

PART V

NATIONAL HEALTH INSURANCE

16. Paying for National Health Insurance¹

One reason why national health insurance is popular in other countries is that the taxes collected to pay for the program are often hidden or disguised. As a result, most people believe they are getting a benefit that is paid for by someone else.²

A similar phenomenon is occurring in the United States, where executives of some large companies have expressed interest in shifting the cost of employer-provided health insurance to “others” through government-provided health insurance. Advocates of national health insurance frequently overlook two facts. First, paying for national health insurance will require broad-based taxes, and industries with a highly paid workforce will pay proportionately more in taxes than other industries. Second, companies with generous health care plans are currently receiving large tax subsidies because of the deductibility of health insurance costs—subsidies that would vanish under a government-funded health care system.

Once they account for the loss of current tax subsidies and the probable effects of new taxes needed to pay for national health insurance, many U.S. employers and their employees will discover that national health insurance will cost them more than their current health care plans. For example, under almost any reasonable set of assumptions, the automobile industry would pay more than twice

¹This chapter is based on a study by Aldona Robbins and Gary Robbins, “What a Canadian-Style Health Care System Would Cost U.S. Employers and Employees,” NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

²In Britain, for example, the national health insurance payroll tax covers only about 5 percent of the actual cost of operating the National Health Service. Polls show that a majority of Britons believe that this tax pays for the entire program. Thus, the British public underestimates what it pays for national health insurance by a factor of 20. See John C. Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980), p. 203. See also discussion in chapter 19.

Table 16.1
ANNUAL COST OF NATIONAL HEALTH INSURANCE¹
(\$ Billions)

Category	Cost
Employer health payments	\$156.9
Out-of-pocket health payments plus other health insurance ²	<u>230.9</u>
Total expenditures ³	<u>\$387.8</u>

¹Refers to nonelderly, non-Medicaid population. Estimates are for 1989.

²Includes payments made under health insurance policies purchased by individuals, as well as unreimbursed care provided for the currently uninsured. About \$58 billion of this amount represents cost of insuring the currently uninsured.

³Equal to about \$3,300 per worker, including family coverage for married workers.

as much for national health insurance as it now pays for private health insurance.

The Cost of National Health Insurance

In a study undertaken for the National Center for Policy Analysis, Aldona Robbins and Gary Robbins calculated the cost of national health insurance for the nonelderly working population not on Medicaid, for the country as a whole, and for specific industries.³ The assumptions they used were intentionally conservative, being those most favorable to the case for national health insurance. For example, they assumed that there would be no increase in health care costs under national health insurance, so that, on the average, the United States would continue to spend about \$3,300 per worker per year (including current spending on deductibles and copayments and coverage for the worker's family).

Under these assumptions, the cost of national health insurance is equal to the total amount of health care costs currently incurred by employers plus all out-of-pocket costs currently incurred by individuals plus the cost of health insurance for the currently uninsured. As Table 16.1 shows, this cost would have been \$387.8 billion in 1989.

³Robbins and Robbins.

Of the \$387.8 billion, approximately \$48.5 billion is assumed to be financed through an increase in income and FICA taxes, because money wages will increase to offset the abolition of a fringe benefit (employer-provided health insurance). Since private health insurance will no longer be necessary, it is reasonable to assume that employees will receive wage increases equal to the present cost of health insurance. Unlike private health insurance fringe benefits, however, money wages are subject to income and FICA taxes. If employers did not increase employee wages, but instead kept the savings to boost company profits, the government would collect more tax revenues in the form of additional corporate income tax payments.

Consider, for example, the case of General Motors. In 1989, General Motors paid about \$4,100 per worker for health care under one of the most lavish health insurance plans found anywhere, and all of it was tax deductible. In the absence of any need for private health insurance, if GM increased employee wages by \$4,100, the federal government would collect as much as \$1,763 per worker in additional personal income and payroll taxes. If GM tried to keep the \$4,100 per worker as profit, about \$1,435 would go for additional corporate income taxes.

