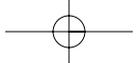
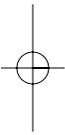
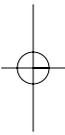


# Lives at Risk



# **Lives at Risk**

## **Single-Payer National Health Insurance around the World**

John C. Goodman, Gerald L. Musgrave,  
and Devon M. Herrick

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## Introduction: Thinking about Reform

As we move further into the twenty-first century, it is clear that we are living with a number of institutions that were not designed for the Information Age. One of those institutions is health care.

Virtually everyone agrees that our health care system needs reform. But what kind of reform? Some on the right would like to see us return to the type of system that prevailed in the 1950s. Some on the left would like to see us copy one of the government-run systems established in the mid-twentieth century and variously called socialized medicine, national health insurance and, more recently, single-payer health insurance. For example, Physicians for a National Health Program, claiming membership of 8,000 physicians and medical students, contends that “single-payer national health insurance would resolve virtually all of the major problems facing America’s health care system today.”<sup>1</sup>

We believe that neither of these two alternatives will work. But before we explain why, let us stop to consider some central problems that every reform faces. Most commentaries on health policy tend to ignore three very important facts about modern health systems:

1. We can potentially spend our entire gross domestic product (GDP) on health care in useful ways.
2. Whatever portion of our income we are spending on health care today, we are likely to want to spend more in the future.
3. We have suppressed normal market forces in dealing with characteristics one and two.

These facts are not in dispute. Rather, they are readily acknowledged by all health policy analysts. Also, the first two characteristics are not unique to

health care. They are true of many other goods and services as well. But when combined with the third characteristic, they have devastating implications.

### **PROBLEM: OPPORTUNITIES TO SPEND MONEY ON HEALTH CARE ARE ALMOST UNLIMITED**

Medical research has pushed the boundaries of what doctors can do for us in every direction. The Cooper Clinic in Dallas now offers an extensive checkup (with a full body scan) for about \$1,500 or more.<sup>2</sup> Its clients include Ross Perot, Larry King, and other high-profile individuals. Yet, if everyone in America took advantage of this opportunity, we would increase our nation's annual health care bill by a third. More than 900 diagnostic tests can be done on blood alone,<sup>3</sup> and one doesn't need too much imagination to justify, say, \$5,000 worth of tests each year. But if everyone did so, we would double the nation's health care bill. Americans purchase nonprescription drugs almost twelve billion times a year and almost all of these are acts of self-medication. Yet, if everyone sought a physician's advice before making such purchases, we would need twenty-five times the number of primary care physicians we currently have.<sup>4</sup> Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another.<sup>5</sup> At, say, \$1,000 a test, it would cost more than \$1 million for a patient to run the full gamut. But if every American did so, the total cost would run to about thirty times the nation's total output of goods and services!<sup>6</sup>

Notice that in hypothetically spending all of this money we have not yet cured a single disease or treated an actual illness. In these examples, we are simply collecting information. If in the process of search we actually found something that warranted treatment, we could spend even more.

One of the cardinal beliefs of advocates of single-payer health insurance is that health care should be free at the point of consumption, regardless of willingness or ability to pay. But if health care really were free, people would have an incentive to obtain each and every service so long as it had any value to them. In other words, everybody would have at least an economic incentive to get the Cooper Clinic annual checkup, order dozens of blood tests, check out all their genes and consult physicians at the drop of a hat. In short order, unconstrained patients would attempt to spend the entire gross domestic product (GDP) on health care even though, as a practical matter, that would be impossible.

"Free" health care is of course not really free. It is care paid directly by employers, government or some other entity, and indirectly by workers and taxpayers. The more employers pay for health care the less employees receive in wages. The more the government pays, the less after-tax income taxpayers

have. Therefore, allowing patients to go on an unconstrained shopping spree in the medical marketplace would ultimately impoverish all of us.

No serious person wants this result. Not even the advocates of single-payer health insurance want it. Instead, they envision placing many obstacles in the path of patients and doctors in order to constrain spending. These obstacles may not be prices, but they most certainly involve costs, such as the cost of waiting for care. Although its advocates call national health insurance “single-payer insurance” these days, its distinguishing characteristic is not control of demand. It is control of supply.

Like the systems of Canada and Britain, American health maintenance organizations (HMOs) also make health care free to their enrollees at the point of delivery. They then control access to care, especially expensive care, on a case-by-case basis. Whether or not an HMO patient gets an MRI brain scan, for example, depends upon the symptoms and the probable outcome of the scan, as well as its cost. HMOs, therefore, control costs by curtailing demand.

