).

2. Canadian provinces and territories set up their own health programs in the years following World War II. Federal legislation enacted from 1968 to 1972 established comprehensive Medicare, the national health insurance system; subsequent legislation put even more restrictions on private health care. See Canada Health Act, 1984, available at www.hc-sc.gc.ca/medicare/Canada%20Health%20Act.htm.

3. John R. Graham and Nadeem Esmail, "The BC Government Is Eroding Patients' and Physicians' Rights," Fraser Institute (December 10, 2003), and interview with the authors; an abridged version appeared in *The Province*, Vancouver, British Columbia (December 10, 2003).

4. In one case, a public hospital sold MRI scans after hours for use by veterinarians on pets. This proved to be controversial, however, and a public outcry forced the program's cancellation. See Jeff Harder, "Hospitals Profit from Pets," *CNEWS*, December 18, 1998; Thomas Walkom, "No Pets Ahead of People. Health Ministry Says Leadership Candidate Eves Was Mistaken about MRI Availability," *Toronto Star*, January 11, 2002. There is, however, a health private market for pet treatments. See Robert Scalia, "Health Care: No Waiting Lists," *Montreal Gazette*, November 30, 2003; Frank Calleja, "Royal Treatment for a Sick Rover. \$5M Animal Hospital to Treat Cancer. Oakville Facility to Be State of the Art," *Toronto Star*, September 25, 2003.

5. The draft EU constitution states, "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices." European Union draft constitution, Part II (The Charter of Fundamental Rights of the Union), Title IV, Article II-35 on Health Care. Available at <http://europa.eu.int/eur-lex/en/treaties/dat/C2003169en.002201.htm>.

6. Long before the advances of modern medicine, 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.

7. "Waiting List Figures, November 2001," UK Department of Health, Statistical Press Release, January 11, 2002.

8. Nadeem Esmail and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, 13th Edition," *Fraser Institute, Critical Issues Bulletin*, October 2003.
9. 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, Norway, 2000.
10. "Purchasing for Your Health 1996/97," New Zealand Ministry of Health, March 1998.
11. 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* 8, no. 3 (1999): 178–92
12. See Hoel and Saether, "Private Health Care as a Supplement."
13. Esmail and Walker, "Waiting Your Turn."
14. "Purchasing for Your Health 1996/97," Figures 5.13 and 5.14.
15. "Purchasing for Your Health 1996/97," Figures 5.13 and 5.14.
16. Michael White and John Carvel, "Private Ops Offer to Cut NHS Queue," *The Guardian*, December 6, 2001.
17. Matthew Young and Eamonn Butler, "The Million-Year Wait," Adam Smith Institute, 2002.
18. Esmail and Walker, "Waiting Your Turn."
19. Hospital Inpatient Statistics, NHS Trust Based: "Green Book" Index for 2001/02 Department of Health, 2002.
20. Hospital Inpatient Statistics, NHS Trust Based: "Green Book" Index for 2001/02 Department of Health, 2002.
21. Karol Sikora and Nick Bosanquet, "Cancer Care in the United Kingdom: New Solutions Are Needed," *British Medical Journal* (November 1, 2003): 1044–46.
22. Sir John Bourn (Comptroller and Auditor General), "Inappropriate Adjustments to NHS Waiting Lists," UK National Audit Office, December 19, 2001.
23. Andrew Smithers, "The Real Problem Budget Must Aim to Solve," *Evening Standard*, April 10, 2002.
24. Anthony Browne, "Cash-Strapped NHS Hospitals Chase Private Patient 'Bonanza'," *The Observer*, December 16, 2001. Also see Browne, "Deadly Rise in Wait for Cancer Care," *The Observer*, March 3, 2002; and Browne, "How Thousands of Cancer Patients and Doctors Have Been Betrayed," *The Observer*, March 3, 2002.
25. Similar results are likely true of other cancers as well. See Noelle O'Rourke and R. Edwards, "Lung Cancer Treatment Waiting Times and Tumour Growth," *Clinical Oncology* (Royal College of Radiologists) 12, no. 3 (June 2000): 141–44, cited in Kirsty Scott, "Treatment Delays Are Killing Cancer Patients," *The Guardian*, July 1, 2000.
26. Anthony Browne and Matthew Young, "NHS reform: Towards Consensus?" *A Partnership for Better Health Report*, Adam Smith Institute, 2002. Approximately 130,000 people in England die of heart disease each year. However, the NHS estimates that only 500 cardiac patients die annually while waiting for care. See Linda

Beecham, "Health Secretary Will Target Heart Disease," *British Medical Journal* (October 23, 1999); "500 Heart Patients Die on Waiting Lists," *BBC News*, June 3, 1999.

27. Audit Commission, "Waiting for Elective Admission: Review of National Findings," *Health: Acute Hospital Portfolio* (London: Audit Commission, June 2003).

28. "Canadian Health Care—A System in Collapse," Fraser Institute, *Background*, 1999.

29. Paul McDonald et al., "Waiting Lists and Waiting Times for Health Care in Canada: More Management! More Money?" Health Canada, Summary Report, July 1998.

30. This figure also includes coronary patients previously treated in Britain who suffered a subsequent heart attack while in Europe.

31. Celia Hall, "Thousand NHS Patients Treated Abroad," *The Daily Telegraph*, August 21, 2001.

32. "More People Will Pay for Healthcare," *BBC News*, May 30, 2001.

33. See Panos Kanavos, Martin McKee and Tessa Richards, "Cross-Border Health Care in Europe," *British Medical Journal* (May 1, 1999):1157–58.

34. Jan Ove Nesse, "Norwegian Patients in EU Hospitals: The Medical Treatment Abroad Project," Norwegian Insurance Administration, December 2001, 3.

35. Kanavos, McKee and Richards, "Cross-Border Health Care in Europe."

36. One British shadow health secretary, Liam Fox, has advocated allowing patients to shop for private care with NHS cash in circumstances when the NHS cannot provide timely care. See David Charter, "Fox Plan Would Allow Patients to Shop Around," *The Times* (London), October 8, 2002; Alice Miles, "A Bold Health Policy to Make Blair Sick with Envy," *The Times* (London), October 8, 2002.

37. Peter Landers, "Longer Dialysis Offers New Hope But Poses Dilemma," *Wall Street Journal*, October 2, 2002.

38. The HeartMate is a small implantable blood pump made out of titanium. The therapy is called Left Ventricular Assist System and is used to support patients with end-stage heart failure who are not eligible for heart transplantation. Theresa Agovino, "Price of Heart Device May Mean Rationing," Associated Press, *Miami Herald*, September 1, 2003.

39. Antonio Regalado, "To Sell Pricey Drug, Lilly Fuels a Debate over Rationing," *Wall Street Journal*, September 18, 2003.

40. Gina Kolata, "50 and Ready for a Colonoscopy? Doctors Say There Is Often a Wait," *New York Times*, December 8, 2003.

41. One of the best new tools for detecting cancer is the Positron Emission Tomography (PET) scanner, which uses radioactive drugs to detect tumors.

42. Results of July 2002 Society of Critical Care Medicine poll. Reported in Regalado, "To Sell Pricey Drug, Lilly Fuels a Debate over Rationing."