

Chapter Three

Needs

MYTH NO. 3: COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH INSURANCE MAKE HEALTH CARE AVAILABLE ON THE BASIS OF NEED RATHER THAN ABILITY TO PAY

“The United States alone treats health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need,” claims Physicians for Single-Payer National Health Insurance. This is an article of faith among supporters of socialized medicine. Indeed, Aneurin Bevan, father of the British NHS, resigned from the Labor government in 1951 when a small charge was instituted for dental services and prescription drugs. As a matter of principle, he explained, health care should be free to the patient.

But is it really true that single-payer systems make care available on the basis of need alone? Precisely because of rationing, inefficiencies and quality problems, patients in single-payer countries often spend their own money on health care when they are given an opportunity to do so. In fact, private-sector health care is the fastest-growing part of the health care system in many of these countries. For example:

- In the first six years of the 1990s, private medical spending in Sweden rose 62 percent, to slightly less than 16 percent of total medical expenditure.¹
- Over the same period, private medical spending in Ireland rose to 25 percent of the health care market.
- In Britain, 13 percent of the population has private health insurance, to cover services they presumably are entitled for free under the NHS, and

private sector spending makes up 15 percent of the country's total health care spending.²

- In Canada, the share of privately funded health care spending rose from 24 percent in 1983 to an estimated 30.3 percent in 1998.³
- In Australia, private health insurance coverage has risen from around 31 percent in 1998 to almost 45 percent of the population by March 2002.⁴
- In New Zealand, 35 percent of the population has private health insurance (again, to cover services theoretically provided for free by the state), and private sector spending is about 10 percent of total health care spending.⁵

PRIVATE HEALTH CARE IN BRITAIN

Under the NHS, people have always had the right to pay for private treatment.⁶ And despite British claims 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.⁷ These patients went to one of Britain's 300 private hospitals, which account for an increasingly large share of total health care services, including 20 percent of all nonemergency heart surgery and 30 percent of all hip replacements.⁸

Altogether, almost seven million people are covered by private health insurance and they account for two-thirds of all patients in private hospitals. The existence of a large private health care industry suggests that many Britons are willing to spend more on their own health care than is their government. According to a survey by the Consumers' Association, 40 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. The affluent were more willing to use private facilities, but one-third of the less well-off said they would also consider it.⁹

Astonishingly, Britain's NHS has become the largest private care provider. While large numbers of British patients waited for care, 10,000 private pay patients—about half of whom are foreign—received preferential treatment in Britain's top NHS hospitals in 2001.¹⁰ Advertisements for one hospital boast that patients come from all over the world and the rooms are well furnished, with televisions that even have Arabic language channels.¹¹ An investigation by *The Observer* found that the NHS earns approximately \$500 million per year in fees from treating private patients and one of the leading cancer hospitals—the Royal Marsden in London—earns one-quarter of its revenue from treating cash-paying patients.¹² Ironically, while NHS provides prefer-

ential services to patients who can pay cash, other British patients are traveling to places such as South Africa where many procedures cost less than they do at private clinics and hospitals in Britain.¹³

CANADIAN MEDICARE

Since Canada does not allow private health insurance for services covered by its Medicare system, Canadians who see the country's few private physicians or get treatment at a private hospital must pay most of the cost out of pocket. For example, Canadians sometimes choose to undergo cataract surgery on an outpatient basis in private clinics. 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 than they can get at a government facility.¹⁴

Also, attempts to find legal loopholes in the prohibition against private pay are becoming routine. We noted above Ontario's recent ban on professional athletes paying for care at Toronto hospitals. In British Columbia, private orthopedic clinics originally set up to treat patients in cases covered by workers compensation and auto insurance (technically outside of the Medicare system) began seeing almost anyone with a checkbook. They interpreted the prohibition against patients paying for their own care literally, and accepted payment from the patients' brothers, sisters, uncles, and so forth, instead. A new law put these clinics out of business, however.¹⁵

There is also a budding private market in sophisticated scanning services. Private clinics that apparently skirt the law on the theory that services are not "necessary" medical care, are booming and now constitute 10 percent of the MRI market. St. Paul's Hospital in Vancouver offers after-hours full-body scans for less than C\$1,000. A Montreal clinic offers a private CT scan for C\$250. Patients wait one or two weeks for these procedures, compared to six-month waits in the public sector. A private company in Vancouver that offers PET scans for C\$2,500 is attracting patients from as far away as Newfoundland.¹⁶

Canadians paying for private care are not all wealthy. A study by the Manitoba Center for Health Policy and Evaluation found that 40 percent of the private-pay cataract surgery patients in Winnipeg were from neighborhoods with average incomes in the lowest two-fifths of the income distribution.¹⁷

To reduce waiting lists for cancer treatment, seven of the ten Canadian provinces are sending some of their breast and prostate cancer patients to the United States for radiation therapy.¹⁸ Canadians spend an estimated \$1 billion

on care in the United States each year.¹⁹ Sometimes the patient's home province pays the bill. In other cases, patients spend their own money.