Nothing like that happens in countries with national health insurance, however. For one thing, doctors in Canada would have no idea how much a scan actually costs and therefore would have no basis for comparing costs with probable medical benefits. The number of brain scans is controlled in Canada, not on the basis of a case-by-case review of patient conditions, but because of spending constraints to limit the number of MRI scanners.

Many American doctors have endorsed the single-payer idea, in part because they envy the ability of Canadian doctors to practice medicine without managed-care-type, third-party interference. What they overlook is that, at least from a budget perspective, Canadian officials have no reason to care what decisions doctors make. They limit the number of scanners, and therefore the expense of scanning, before doctors see even a single patient. American physicians who support single-payer insurance also tend to discount lack of access to expensive diagnostic equipment in Canada, believing that the problem could be ameliorated by just spending more. They do not realize that the only reason the Canadian system works at all is because the government controls supply. If Canadian doctors (who, again, have no idea what anything costs) had access to an unlimited supply of MRI units, they might spend Canada’s entire GDP on brain scans!

In general, countries with national health insurance control costs by imposing arbitrary limits. They strictly control the number of doctors who can be specialists. They limit access to modern medical technology. The more expensive the service, the more difficult they make access. As a result, in countries with national health insurance, people wait. They wait in the offices of general practitioners. They wait to see specialists. They wait for surgeries. And waiting is a rationing device comparable to money prices in a market system.

In this book we will stress many differences between the U.S. health care system and government-run health care systems. But on the demand side, the differences are not as great as one might suppose. Although health care is not free at the point of consumption for the average American, it is almost free. On the average, every time a patient spends a dollar on hospital care in our country, only two cents comes out of the patient's own pocket. The other ninety-eight cents is paid by a third party (an employer, insurer or government.). On the average, for every dollar patients spend on physician care, only twelve cents comes out of their own pockets. And for the health care system as a whole, patients pay directly only eighteen cents of every dollar they spend. The rest is spent by some other entity.<sup>7</sup>

On the demand side, the problem with a system with no money prices is that people view each good or service as though its price were zero. As a result, they tend to try to consume the item so long as it has any value at all. The problem this creates is enormous waste. People seek services until the value to them is almost zero, even though the cost of these services may be quite high. The upshot is that people consume services for which the social benefit is well below the social cost. In Britain, for example, people have to pay out of pocket to see a movie, go to the theater or witness a sporting event. But the only costs to see a physician are the costs of travel and waiting time. So although the government makes an enormous investment in their training, British physicians spend an inordinate amount of time on trivial complaints.

In the United States, things are not that much better. Although no one wants to enter a hospital, once there, the typical patient in this country has an incentive to use hospital services until they are worth only two cents at the margin (or about 1/50th of the actual cost). Aside from the costs of time and travel and the risk of being around other sick people, patients have an incentive to utilize physicians' services until they are worth only twelve cents on the dollar. And for the health care system as a whole, our incentive is to spend until the services we receive are worth only eighteen cents on the dollar. No wonder there is so much waste!

In principle, there are not many solutions to this problem. Someone must choose between health care and other uses of money. The question is, who will that someone be? The answer of single-payer advocates is medical bureaucracies answerable to politicians. And much of this book will be spent looking in some detail at how rationing decisions are made in these systems.

A second method for choosing between health care and other uses of money is the method of managed care. The paradigm is the HMO. As noted above, HMOs have far less rationing by waiting than do national health insurance schemes. One reason for the difference is that HMOs tend to make rationing decisions based on medical and economic rather than political considerations. Because some policy analysts believe that a system of competing

managed care organizations can solve the problems of single-payer health insurance, we devote a chapter to that idea.

The third method of choosing between health care and other uses of money is to allow patients themselves to choose. A vehicle that facilitates such choices is a health saving account (HSA), from which patients pay medical expenses directly. Funds not spent on health care grow in the account and may be used for other purposes. Singapore has had a compulsory system of “medisave” accounts since 1984.<sup>8</sup> Medical savings accounts (MSAs) were introduced in South Africa in the early 1990s and today represent 65 percent of the market for private health insurance in that country.<sup>9</sup> The United States experimented with a pilot program for several years and as of January 1, 2004, HSAs are available to all nonelderly Americans.<sup>10</sup>

So far, these accounts have mainly been used to pay relatively small medical bills, less than a few thousand dollars. These are the expenses that fall under a health insurance deductible. But as the accounts grow and if health insurance evolves toward the casualty model, the accounts could play a role in almost every aspect of health care. Consider homeowner’s casualty insurance, for example. If hail damages a roof, an insurance adjuster surveys the damage and agrees to a sum sufficient to cover the cost of repair—usually by a repair service the insurer knows. But the homeowner is not restricted to this option. He or she can choose other, more expensive repair services or even choose to replace the damaged roof with a nicer roof.

