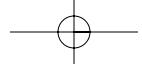
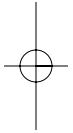
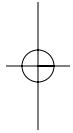


Part Two

**THE POLITICS AND ECONOMICS
OF HEALTH CARE SYSTEMS**



Chapter Twenty-one

The Politics of Medicine

“Public choice” is the discipline that attempts to integrate economics and political science.¹ Its chief goal is to explain political phenomena, just as economists explain purely economic phenomena. The name, however, is potentially misleading. The new discipline could more 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 outcome—efficient production—is independent of any particular producer’s wishes or desires.

In a similar way, political competition inexorably leads candidates to adopt specific positions, called the winning platform.² The idea of a winning platform is a fairly simple one. It is a set of political policies that can defeat any other set of policies in an election. Politicians who want to be elected or re-elected have every incentive to endorse the winning platform. If they do not, they become vulnerable; for if their opponents adopt the winning platform and they do not, the opponents 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, ethnicity, gender, general appearance, speaking ability, party affiliation, and so forth. Even when voters are influenced by real political issues, politicians do not always know what the winning platform is. Often they must guess at

it. Nonetheless, public choice theory holds that, other things being 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.

This line of reasoning leads to the conclusion that in democratic systems with two major political parties, both 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. 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 to 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 that determine the nature of the winning platform.

This corollary is crucial to understanding single-payer health insurance. A great many British health economists who support socialized medicine are quick to concede that the British NHS has defects. But these defects, in their view, are not those of socialism; they merely represent a failure of political will or of the politicians 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 single-payer health insurance systems are 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 NHS, seems to have appreciated this insight. Powell wrote that “whatever is entrusted to politicians becomes political even if it is not political anyhow,”³ and he went on to say that

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.⁴

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.⁵ 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 AMOUNT OF SPENDING ON HEALTH SERVICES

One argument used to justify national health insurance 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 1948.⁶ Many expected that, under socialized medical care, more total dollars would be spent on health care than would otherwise have been the case.

Yet, it is not clear that socialized medicine in Britain has increased overall spending on health care. It may even have had the opposite result. This was 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.”⁷ The same may be true of the single-payer systems 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, suppose the politician has access to ten dollars to spend on the voter’s behalf. To maximize his chance of winning, the politician should spend the ten dollars precisely as the voter wants it spent. If the voter’s choice is five dollars on medical care, three dollars on a retirement pension and two dollars on a rent subsidy, that should also be the choice of the vote-maximizing politician. If the politician does not choose to spend the ten dollars in this way, he risks losing this voter to a clever opponent.

Now it might seem that if the voter wants five dollars spent on medical care, we can conclude that he would have spent the five dollars on medical care himself if he were spending ten dollars 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 other government spending programs—nonprice rationing. Nonprice 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 being equal, five dollars of spending on government health care will be less valuable to the average voter than five dollars 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 that do not involve nonprice 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 nonmarket 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 user fees.

In the real world, politicians can rarely tailor their spending to the desires of a specific voter. Generally, they must allocate spending among programs that affect thousands of voters. New spending for a hospital, for example, provides benefits for every one in the surrounding community. And no matter what level of spending is chosen, some voters will prefer more and others less. Often, 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 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, levels of provision among the geographical areas of Britain, Canada and New Zealand today may be 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.

Policy makers 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 sug-

gests 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 in the previous section, let us suppose that ten dollars is going to be spent in the region of Merseyside, England. If a majority of residents want two dollars spent on health services and eight dollars spent on other programs, political competition will tend to produce that result. Yet, if the residents of some other city want eight dollars spent on health services and two dollars spent on other programs, political competition will also tend to produce that result.

Prior to the establishment of national health insurance, 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 VERSUS CURING

The British NHS’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.⁸ Commenting on this response, Rozbicki writes⁹

It is difficult for an American observer to comprehend that view. He has been impressed by the support services already afforded the nonacute 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

