

## *Chapter Two*

# Equality

### **MYTH NO. 2: IN COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH CARE SYSTEMS, ALL PEOPLE HAVE EQUAL ACCESS TO HEALTH CARE**

One of the most surprising features of single-payer care systems is the enormous amount of rhetoric devoted to the notion of equality and the importance of achieving it, especially in relation to the tiny amount of progress that appears to have been made. “Only a single comprehensive program, covering rich and poor alike, can end disparities based on race, ethnicity, social class, and geographic region, . . .” claims the U.S. Physicians’ Working Group for Single-Payer National Health Insurance.<sup>1</sup>

Similar sentiments were expressed when the British NHS was established in 1948. Aneurin Bevan, father of the NHS, declared that “everyone should be treated alike in the matter of medical care.”<sup>2</sup> The Beveridge Report, the blueprint for the NHS, promised “a health service providing full preventive and curative treatment of every kind for every citizen without exceptions.”<sup>3</sup> The *British Medical Journal* predicted in 1942 that the NHS would be “a 100 percent service for 100 percent of the population.”<sup>4</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>5</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 more than thirty years into the program (in the 1980s), an official task force (the Black Report) found little evidence that access to health care was any more equal than when the NHS was started.<sup>6</sup> Almost twenty years later, a second task force (the Acheson Report) found evidence that access had become less equal in the years between the two studies.<sup>7</sup>

Across a range of indices, 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 refers to the NHS as a "postcode lottery" in which a person's chances for timely, high-quality treatment depend on the neighborhood or "postcode" in which he or she lives.<sup>8</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>9</sup> Scholarly studies of the issue have come to similar conclusions. For example, a study by the Joseph Rowntree Research Trust published in 2000 found discrepancies between areas for all causes of death:<sup>10</sup>

- Nonelderly Britons living in areas with the worst-performing hospitals were 42 percent more likely to die on any given day than the average for Britain as a whole.
- The nonelderly 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 health care inequity were merely decreased to 1983 levels, some 7,500 premature death among people younger than sixty-five could be avoided each year.

Other researchers reinforce these conclusions:

- 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>11</sup>
- The British Heart Foundation (BHF) found that the premature death rate for working-class men is 58 percent higher than non-working-class men;<sup>12</sup> the BHF estimates that more than 5,000 working-class men under the age of sixty-five die of coronary heart disease each year in Britain because of variations in health care access for different socioeconomic groups.<sup>13</sup>

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/Westminster 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 Midcox 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: Dr. Foster, *Good Hospital Guide* (London: Dr. Foster, Ltd., January 2001).

The disparity between rich and poor areas in Britain was confirmed by the *Good Hospital Guide*, which graded every hospital in Britain according to a mortality index.<sup>14</sup> The index was calculated so that a hospital with a survival rate that matched exactly the national average scored 100 points. Hospitals with a lower survival rate than the national average scored above 100, while those with a higher survival rate scored below. The disparity was especially striking among London hospitals. Table 2.1 shows the following:

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

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. Generally, 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.

There are also differences in health outcomes. For example, a man with prostate cancer in Bexley and Greenwich in southeast London has a 34 percent chance of surviving for five years, while a man in the Kensington/Westminster area has a 60 percent chance.<sup>15</sup>

## INEQUALITY IN CANADA

Canadian officials also put a high premium on equality of access to medical care. In 1999, for instance, Health Minister Allan Rock stated, "Equal access regardless of financial means will continue to be a cornerstone of our system."<sup>16</sup> How well have the Canadians done? A series of studies from the University of British Columbia in the 1990s consistently found widespread inequality in the provision of care among British Columbia's twenty or so health regions. These studies are unique because researchers identified patients by the region in which they live rather than the region where they received care. This allowed investigators to identify inequities in the amount of care received by residents of each region, including those

patients forced to travel hundreds of miles (from one region to another) for treatment.<sup>17</sup>

For example, take the amount spent on the services of physician specialists for Vancouver, the largest city, with a population of almost two million, and Peace River, a rural area of about 60,000. As table 2.2 shows,<sup>18</sup>

TABLE 2-2

**Services of All Specialists for  
Residents of Two Areas in Canada**  
(Spending per person)<sup>1</sup>

	Vancouver <sup>2</sup>	Peace River <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	1,302.0	452.4
Female	1,044.1	484.8
All ages:		
All specialist	609.5	231.6
Internists	50.5	11.6
OB/GYNs	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.