In principle, health insurance could work the same way. In the case of expensive heart surgery or cancer care, the insurer could direct the patient to a hospital or clinic and agree to pay the full cost. But the patient would be free to take the same reimbursement amount and apply it to another hospital or clinic, paying any extra charges from an HSA account.

In the world of casualty insurance, auto repair shops act as agents of automobile owners. Roofing repair services act as agents of homeowners. Suppliers of these services do not see themselves as agents of third-party insurers. In a similar way, HSAs could free patients to become the real decision makers, choosing between health care and other uses of money in virtually every part of the health care system. In such a world, doctors, nurses and other providers would see themselves as agents of their patients rather than agents of impersonal bureaucracies.

### **PROBLEM: THE DESIRE TO SPEND WILL GROW IN THE FUTURE**

Let’s now turn to a second well-documented, but rarely discussed, fact about modern health care systems. Whatever we are spending on health care

today, we are probably going to want to spend more tomorrow. This is true for two reasons: first, the average age in all developed countries is rising and health needs increase with age, and second, health care is a “superior good,” which means as income grows people choose to spend more of it on health care.

At 15.2 percent of the GDP, the United States spends more of its income on health care than any other nation, a sum that equals \$1.6 trillion.<sup>11</sup> This fact is a usual source of criticism both at home and abroad. But if you think 15 percent is high, you haven’t seen anything yet. Currently, senior citizens (over sixty-five years of age) spend about 45 percent of all their consumption (regardless of who pays for it) on medical care. By 2020, it is estimated that three-fourths of all consumption by seniors will be on health care.

Is such spending good or bad? That depends on whether people are getting their money’s worth for the dollars they spend. If people are getting value for money, nothing is wrong with devoting more resources to health care. If they are not getting value for money, something *is* wrong with it.

This way of looking at the issue is very different from what one hears in most public policy discussions. The standard complaint is that health care “costs” are rising. And innumerable conferences, briefings, books, articles, essays and so forth have sought to “solve the problem” of rising health care costs.

Note that in a general sense “spending” and “costs” are the same thing. If people are aging and their incomes are rising, one can predict with great confidence that they will want to devote more of their income to medical care. Not only is this not a “problem,” it is a natural and inevitable part of life. Indeed, to the degree that this phenomenon is viewed as a problem, it is not a problem that is going to be solved. It will only get worse through time.

We noted above that in a system with no prices, decision makers cannot determine what value people place on different services. Thus, they cannot know what’s being oversupplied or undersupplied. A similar problem arises with respect to total spending on health care. Given that it should rise over time, by how much should it rise? How would one know? Without markets through which people can reveal their preferences for health care versus other goods and services, it’s anybody’s guess.

American employers who complain about the “problem” of rising health care costs are in a similar situation. Because decisions about health care typically are made collectively at the workplace and because the premiums employees pay rarely reflect real costs, employers have no way of discerning their employees’ willingness to trade off higher wages for more

health care, except through union negotiations and other imperfect devices. Fortunately, when American employers make a mistake, its consequences are confined to their companies and their workforces. But when the managers of national health insurance make mistakes, the whole nation suffers.

### **PROBLEM: WE HAVE SUPPRESSED NORMAL MARKET RESPONSES**

Some of the things we have been saying about health care are also true of other goods and services. For example, we could probably spend our entire gross domestic product on automobiles, with each of us owning several to use over different terrains and in different seasons. But no one ever asserts that this is a problem. To the contrary, most people regard it as an opportunity. The fact that automobile manufacturers have discovered so many different ways to satisfy our needs makes us better off, not worse off (pollution problems aside).

Similarly, fine wine is probably a superior good. As people's income rises, they tend to buy more of it. And in recent years, supply has increased to meet demand, as vineyards have expanded all over the world. Again, no one regards this as a problem.

So what makes automobiles and fine wine different from health care? Why are problems that cause so much hand-wringing in health care not seen as problems in the other two markets? The answer is that in this country and in all developed countries we have suppressed the ability of the market to allocate health care resources.