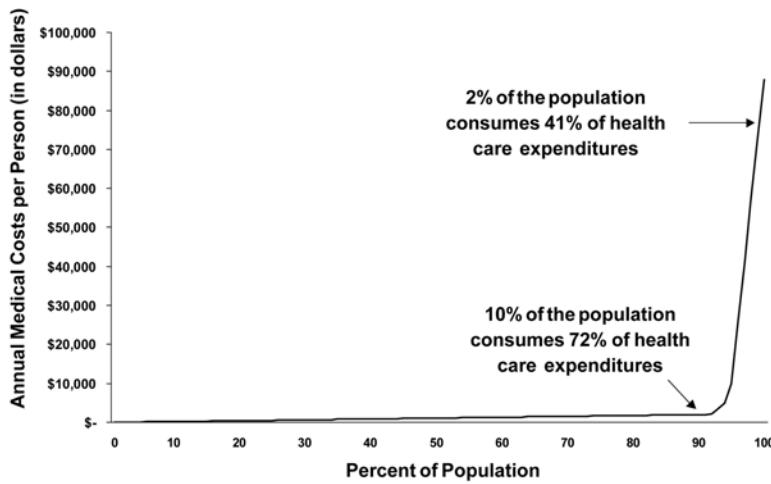
confidently expects immediate delivery of all that medical science has to offer if life or health is under immediate threat.

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 affects far more people than money spent on curing. Rozbicki writes,¹⁰

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.*

In the United States, almost three-quarters of health expenditure is consumed by only 10 percent of the population. As much as 41 percent of health expenditure is consumed by the 2 percent of the population that is most in need of care (see figure 21.1). But when health care is allocated through the

FIGURE 21-1
U.S. 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*, October 2000.

political system, politicians cannot afford to spend 40 percent of the budget on 2 percent of the voters—people who may be too sick to get to the polls and vote in any event.

This explanation is persuasive, as far as it goes. But it is not 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 acute care, even if they do not currently need it. To understand these priorities, we must understand why the average citizen would approve of them.

Like the citizens of other countries, most Britons are relatively uninformed about the latest 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 or her counterpart in the United States. Precisely because the U.S. medical market is largely private, a better-informed person can become a better consumer.

But under 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, 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 of many OECD countries are tolerant of single-payer health insurance systems has to do with a simple fact. Most of them are not sick. 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 it is consumed by the bulk of the population. The flaws of single-payer health insurance systems are most apparent where expensive intervention is needed by the few who are very ill.

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, the suppliers

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.

Public choice theory, then, would predict that under a socialized medical system, people will acquire less knowledge about medical care than they would have acquired in a private system. The evidence confirms this prediction. More than two decades ago, Rozbicki wrote that "the British populace appears much less sophisticated in its medical demands than the American populace."¹¹ Through the years other commentators have made the same observation and the generalization still appears to be true.

The comparative ignorance about medical science that 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 nonacute services provided by the NHS. He or she is probably unfamiliar with and uncertain about the personal value of advanced services for acute ailments.

Another reason why voters will tend to prefer caring to curing services stems from a characteristic of nonprice 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 spend less time with each patient and presumably render fewer services. Nonetheless, this type of adjustment allows the typical patient to actually visit his or her GP within two or three days of making an appointment. The quality of treatment may be inferior to what U.S. patients receive, 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 nonprice rationing tends to make all health care services less valuable than those services would be in a free market. But because nonacute services can be adjusted to increase the certainty of some treatment, whereas acute services generally cannot, the former tend to gain

value relative to the latter. Thus, the priority given to nonacute treatment seems 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,¹² Anthony Culyer¹³ and many other British health economists, this discretion is the principal reason for many of the gross inefficiencies found in the British NHS.

In addition to the power of GPs and consultants, other producer interest groups have gained power and influence. Within the NHS, these include hospital administrators, junior 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,¹⁴

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 byproduct, 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. 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. More than 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.¹⁵ We should not 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 factor, this might be so. But two additional factors put consumers at a disadvantage: the cost of information and the cost of political organization.

To achieve any fundamental change of policy, voters must be informed about what kinds of changes they specifically seek. They also must 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 be more than sufficient to overcome their relative vulnerability in terms of sheer voting power. This insight was provided by Professor Milton Friedman forty years ago¹⁶:

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 barbing. 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 con-

tinue 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?”¹⁷ That British patients do like the NHS had been confirmed repeatedly by public opinion polls, although its popularity has been declining.¹⁸ And although the popularity of Medicare has also been declining in Canada, Canadians show little interest in moving to a U.S.-type health care system.¹⁹

The principle of national health insurance is accepted in other countries for three reasons. First, the wealthy, powerful and sophisticated—those most skilled at articulating their complaints—find ways to maneuver to the front of the rationing lines. In this sense, national health insurance “works” in other countries because those who could change the system are best served by it. If a member of the British Parliament, the CEO of a large British company or the head of a major British trade union had no greater access to renal dialysis than any other British citizen, the British NHS would not last a week.