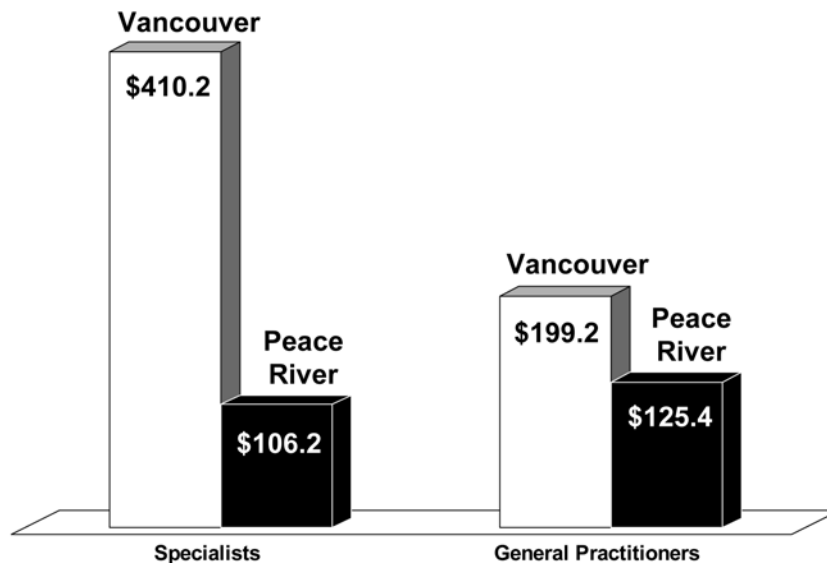
Source: Arminée Kazanjian et al., "Fee Practice Medical Expenditures per Capita and Full-Time-Equivalent Physicians in British Columbia, 1993-94," University of British Columbia, 1995.

- Residents of Vancouver received almost three times more specialist services per person than residents of Peace River, and this inequality held for groups with comparable health needs, males and females, and across all age groups.
- The differences were even more striking for certain specialties, with a five-to-one difference in the services of internists and a thirty-one-to-one difference in the services of psychiatrists.

One might suppose that a higher level of GP services would offset the lower level of specialist services in Peace River. As figure 2.1 shows, that was not the case. Vancouver residents also enjoyed about 60 percent more GP services.

FIGURE 2-1

**Amounts Spent on Physician Services for  
Residents of Two Canadian Hospital Districts<sup>1</sup>**  
(Per capita spending)



<sup>1</sup> Figures are expressed in Canadian dollars and are age/sex standardized.

Source: 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.

In general, spending on medical services varied widely by region throughout British Columbia. As table 2.3 shows,<sup>19</sup>

- Spending on specialist services in Vancouver was almost four times higher than spending on specialists in rural Cariboo.
- Per capita spending on all services was almost three times as high in Vancouver (\$609) as in Peace River (\$231).
- Differences between the lowest- and highest-spending regions in British Columbia were especially striking in certain specialties—a fourfold difference in spending on internal medicine, a thirty-one-fold difference in spending on psychiatric services and a fourfold difference in spending on obstetrics-gynecology (OB/GYN).

TABLE 2-3

### Spending per Person on Physician Services By Hospital Districts in British Columbia<sup>1</sup>

Hospital Districts	Total Spending	Specialists	OB/GYN	Psychiatrists	Internists
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 Districts:					
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.

Source: Arminée Kazanjian et al., "Fee Practice Medical Expenditures per Capita and

These results are now a decade old, and the study has not been repeated. However, as we shall see below, the same researchers have continued to track the supply of resources on a region-by-region basis, and inequalities of supply have continued through time and in some cases gotten worse.

In most countries with waiting lists for care, the poor wait longer than the wealthy and powerful. For example, a survey of Ontario physicians found 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.<sup>20</sup>

Other studies have reached similar conclusions. One study found that the wealthy and powerful have significantly greater access to medical specialists than the less-well-connected poor.<sup>21</sup> A University of Toronto study finds that high-profile patients enjoy more frequent services, shorter waiting times and greater choice in specialists.<sup>22</sup>

These findings are supported by anecdotal evidence. In recent years, the Canadian media has reported numerous examples of wealthy and prominent patients “jumping the queue” for quicker treatment, while ordinary citizens languish.<sup>23</sup> For example, Canada’s health minister, Allan Rock, underwent a successful surgery after he was diagnosed with prostate cancer in January 2001. Rock was sharply criticized by other Canadian prostate cancer patients who waited much longer for treatment, often more than a year between diagnosis and surgery.<sup>24</sup> The president of the Canadian Medical Association, Dr. Victor Dirnfeld, suggested in 1998 that the Canadian system is in fact a two-tiered system, and said that he knew of seven prominent political figures in British Columbia and Ontario who received special treatment. “Instead of waiting three months for an MRI,” he said, “they will have it done in three or four days.”<sup>25</sup>