After adjusting for the increased revenues the government would receive through the abolition of private health insurance (\$48.5 billion), an additional \$339 billion would be needed to pay for national health insurance. This remaining \$339 billion would have to be financed through new taxes.

Three General Tax Options: Payroll, Income, or Value-Added Taxes

Because the cost of national health insurance would be so high, funding it would require a broad-based tax. Table 16.2 shows what tax rates would be necessary to fund the program under each of three possible taxes.⁴

⁴The calculations in this chapter assume that employees rather than employers will bear the full excess burden of national health insurance. Similar calculations—with similar results—were performed using the assumption that employers rather than employees would bear the full burden. Because, in the long run, employers will not continue to employ workers unless the total labor costs are equal to the value of what workers produce, the ultimate burden of national health insurance must fall on employees.

Table 16.2
 ADDITIONAL TAXES NEEDED TO FINANCE NATIONAL
 HEALTH INSURANCE

Tax	Tax Rate Increase
Payroll tax	15.0%
Income tax	15.7
Consumption tax	9.75

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

If funded by a payroll tax, for example, the payroll tax rate would rise from its current level of 15 percent to at least 30 percent. If funded by an income tax, the income tax rate would increase by at least 15.7 percentage points, causing the highest rate to rise from 34 percent to 50 percent.⁵ If funded by a consumption (value-added) tax, the price of almost everything we buy would increase by about 10 percent, relative to our income.

To see what these higher tax rates would mean, consider the effects of financing national health insurance with a payroll tax. For low-income employees, who currently pay no income taxes, the amount of taxes paid would double—from a current payroll tax that takes 15.3 percent of wages to a new tax that would take 30.3 percent of income. For employees who are currently in the 15 percent income tax bracket, the marginal tax rate would increase by 50 percent—rising from a combined (income and payroll tax) marginal tax rate of 30.3 percent to a rate of 45.3 percent. Employees who are currently in the 28 percent income tax bracket (and facing a 15.3 percent FICA tax) would see their combined marginal tax rate rise to 58.6 percent, with the government taking more than half of each additional dollar earned.

In general, the cost of national health insurance for any particular industry will be highest if the program is financed by a payroll tax. Under a payroll tax, for the most part, those who receive the benefits of national health insurance (the nonelderly working population)

⁵For taxpayers in the 15 percent income tax bracket, the income tax rate would rise to 31 percent; for taxpayers in the 28 percent tax bracket, the income tax rate would rise to 44 percent.

Table 16.3
INCREASE IN HEALTH CARE COSTS IN THE AUTO INDUSTRY
UNDER NATIONAL HEALTH INSURANCE

Tax	Increase per Production Worker	Increase as a Percent of Total Production Costs
Payroll tax	\$3,491	5.9%
Income tax	2,962	13.3
Consumption tax	687	11.6

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

will be paying the costs of those benefits. If the program is financed with an income tax, elderly taxpayers covered by Medicare will pay part of the cost of the new program, even though they will receive no benefits from it. With a consumption tax, part of the cost of the program will also be borne by people covered by Medicaid, even though they too will receive no additional benefits.

Why National Health Insurance Will More Than Double Health Care Costs in the Automobile Industry

The cost of national health insurance will not be spread equally over all sectors of the American economy. Some industries will incur large losses, whereas others will gain. Other things being equal, the more generous an industry's current health care benefits, the more it will lose under a switch to national health insurance because of the loss of tax subsidies. Other things being equal, the more highly paid the workforce, the more an industry will lose because the taxes needed to pay for national health insurance will rise with income. Take the auto industry, for example. Table 16.3 shows the cost of national health insurance for auto production workers under each of the three types of broad-based taxes.