Second, those pushed to the end of the waiting lines are generally unaware of medical technologies they are being denied, at least in comparison to American patients. And, as we have seen, doctors and health authorities have little incentive to increase their level of awareness. As a result, patients in other countries frequently do not know what they are not getting.

Third, patients pushed to the rear of the waiting lines in other countries are often not very insistent about getting their needs met. A number of comparisons of British and American patients through the years have concluded that British patients are more docile.²⁰ Conditioned for decades by a culture of rationing, British patients put up with inadequacies that most Americans would not tolerate.

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.”²¹ 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 whatever is done.”²² Another doctor summarized the difference in British and American attitudes this way²³:

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.

In general, the British public has little idea of how much they are paying for health care. Since the NHS is financed through hidden taxes, the perception that it costs little is widespread. 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."²⁴

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.²⁵

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.²⁶ They not only support it, they also resisted proposals to open it to minimal competition by prime ministers Margaret Thatcher and John Major and more recently by Tony Blair.

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. But among developed countries, most serious attempts at fundamental reform have been blocked by the politics of medicine. Reforms in public sector health care are likely to come about as people seek private sector alternatives rather than through changes at the ballot box.

NOTES

1. 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, Mich.: 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* 59 (1988): 51–66; Gary S. Becker, "A Theory of Competition among Pressure Groups for Political Influence," *Quarterly Journal of Economics* 48, no. 3 (1983): 371–400.
2. The winning platform is not the written platform of parties (documents which tend to be ignored by voters), but the programs and policies candidates promise to implement.
3. Enoch Powell, *Medicine and Politics, 1975 and After* (New York: Pitman, 1976), 5.
4. Powell, *Medicine and Politics*, 67.
5. Goodman, *National Health Care in Great Britain: Lessons for the U.S.A.*, ch. 10.
6. Dennis Lees, "An Economist Considers Other Alternatives," in Helmut Schoeck, ed., *Financing Medical Care: An Appraisal of Foreign Programs* (Caldwell, Idaho: Caxton Printers, 1963), 80.
7. Dennis Lees, "Economics and Non-economics of Health Services," *Three Banks Review*, no. 110 (June 1976): 9.
8. 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, 17.
9. Rozbicki, "Rationing British Health Care."
10. Rozbicki, "Rationing British Health Care," 18 (emphasis added).
11. Rozbicki, "Rationing British Health Care," 17.
12. Michael Cooper, *Rationing Health Care* (London: Croom Helm, 1975), 73.
13. Anthony Culyer, "Health: The Social Cost of Doctors' Discretion," *New Society* (February 27, 1975).
14. Lees, "Economics and Non-economics of Health Services," 12.
15. See Paul W. MacAvoy, ed., *Crisis of the Regulatory Commissions* (New York: Norton, 1970).
16. Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), 143.

17. John J. Fisher, "If Britain's Health Care Is So Bad, Why Do Patients Like It?" *Medical Economics* (August 21, 1978).
18. In a poll, the portion of people who were "fairly dissatisfied" or "very dissatisfied" rose to 28 percent in 1998. People reporting they were "very satisfied" fell to 13 percent, while the portion who were "fairly satisfied" fell to 45 percent. Fully 90 percent of those surveyed thought the NHS needs improvement. See Annabel Ferrierman, "Public's Satisfaction with the NHS Declines," *British Medical Journal* 321, no. 7275 (December 16, 2000): 1488.
19. Between 1987 and 1997, the proportion of Canadians who were satisfied with their health care system dropped from 56 percent to 20 percent. Commonwealth Fund 1998 International Health Policy Survey, cited in Karen Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* (May/June 1999): Exhibit 6.
20. For a comparison of how patient attitudes and treatments vary by culture, see Lynn Payer, *Medicine and Culture* (New York: Henry Holt, 1996).
21. Derek Robinson, "Primary Medical Practice in the United Kingdom and the United States," *New England Journal of Medicine* 297, no. 4 (July 28, 1977): 189.
22. Rozbicki, "Rationing British Health Care," 18.
23. Quoted in Harry Swartz, "The Infirmitiy of British Medicine," in Emmett Tyrrell Jr., ed., *The Future That Doesn't Work: Social Democracy's Failures in Britain* (New York: Doubleday, 1977), 31.
24. Quoted by Lew Rockwell in *World Research INC*, March 1979, 5.
25. Quoted by Lew Rockwell in *World Research INC*, March 1979, 6.
26. John Walsh, "Britain's National Health Service: the Doctors' Dilemmas," *Science* 201 (July 28, 1979): 329.