Despite the removal of financial barriers, Canadians apparently do not have equal access to health care. Access is influenced by education and income as well as political influence.<sup>26</sup>

## ACCESS IN THE UNITED STATES

There are also disparities in access to health care in the United States. The latest count shows that 43.6 million Americans, approximately 15.2 percent of the U.S. population, lack private health insurance and are not enrolled in pub-



lic health programs.<sup>27</sup> Studies show that the uninsured consume about 50 percent less health care than those with insurance, other things equal.<sup>28</sup>

Many of the uninsured are uninsured by choice, which implies that they have no problem paying for the care they need, they are getting free care, or they are relatively healthy and do not see a need for insurance. For example, about one-third of the uninsured qualify for government coverage through S-CHIP (for low-income children)<sup>29</sup> and Medicaid (for low-income families), but have not enrolled. Roughly one-third live in households with incomes above \$50,000 and apparently can afford health insurance even though they choose not to purchase it. In fact, within the last seven to eight years, virtually all of the increase in the uninsured has been among families with incomes in excess of \$50,000 and more than half of those earn \$80,000 a year or more. Of those who become uninsured at any point in time, Census Bureau data show that about three-quarters (74.7 percent) obtain insurance within one year, while only 2.5 percent remain uninsured for more than three years.<sup>30</sup>

For decades, the socialist press in Europe has repeated the canard that poor people in the United States get no care because they cannot afford it. Nothing could be further from the truth. Almost all of the elderly (including the low-income elderly) are enrolled in Medicare, through which they are entitled to virtually all the U.S. health care system has to offer (with some exceptions noted in chapter 1).<sup>31</sup> Furthermore, Medicaid, the federal-state program for the poor, now spends more than Medicare even though it covers roughly the same number of people; and those who enroll in Medicaid and seek care use services at rates comparable to those with private insurance.<sup>32</sup> The Veterans Administration provides yet another safety net. And, every state has a system of public hospitals and clinics that provide medical services to the indigent.

Despite the European notion that the poor and the uninsured are turned away at the hospital admitting room door, federal law requires emergency rooms to take all comers, regardless of ability to pay.<sup>33</sup> State and federal laws also require many hospitals to provide charity care, and federal and state matching funds are available to institutions that provide a disproportionate share of care to Medicaid patients and the uninsured. Through these multiple channels, the poor often have access to the most advanced technology and therapies.

A study by the Texas Comptroller of Public Accounts found that public and private organizations in Texas spend, on the average, approximately \$1,000 per year on care for each uninsured Texan.<sup>34</sup> This is equivalent to \$4,000 for a family of four, enough to buy private health insurance in many Texas cities. Another study from the Urban Institute in Washington, D.C., found that United States spends \$34.5 billion on free health care for the uninsured, or about \$820 per person each year.<sup>35</sup> If the value of uncompensated physicians'

time is included, the amount probably exceeds \$1,000 per uninsured individual. Further, evidence from Texas indicates that free care for the uninsured and spending on Medicaid tend to be substitutes for each other. That is, those health regions that spend more through Medicaid, spend less on free care and vice versa.<sup>36</sup>

To see what this means on the local level, consider Parkland Hospital in Dallas, a primary source of care for the indigent as well as those covered by Medicaid. Although many studies suggest that being uninsured results in less health care, this conclusion would not be at all obvious to an observer sitting in Parkland's emergency room. Uninsured patients and Medicaid patients pass through the same emergency room door; they see the same doctors; they receive the same treatments; and if required, they are admitted to hospital rooms on the same floors.

The only people who seem to care very much about who is insured or uninsured at Parkland are the hospital staff (presumably because that affects how they get paid). For that reason, full-time employees work their way through the emergency room waiting area in an attempt to enroll all eligible patients in Medicaid (most of the time they fail). With the same goal in mind, employees also go room to room to visit those who are admitted (their success rate is much higher).

Interestingly, eligible patients in Texas can enroll in Medicaid and have the state pay their medical bills three months after the fact. So if there is any reason for a patient to enroll, clearly there is no need for haste.

At Children's Medical Center, next door to Parkland, a similar exercise takes place. Children on Medicaid, children on S-CHIP (for low-income families who do not qualify for Medicaid), and uninsured children all come through the same emergency room door. Again, they all see the same doctors and receive the same treatment. Again, it is only the hospital that seems to care whether anybody is insured and by whom.