Effects of a Payroll Tax

As Tables 16.4 and 16.5 show, the auto industry will pay almost \$6,800 per auto worker in additional taxes each year as a result of national health insurance funded by a payroll tax. But the value of national health insurance is assumed to be only \$3,300. As a result,

Table 16.4
**NATIONAL HEALTH INSURANCE TAXES FOR AN
 AUTO WORKER¹**
 (Program Funded by Payroll Tax)

Source of New Tax Burden	Additional Tax
Loss of tax subsidy for private insurance	
Increase in FICA tax	\$ 428
Increase in income tax	427
NHI payroll tax ²	<u>5,936</u>
Total tax burden	\$6,791

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (National Center for Policy Analysis, February 1990).

¹Based on an initial annual salary of \$36,760, the average salary currently paid to auto workers.

²New salary multiplied by the new national health insurance (NHI) payroll tax rate of 15 percent.

Table 16.5
**NET COST FOR AN AUTO WORKER OF NATIONAL HEALTH
 INSURANCE**
 (Program Funded by Payroll Tax)

Source of Cost	Net Tax Burden
Loss of tax subsidy for private insurance ¹	\$ 855
Excess of NHI payroll tax over NHI benefits ²	<u>2,636</u>
Total net cost	\$3,491

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

¹From Table 16.3.

²The benefit of national health insurance is assumed to be \$3,300. The new payroll tax rate is 15 percent.

the auto industry will pay about \$3,500 more in taxes than it will receive in benefits for each auto worker. Because the cost of employer-provided health insurance currently is about \$3,055 a year,⁶ the industry's costs will more than double.

Effects of an Income Tax

As noted above, an income tax has a lower cost per worker than a payroll tax, because the income tax reaches the elderly even though they do not directly benefit from the program. That does not mean that the payroll tax is more expensive in terms of total costs of production, however. An income tax reaches holders of capital and will cause the service price of capital to rise. As a result, the initial impact on the cost of production will be quite high.⁷ As Table 16.3 shows, the impact of the income tax on total costs of production will be more than twice as great as the impact of a payroll tax.

Effects of a Consumption Tax

As noted above, a consumption tax reaches the broadest base of taxpayers, including people who receive no benefit from the program. Table 16.2 shows that an across-the-board value-added tax rate of 9.75 percent will be required in all industries to pay for national health insurance. Table 16.3 assumes that industries initially will try to impose the cost of this tax on consumers by raising prices. Given that auto workers (in their role as consumers) have above-average incomes, their costs will equal about 11.6 percent of production costs in the auto industry. As an economic principle, however, it is impossible for all firms to raise their prices by 10 percent, since consumers do not have 10 percent additional income to pay those prices. Ultimately, therefore, a value-added tax will be borne, not by consumers, but by the suppliers of labor and capital.

⁶This is the average health insurance benefit for the auto industry as a whole.

⁷In general, a tax on capital has a much more severe impact on input prices than a tax on labor. For example, a 13 percentage point increase in the income tax rate will increase the tax rate on capital by about 50 percent. If the aftertax rate of return on capital is to be held constant (as economic theory and historical experience suggest), this implies a 25 percent increase in the service price of capital to employers.

Why National Health Insurance Would Be Especially Costly to U.S. Manufacturing Industries

National health insurance involves much more than government provision of health care. Through the act of raising taxes to pay for such insurance, an enormous redistribution of income takes place. Workers in some industries will pay more in taxes than the value of their national health insurance benefits, and workers in others will pay less.

Because the manufacturing sector of our economy tends to pay above-average wages and to provide above-average (tax-subsidized) private health insurance benefits, this sector will be especially hard hit by national health insurance. As Table 16.6 shows, among those manufacturing industries hardest hit financially, the additional cost (over and above any national health insurance benefit) will range from about \$1,600 to \$3,500 per employee. In the industries that manufacture motor vehicles and equipment, primary metals, and chemicals, as well as in the telecommunications industry, the total additional cost to the industry in each case will be in excess of one billion dollars per year.