NOTES

1. James A. Monroe, "Citizens or Shoppers? Solidarity Under Siege," *Journal of Health Politics, Policy and Law* 25, no. 5 (October 2000): 959–68.

2. Out of a population of 53 million, 6.7 million are covered by private health insurance and another one million have cash-benefit critical illness policies. See Oliver Wright, "Private Health Cover Slumps as Cost Spirals," *The Times*, September 17, 2003. Also see Caroline Richmond, "NHS Waiting Lists Have Been a Boon for Private Medicine in the UK," *Canadian Medical Association Journal* 154, no. 3 (February 1, 1996): 378–81; and Timothy Besley, John Hall and Ian Preston, "The Demand for Private Health Insurance: Do Waiting Lists Matter?" *Journal of Public Economics* 72, no. 2 (May 1, 1999): 155–81.

3. "The Evolution of Public and Private Health Care Spending in Canada, 1960–1997," Table C.2.4, Canadian Institute for Health Information, 1999. The proportion of private medical spending in Canada is currently 30 percent. See Cynthia Ramsay, "Beyond the Public-Private Debate: An Examination of Quality, Access and Cost in the Health-Care Systems of Eight Countries," Marigond Foundation, July 2001.

4. "Health: Private Health Insurance," *Year Book Australia 2003*, Australian Bureau of Statistics, January 24, 2003, table 9.29.

5. Daniel Riordan, "Health Insurance Faces a Bitter Pill," *New Zealand Herald*, January 24, 2002.

6. 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* 317, no. 7150 (July 4, 1998): 66–69.

7. "NHS Patients Opt for Private Surgery," *BBC News*, January 15, 2002. The survey was conducted by Medix UK plc, an Internet service for doctors.

8. Richmond, "NHS Waiting Lists."

9. "Forty Percent Would Go Private Unless Access to NHS Improved," Consumers' Association, May 30, 2001, available at www.which.net/whatsnew/pr/may01/general/nhs.html.

10. Anthony Browne, "Scandal of NHS Beds Auction," *The Observer*, January 6, 2002.

11. Browne, "Scandal of NHS Beds Auction."

12. Anthony Browne, "Cash-Strapped NHS Hospitals Chase Private Patient Bonanza."

13. Anthony Browne, "NHS Cases Pay for Quick Ops in South Africa," *The Observer*, March 17, 2002.

14. Carolyn DeCoster et al., "Surgical Waiting Times in Manitoba," Manitoba Centre for Health Policy and Evaluation, June 1998; and Pippa Wysong, "The Wait-

ing Game,” *Medical Post* 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 perform some of the private services. For a discussion of parallel public/private systems in Canada, see Charlotte Gray, “Visions of Our Health Care Future: Is a Parallel Private System the Answer?” *Canadian Medical Association Journal* 154, no. 7 (April 1, 1996): 1084–87.

15. For a discussion of attempts to stop private clinics, see John R. Graham and Nadeem Esmail, “The BC Government is Eroding Patient’s and Physicians’ Rights,” Fraser Institute, December 10, 2003.

16. Tom Arnold, “Canada’s Medical System Lacks Many Bells and Whistles,” *National Post*, November 17, 2001.

17. C. A. DeCoster and M. D. Brownell, “Private Health Care in Canada: Savior or Siren?” *Public Health Reports* 112, no. 4 (August 1997): 298–305.

18. Cardwell, “Quebec Cancer Patients to Head South”; Walker, “Alberta Centre May Soon Fly Its CA Patients South”; and Haley et al., “Guarding the Border.”

19. Steven J. Katz et al., “Phantoms in the Snow: Canadians’ Use of Health Care Services in the United States,” *Health Affairs* 21, no. 3 (May/June 2002): 19–31. Also see Victor Dirnfeld, “The Benefits of Privatization,” *Canadian Medical Association Journal* 155, no. 4 (August 15, 1996): 407–10.