The experience of these two hospitals illustrates that the uninsured in American are often not uninsured in any real sense of the term. Many of them get their care in hospital emergency rooms, just as many Canadians and Britons do. They do not pay for the care they receive and usually are not even sent a bill, just like in London or Toronto. It is only on paper and in statistics examined by academic researchers that the patients in London and Toronto are classified as "insured," while U.S. patients are "uninsured." The difference appears to be one of form, not of substance.

Europeans who have grown up on a steady diet of anti-American-health-care propaganda would probably be surprised to learn how much Americans actually spend on health care for low-income families. Each year, Medicaid costs U.S. taxpayers almost \$1,000 for every man, woman and child in the

country, or \$4,000 for a family of four.<sup>37</sup> Free care for the uninsured costs another \$4,000. And if taxpayer support for the low- and moderate-income elderly are included, the average family of four is probably spending \$10,000 or more on other people's health care. Indeed, most taxpayers with private insurance are paying far more in taxes to fund health insurance for other people than they pay for private health insurance for themselves and their own families.

Low-income beneficiaries on Medicaid probably have more access to better health care than low-income citizens in any other country. According to a recent study by Health Services Research,<sup>38</sup>

- Low-income persons in the United States without job-related health insurance spend only about fifty dollars per year more out of pocket for health services than those 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.
- However, when seriously ill, uninsured low- and moderate-income Americans receive about the same level of treatment and services as those with employment-based coverage, and their out-of-pocket costs are about the same.

This suggests that the health care safety net in the United States is actually more reliable than many people think. About 3 percent of the U.S. population is uninsured for six months or longer. By contrast, one study found that about 5 percent of British Columbians are not registered for the provincial health insurance program and are therefore uninsured.<sup>39</sup> Almost all of these uninsured Canadians are poor. Like the Medicaid-eligible uninsured in the United States, they need only register to become formally insured.

### COMPARING THE UNITED STATES WITH OTHER COUNTRIES

There are inequalities in access to health care in every country. 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, especially when the use of medical services is weighted by the incidence of illness. As we shall see, this is only partly due to barriers people face in obtaining care. However, in the United States, patients say the main barrier is financial; in countries that have presumably removed financial barriers to care, there are other barriers.

In an international opinion survey sponsored by the Commonwealth Fund, 21 percent of Americans said they had serious problems paying for health care compared to only 11 percent in Canada.<sup>40</sup> Roughly the same proportion of Americans (17 percent) and Canadians (16 percent) had experienced difficulty seeing a medical specialist when needed. In the United States, cost was most frequently cited as the major obstacle, while waiting times and physician shortages were the main barriers in Britain and Canada.<sup>41</sup> In fact, among patients who describe themselves as in “fair” or “poor” health, the percent who experience long waits to see specialists is twice as high in Canada as in the United States.<sup>42</sup> (See the discussion in chapter 6.)

Another survey queried those who rated their health as “fair” or “poor” about the “biggest problem with their respective health care system.” While only 13 percent of Canadians complained about the high cost of health care, 16 percent cited inadequate government funding, 27 percent complained about waiting times, and 54 percent cited a shortage of health care professionals and hospital beds.<sup>43</sup> By contrast, 48 percent of Americans complained about the high cost of health care. Only 1 percent, 3 percent and 5 percent of Americans (respectively) complained about inadequate government funding, waiting lines or a shortage of health care professionals and hospital beds.<sup>44</sup>

## NOTES

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4. *British Medical Journal* (December 12, 1942): 700.

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6. *Inequalities in Health*, Black Report (London: UK Department of Health and Social Security, 1980).

7. *Independent Inquiry into Inequalities in Health*, Acheson Report (London: Stationery Office, 1998). See also “Geographic Variations in Health,” UK Office for National Statistics, Decennial Supplement 16, 2001.

8. 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.