Why Some Industries Will Gain Financially under National Health Insurance

Some industries actually will gain as a result of national health insurance, at least in a purely financial sense. They are industries that currently provide small health insurance benefits and hence receive little tax subsidy for health insurance. Because they tend to have below-average wages, they would pay below-average payroll or income taxes. Indeed, it is ironic that, under national health insurance, the industries with the most generous health care benefits and the greatest inclination to seek government relief would be hurt the most, while those providing minimal health care benefits today would gain the most.

To see how an industry could gain, consider a national health insurance annual benefit of \$3,300 per worker financed by a payroll tax or an income tax with a 15 percent tax rate. For an industry with an average annual wage of \$10,000, the average national health insurance tax would be \$1,500. Compared with a \$3,300 benefit, this industry would gain \$1,800 per worker. On the other hand, an

Table 16.6
NET BURDEN OF NATIONAL HEALTH INSURANCE FOR SELECTED MANUFACTURING INDUSTRIES*

Industry	Cost per Employee	Total Cost
Motor vehicles and car bodies	\$3,524	\$ 951,210,000
Tires and inner tubes	3,242	210,730,000
Petroleum and coal products	3,203	320,300,000
Motor vehicles and equipment	2,602	1,753,748,000
Photographic equipment and supplies	2,490	126,990,000
Telecommunications	2,254	1,485,386,000
Primary metals	2,007	1,216,242,000
Chemicals and allied products	1,939	1,206,058,000
Drugs	1,665	179,820,000
Pharmaceuticals	1,594	141,866,000

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

*National health insurance tax burden minus health insurance benefits. The calculations presented here assume that the excess burden of national health insurance is borne by employers and that national health insurance is funded by a payroll tax. Similar calculations were done assuming that the full burden falls on workers and produces similar results.

Table 16.7
 NET BENEFIT OF NATIONAL HEALTH INSURANCE FOR A
 WORKER IN RETAIL TRADE
 (Program Funded by Payroll Tax)

Source of Net Burden or Net Benefit	Net Burden or Net Benefit
Loss of tax subsidy for private insurance	-\$ 221
Excess of NHI benefits over NHI payroll tax	+1,714
Net benefit	<u>+ \$1,493</u>

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

industry with an average annual wage of \$30,000 would pay an annual tax of \$4,500 per worker and lose \$1,200 per worker.

Effects on Retail Trade

As an example of an industry that gains, consider retail trade. Table 16.7 shows that the average loss of health insurance tax subsidy would be about \$221, and the average national health insurance tax would be about \$1,714. Given that the average national health insurance benefit is \$3,300, the industry would gain \$1,493 per worker.

The fact that retail trade gains, incidentally, is bad for the automobile industry. Table 16.8 is constructed on the assumption that the initial burden, or gain, from the imposition of national health insurance is realized by employers—prior to being passed on to employees. As the table shows, if a foreign car dealership exhibits the characteristics of the average employer in retail trade, the dealership would experience a reduction in payroll and production costs and enjoy a competitive advantage over its domestic competitors. (See, for example, Figure 16.1.)

Why the Costs Could Be Much Higher

Our estimate that national health insurance would require \$339 billion in additional taxes, increase health care costs in manufacturing by 50 percent, and double health care costs in the automobile