The suppression of the market in health care began more than 100 years ago. It started with controls on who could be a physician and how those licensed to practice should behave. By the mid-twentieth century, controls were extended to the hospital sector and then to health insurance. By the 1970s, with government paying more and more medical bills, policy makers realized that prices and markets were not able to do their job. Similar trends occurred in other developed countries.<sup>12</sup>

What does it mean to suppress normal market forces in health care? Not long ago, if a doctor competed aggressively against other doctors, say, the way auto companies compete against each other, he or she could be in real trouble. For example, if the doctor posted his normal fees and compared them to other doctors' fees, if he compared the quality of his practice to that of another physician or if he advertised at all he could be expelled from the county medical society. That, in turn, would lead to a loss of privileges at

all the hospitals in his area. If the offense were bad enough (irritating enough to his fellow physicians), he could lose his license to practice medicine.

Until very recently, the hospital sector was dominated by nonprofit institutions whose sole task was to facilitate the doctors' goal of treating patients. Not only were hospitals not supposed to function like businesses, they went out of their way to avoid certain common business practices. For example, for a hospital to compare the quality of its care to the quality offered by a competitor would have been unthinkable. Advertising itself was unthinkable. Not only did hospitals not post their prices, no one paid them other than the occasional uninsured patient. At the time Medicare (for seniors) and Medicaid (for the poor) were adopted in the 1960s, virtually every hospital in the United States was paid by insurers based on cost-plus reimbursement. And when the federal government set up Medicare, it joined the cost-plus system, paying for health care the way it paid for weapons systems. All in all, the health care system in this country and throughout the developed world functioned according to rules that resembled a medieval guild more than a complex modern market.<sup>13</sup>

Times have changed. And they have changed more in the United States than anywhere else. Other countries have left in place the medieval guild approach to medicine and tried to control costs in crude ways that we will examine. In this country, however, we have made dismantling the guild and promoting competition a public policy goal.

Doctors today can compete in almost any way they like. They can post prices; they can advertise; they can boast about the quality of care they deliver. Hospitals can do the same. And insurers can pay hospitals based on any arrangement that can be reached through no-holds-barred voluntary exchange in the marketplace. But although the shackles have been removed and although the law no longer protects it, the 100-year-old culture that has dominated medical practice has not disappeared.

Pick up almost any daily newspaper and you will find evidence that the medical marketplace is still not functioning like other markets. "Hospitals Say They're Penalized by Medicare for Improving Care," blares a front page headline in the *New York Times*.<sup>14</sup> "More Care Is Not Better Care," leads a *Times* guest editorial, citing evidence that Medicare spends twice as much on seniors in Manhattan as it does Portland, Oregon, without getting any improvement in quality or patient satisfaction.<sup>15</sup>

But there are two consoling observations: first, the medical marketplace is becoming more competitive, and second, things are much worse in every other country.

## HAVE OTHER COUNTRIES FOUND THE ANSWER?

American advocates of single-payer national health insurance propose to<sup>16</sup>

- Eliminate HMOs and most other forms of managed care
- Have all health care financed by the government, with no premiums or co-payments from those covered
- Control costs by assigning global budgets to hospitals and setting fees and salaries for physicians
- Prohibit private insurance or personal payment for any service covered by the single-payer system

In advancing this idea, they point to other countries as examples of health care systems that are superior to our own. Are they right?

The promise of national health insurance is that government will make health care available on the basis of need rather than ability to pay. That implies a government commitment to meet health care needs. It implies that rich and poor will have equal access to care. And it implies that more serious needs will be given priority over the less serious. Unfortunately, these promises have not been kept.

- Wherever national health insurance has been tried, rationing by waiting is pervasive—with waits that force patients to endure pain and sometimes put their lives at risk.
- Not only is access to health care not equal, if anything it tends to correlate with income—with the middle class getting more access than the poor and the rich getting more access than the middle class, especially when income classes are weighted by incidence of illness.
- Not only are health care resources not allocated on the basis of need, these systems tend to overspend on the relatively healthy while denying the truly sick access to specialist care and lifesaving medical technology.
- And far from establishing national priorities that get care first to those who need it most, these systems leave rationing choices up to local bureaucracies that, for example, fill hospital beds with chronic patients while acute patients wait for care.

It might seem that some of these problems could be easily remedied. Yet, as the years of failed reform efforts in Britain and Canada have shown, the defects of single-payer systems of national health insurance are not easily

remedied. The reason: the characteristics described above are not accidental byproducts of government-run health care systems. They are the natural and inevitable consequences of placing the health care market under the control of politicians.<sup>17</sup> It is not true that health care policies in countries with single-payer health insurance just happen to be what they are. In most cases, they could not be otherwise.