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14. *The Good Hospital Guide*, Dr. Foster, January 14, 2001.
15. Data based on clinical indicators published by the British Department of Health. See Sebastian O'Kelly, "Consumer: Lottery of Life and Death," *The Guardian* (Manchester), October 1, 1998.
16. News release, "Minister Rock Announces Funding for Community Health and Research Initiatives in Alberta," Regional News Release, 1999–1992, *Health Canada* (July 12, 1999).
17. Arminée 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, available at [www.chspr.ubc.ca/hhru/pdf/hhru01-3.pdf](http://www.chspr.ubc.ca/hhru/pdf/hhru01-3.pdf).
18. A new series of studies from British Columbia tracks full-time equivalent (FTE) physicians by region. These studies show far more physicians per capita in urban areas than in rural ones. Arminée Kazanjian, Alice Chen, Laura Wood and Patrick Wong Fung, "Doctors & Patients: Supply, Use and Payments in British Columbia, 1998–1999," Part I—Physician FTEs and Distribution in B.C., Centre for Health Services and Policy Research, University of British Columbia, June 2001. The "Doctors & Patients" reports are an updated version of the HHRU series of reports formerly titled "Fee Practice Medical Services Expenditures per Capita and Full-Time-Equivalent (FTE) Physicians."
19. Arminée Kazanjian et al., "Fee Practice Medical Expenditures."
20. 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* 129, no. 7, 1998.
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24. Jake Rupert, "Man Protests Rock's Speedy Surgery," *Ottawa Citizen*, February 17, 2001.

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28. M. Susan Marquis and Stephen H. Long, "The Uninsured Access Gap: Narrowing the Estimates," *Inquiry* 31 (Winter 1994/95): 405–14. Marquis and Long found that uninsured adults have about 60 percent as many physician visits and 70 percent as many inpatient hospital days as they would if they were covered by insurance. See also M. Susan Marquis and Stephen H. Long, "The Uninsured 'Access Gap' and the Cost of Universal Coverage," *Health Affairs* (Spring [II] 1994): 221–20.
29. The State Children's Health Insurance Program (S-CHIP) was created by the Balanced Budget Act of 1997 (BBA). It is a federal-state program designed to insure children in families with incomes too high for Medicaid but too low to be able to afford private health insurance.
30. Devon M. Herrick, "Uninsured by Choice: Update," Brief Analysis No. 460, National Center for Policy Analysis, October 7, 2003, available at [www.ncpa.org/pub/ba/ba460](http://www.ncpa.org/pub/ba/ba460).
31. Low-income seniors are also covered by Medicaid, the program that provides health care to the indigent.
32. M. Susan Marquis and Stephen H. Long, "Reconsidering the Effect of Medicaid on Health Care Services Use," *Health Services Research* 30, no. 6 (February 1996): 792–808.
33. The law that requires hospitals with emergency rooms to treat (or stabilize before transferring) emergency patients is the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See Joseph P. Wood, "Emergency Physicians' Obligations to Managed Care Patients under COBRA," *Academic Emergency Medicine* 3, no. 8 (August 1996): 794–800.
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36. Sen. Chris Harris (Chairman) et al., "Texas Blue Ribbon Task Force on the Uninsured: Report to the 77th Legislature," State of Texas, February 2001.
37. Michael Bond, John C. Goodman, Ronald Lindsey, and Richard Teske, "Reforming Medicaid," Policy Report No. 257, National Center for Policy Analysis, February 2003.
38. Richard W. Johnson and Stephen Crystal, "Uninsured Status and Out-of-Pocket Costs at Midlife," *Health Services Research* 35, no. 5, Part I (December 2000): 911–32.
39. Two provinces, Alberta and British Columbia, charge premiums, and people who do not pay them are technically uninsured. See Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain about their Health Care System," *Back-*

*grounders*, no. 883, Heritage Foundation, February 19, 1992. It was reported that at one Vancouver hospital, nearly 10 percent of the patients in the emergency room were uninsured. See Linda Gorman, "Paying Twice for Government Health Care," Independence Institute, August 30, 2001.

40. Cathy Schoen, Robert J. Blendon, Catherine M. DesRoches, and Robin Osborn, "Comparison of Health Care System Views and Experiences in Five Nations, 2001," Issue Brief, Commonwealth Fund, May 2002, available at [www.cmwf.org/programs/international/schoen\\_fivenation\\_ib\\_542.pdf](http://www.cmwf.org/programs/international/schoen_fivenation_ib_542.pdf).

41. Schoen et al., "Comparison of Health Care System Views."

42. See Robert J. Blendon, Cathy Schoen, Catherine M. DesRoches, Robin Osborn, et al., "Inequities in Health Care: A Five Country Survey," *Health Affairs* 21, no. 3 (May/June 2002): 182–91; and Robert J. Blendon et al., "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs* 22, no. 3 (May/June 2003): 106–21.

43. Blendon et al., "Common Concerns amid Diverse Systems," Exhibit 2.

44. Blendon et al., "Common Concerns amid Diverse Systems."