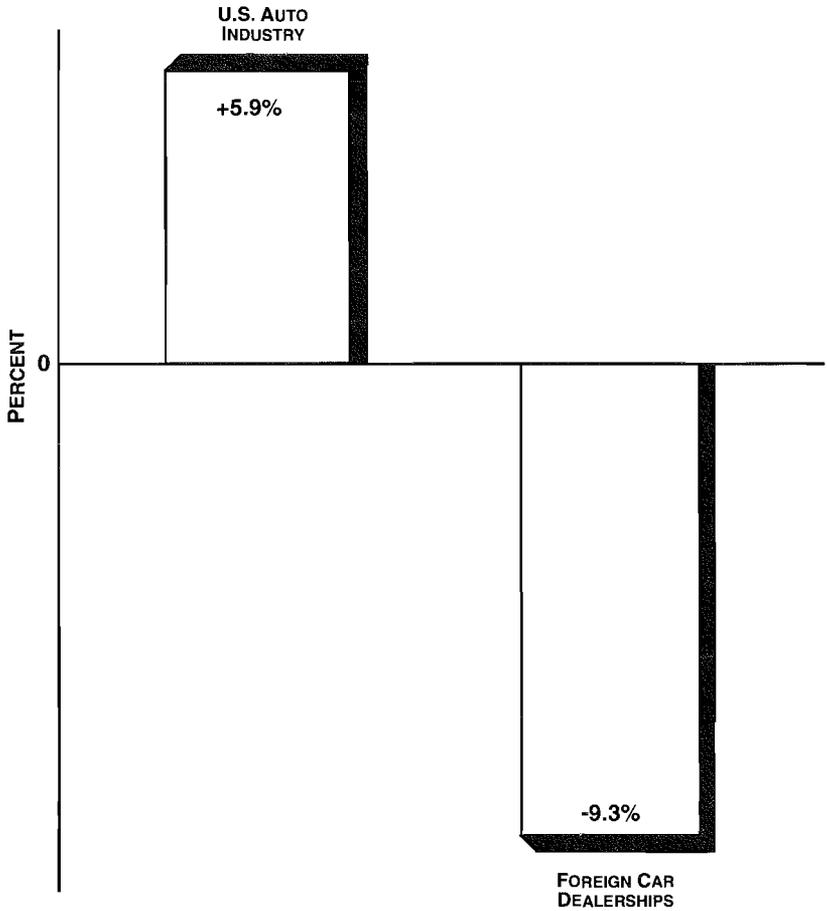
Table 16.8
 COST OF NATIONAL HEALTH INSURANCE: U.S. AUTO INDUSTRY VERSUS
 FOREIGN AUTO DEALERSHIPS*

	Domestic Auto Industry	Foreign Car Dealership
Cost per production worker		
Payroll tax	+\$3,524	-\$1,488
Income tax	+ 3,019	- 2,520
Consumption tax	+ 1,018	- 2,074
Cost as percent of total production costs		
Payroll tax	+ 5.9%	-9.3%
Income tax	+12.6	-8.2
Consumption tax	+11.6	-4.5

SOURCE: Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

*Assumes costs or benefits are initially realized by employers prior to being passed on to employees.

Figure 16.1
HOW NATIONAL HEALTH INSURANCE
WILL AFFECT COSTS IN THE AUTOMOBILE MARKET



industry is based on very conservative assumptions, which put national health insurance in its most favorable light. More realistic assumptions would yield even more pessimistic results.

For example, it is almost certain that Medicare beneficiaries would be included in a program of national health insurance (add \$30 to \$40 billion), and it is highly likely that long-term care for the elderly would be tacked on as well (add \$60 to \$70 billion). It is also virtually

certain that national health insurance would lead to a surge in demand for health care (add at least \$50 billion), as has been the case in every other country. Thus, only a modest relaxation of the assumptions of this report in the direction of greater realism could easily add \$150 billion to our estimate of the total costs of national health insurance—almost a 50 percent increase in the amount of new taxes that would have to be imposed.

17. National Health Insurance in Other Countries

In virtually every country with national health insurance, politicians, health ministers, and other government officials are searching for ways to reform their health care systems. Increasingly, they are adopting reforms that involve privatization, competition, and market incentives (see chapter 19). As those in other countries struggle to reform their health care systems, they often look to the United States for guidance. Yet many in this country are encouraging us to copy the health care system of some other country. Unfortunately, the advocates of national health insurance have painted a rosy picture of how it works elsewhere—often ignoring the many problems and failures.