Why do single-payer health insurance schemes skimp on expensive services to the seriously ill while providing so many inexpensive services to the marginally ill? Because the latter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small numbers of voters). Democratic political pressures dictate the redistribution of resources from the few to the many.

Why are sensitive rationing decisions and other issues of hospital management left to hospital bureaucracies? As a practical matter, no government can make it a national policy to let 25,000 of its citizens die from lack of the best cancer treatment every year, as apparently happens in Britain.<sup>18</sup> Nor can any government announce that some people must wait for surgery so that the elderly can use hospitals as nursing homes or that elderly patients must be moved so that surgery can proceed. These decisions are so emotionally loaded that no elected official could afford to claim responsibility for them. Important decisions on who will receive care and how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.

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

Why do the rich and the powerful manage to jump the queues and obtain care that is denied to others? Because it could not be otherwise. These are the people with the power to change the system. If members of Parliament had to wait in line for their care like ordinary people, the system would not last for a minute.

### **DO OTHER COUNTRIES THINK THEY HAVE FOUND THE ANSWER?**

Despite the official rhetoric, over the course of the past decade almost every European country with a national health care system has introduced market-

oriented reforms and turned to the private sector to reduce the costs of care and increase the value, availability and effectiveness of treatments.<sup>19</sup> In making these changes, more often than not these countries looked to the United States for guidance.

- About seven million people in Britain now have private health insurance; and since the Labor government assumed power, the number of patients paying out of pocket for medical treatment has increased by 40 percent.<sup>20</sup>
- To reduce its waiting lists, the British National Health Service (NHS) recently announced that it will treat some patients in private hospitals, reversing a long-standing policy of using only public hospitals;<sup>21</sup> and, the NHS has even contracted with HCA International, America's largest health care provider, to treat 10,000 NHS cancer patients at its facilities in Britain.
- Australia has turned to the private sector to reform its public health care system to such an extent that it is now second only to the United States among industrialized nations in the share of health care spending that is private.<sup>22</sup>
- Since 1993, the German government has experimented with American-style managed competition by giving Germans the right to choose among the country's competing sickness funds (insurers).<sup>23</sup>
- The Netherlands also has American-style managed competition, with an extensive network of private health care providers and slightly more than one-third of the population insured privately.<sup>24</sup>
- Sweden is introducing reforms that will allow private providers to deliver more than 40 percent of all health care services and about 80 percent of primary care in Stockholm.<sup>25</sup>
- Even Canada has changed, using the United States as a partial safety valve for its overtaxed health care system; provincial governments and patients spend more than \$1 billion a year on U.S. medical care.<sup>26</sup>

In each of these countries, growing frustration with government health programs has led to a reexamination of the fundamental principles of health care delivery. Through bitter experience, many of the countries that once touted the benefits of government control have learned that the surest remedy for their countries' health care crises is not increasing government power, but increasing patient power instead.<sup>27</sup>

## GOAL OF THIS BOOK

This book is not intended as a defense of the existing health care system in the United States. To the contrary, we count ourselves among its harshest critics.

Our goal here is to dispel certain myths about health care as delivered in countries that have national health insurance. These myths have gained the status of fact in both the United States and abroad, even though the evidence shows a far different reality.

In this book we will examine the critical failures of national health insurance systems without focusing on minor blemishes or easily correctable problems. In doing so, our goal is to identify the problems common to all countries with national health insurance and to explain why these problems emerge. Most national health care systems are in a state of sustained internal crisis as costs rise and the stated goals of universal access and quality care are not met. In almost all cases, the reason is the same: the politics of medicine. The problems of government-run health care systems flow inexorably from the fact that they are government-run rather than market driven.

We have chosen to focus primarily, though not exclusively, on the health care systems of English-speaking countries whose cultures are similar to our own. Britain, Canada and New Zealand in particular are often pointed to by advocates of national health insurance as models for U.S. health care system reform. In amassing evidence of how these systems actually work, many of our sources are government publications or commentary and analysis by reporters and scholars who fully support the concept of socialized medicine.

The failure of national health insurance is a secret of modern social science. Not only have scholars failed to understand the defects of national health insurance, too often advocates and ordinary citizens hold an idealized view of it. For that reason, we present much of the information in the form of rebuttals to commonly held myths.<sup>28</sup>

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28. The "Myths" section is an expanded and completely updated version of a study published by the National Center for Policy Analysis in 1991: John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," NCPA Policy Report No. 128, National Center for Policy Analysis, December 1991.