National health insurance promises to make medical care a right and to grant all citizens equal access to it. But in those countries that have national health insurance, people are often denied access to modern medical technology, and the distribution of health care resources is far from equal. The special victims of national health insurance are the poor, the elderly, members of minority groups, and residents of rural areas.

This chapter does not focus on minor blemishes or easily correctable problems in the health care systems of other countries. Instead, it seeks an understanding of fundamental principles—by identifying common patterns that tend to emerge in all countries with national health insurance. In chapter 18 we will explain why those patterns emerge inevitably from the politics of medicine.

Twenty Myths about National Health Insurance

As the United States wrestles with the problems of its own health care system, it is tempting to look elsewhere for solutions. In general, countries with national health insurance spend less per person (and less as a percent of national income) on health care than does

the United States. The assumption made by those unfamiliar with other systems is that the United States could control health care costs through national health insurance without any loss of benefits or deterioration of care. In what follows, we briefly discuss this and other common myths about national health insurance.

Myth No. 1: In Comparison with the United States, Countries with National Health Insurance Have Succeeded in Controlling Health Care Costs

The United States spends more on health care than any other country in the world, whether measured in dollars per person or as a percent of gross national product (GNP). Does that mean that the United States, with a predominately private system, is less able to control health care spending than developed countries with national health insurance schemes?

First, we should note that the United States is wealthier than other countries. Almost without exception, countries with more income spend more on health care. In fact, health economists have discovered they can explain 90 percent of the variation in health care spending among developed countries on the basis of income alone.¹ Apparently, as people obtain more income, they spend more on health care. Per capita income, therefore, is the primary force that drives health care spending, whether the spending takes place through the market, through the political system, or through quasi-public institutions. This fact should give pause to anyone who believes that the United States could significantly lower its health care spending by adopting the health care system or institutions of some other country.

Second, as we shall see below, international comparisons of health care spending are fraught with difficulties, not the least of

¹The regression equation is:

$$\text{HEXP} = -5.99 + 1.36 \text{ GDP} \quad (R^2 = 0.89) \\ (-5.6) \quad (11.9)$$

where HEXP is the logarithm of per capita health care spending, GDP is the logarithm of per capita gross domestic product, and the numbers in parenthesis are *t* values. The U.S. figure falls near the upper bound of a 95 percent confidence interval. Figures for the higher income countries such as Denmark, Luxembourg, and Norway fall closer to the lower bound, possibly because of underreporting of certain types of expenditures, such as nursing home care. See Bengt Jönsson, "What Can Americans Learn from Europeans?" paper presented at a symposium on international health care systems; published in *Health Care Financing Review*, 1989 annual supplement.

which are differences in the ways in which health care spending is measured. Let's look first at the problems of comparing the United States and Canada. Then we will turn to a comparison with other developed countries.

United States versus Canada: Growth in Spending²

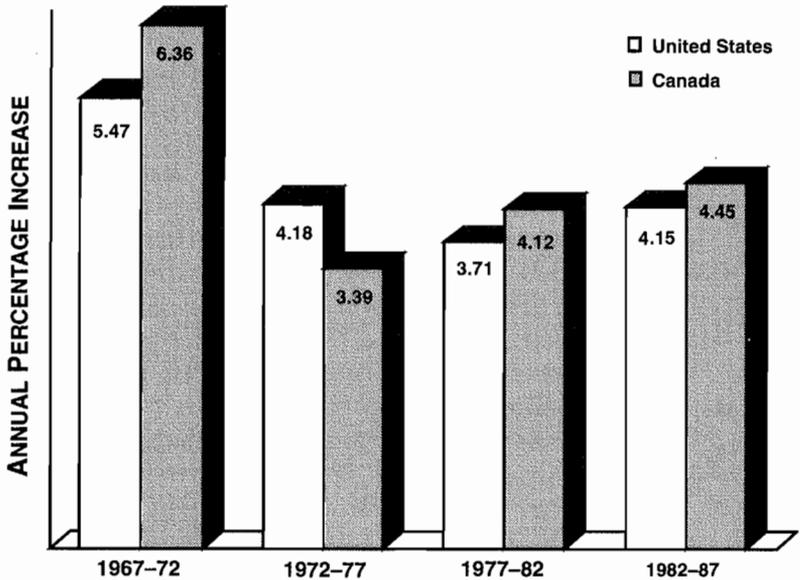
In 1987, the United States spent \$2,004 per person on health care, whereas Canada spent only \$1,520. Some people argue that if the United States adopted Canada's health care system, it could cut health care spending by 25 percent. They buttress their argument by looking at the record over time. In 1967, the United States and Canada spent virtually identical proportions of GNP on health care (6.33 percent in the United States and 6.38 percent in Canada). After Canada's system of national health insurance was implemented between 1968 and 1971, though, the United States surged ahead. In 1987, we spent about 11.1 percent of our GNP on health care, whereas Canada spent only 9 percent.

The problem with such comparisons is that health care spending as a percent of GNP is a fraction. If the fraction grows over time, we need to know whether the growth is being caused by changes in the numerator (health care spending) or in the denominator (GNP). In this case, the differences can be almost totally explained by the behavior of the denominator. Over the 20-year period from 1967 to 1987, Canada's real GNP per capita grew 74 percent, while that of the United States grew only 38 percent.³ If we look at health care spending alone, rather than its relationship to GNP, we discover that, before Canada implemented its system of national health insurance, the country was spending 75 percent of what the United States spent on health care per person, and in 1987, Canada continued to spend 75 percent of the U.S. level. Over the 20-year period, real increases in health care spending per capita have been virtually the same in both countries (4.38 percent in the United States versus 4.58 percent in Canada). Canada has been no more successful than

²The analysis that follows is based on Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington: Health Insurance Association of America, 1989), pp. 37–53. For a critique of this approach, see Morris L. Barer, W. Pete Welch, and Laurie Antioch, "Canadian/U.S. Health Care: Reflections on the HIAA's Analysis," *Health Affairs* (Fall 1991), pp. 229–36.

³Neuschler, pp. 37–53.

Figure 17.1
 INCREASE IN REAL HEALTH CARE SPENDING PER CAPITA IN
 UNITED STATES AND CANADA, 1967 TO 1987



SOURCE: Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington: Health Insurance Association of America, 1989), Figure 4.4 (p. 41).

the United States in controlling health care spending. In fact, as Figure 17.1 shows, in recent years it has been less successful.⁴

United States versus Canada: Levels of Spending

There are other problems with this comparison. First, Canadian health care spending does not include capital spending to the same extent that the U.S. number does. Second, although both totals include research and development (R&D) costs, Canada engages in very little R&D spending, whereas U.S. R&D spending results in technological innovations that benefit Canada, as well as the rest of the world. Third, the U.S. population is slightly older, and older people inevitably consume more health care. According to one

⁴Ibid.

study, correcting for these differences between the two countries cuts in half the gap in the fraction of GNP spent on health care.⁵

Other adjustments also must be made. In both countries, the costs of administering government health care spending are largely hidden. For example, the cost of collecting tax dollars to pay for health care does not show up in the health care budgets of either country, whereas the cost of collecting private insurance premiums is counted as part of U.S. health care costs. Similarly, auditing expenses are usually included in the budgets of other public agencies. But because the proportion of health care spending done by government is so much larger in Canada than in the United States, much more of Canada's costs are buried in the budgets of other bureaucracies.

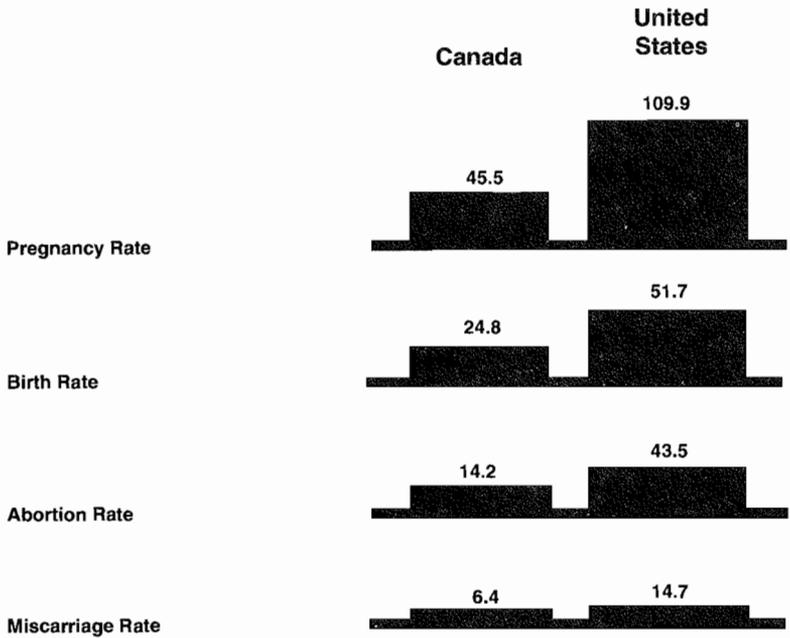
United States versus Canada: Differences in Health Care Needs

Because of historical and cultural differences between the two countries, the need for health care spending is often higher in the United States than in Canada. For example, the United States has a much higher violent crime rate (almost ten times the number of homicides in Canada among young males), heavier illegal drug use, and a greater incidence of AIDS, all of which generate more health care spending. According to Leroy Schwartz of Health Policy International, the U.S. male homicide rate is five times that of Canada, and for every homicide there are 100 assaults reported to hospital emergency rooms. The U.S. rate of incidence of AIDS is three times that of Canada, and the lifetime cost of treatment is about \$85,000 per patient. More than 25 percent of the 10,000 to 15,000 annual spinal cord injuries in the United States are attributable to violent assaults, and treatment and rehabilitation costs are about \$600,000 per patient. There are about 375,000 drug-exposed babies in the United States and the average treatment cost is \$63,000 per baby—a problem that is negligible in Canada.⁶

⁵Jacques Krasny, *The Canadian Health Care System in Perspective* (Morristown, NJ: Bogart Delafield Ferrier, Inc., 1989); and Jacques Krasny and Ian R. Ferrier, "A Closer Look at Health Care in Canada," *Health Affairs* (Summer 1991), pp. 152–58. See, however, a critique of this approach in Daniel R. Waldo and Sally T. Sonnefeld, "U.S./Canadian Health Spending: Methods and Assumptions," *Health Affairs* (Summer 1991), pp. 159–64.

⁶See, for example, Leroy L. Schwartz, "The Medical Cost of America's Social Ills," *Wall Street Journal*, June 24, 1991. See also Spencer Rich, "Tracing Medical Costs to Social Problems," *Washington Post*, August 28, 1991.

Figure 17.2
**TEENAGERS IN CANADA AND THE UNITED STATES:
 RATE PER 1,000 WOMEN AGED 15 TO 19**



SOURCE: Alan Guttmacher Institute; reprinted in Jacques Krasny, *The Canadian Health Care System in Perspective* (Morristown, NJ: Bogart Delafield Ferrier, Inc., 1990).

The United States also has health care costs related to recent war injuries (including those of Vietnam War veterans), which Canada does not have. And Figure 17.2 illustrates another important difference: In comparison with their Canadian counterparts, U.S. teenage women have almost two and a half times the pregnancy rate, twice the birthrate, about three times the abortion rate, and more than twice the miscarriage rate. Because teenage mothers are more likely to have premature babies and complications of pregnancy, these differences cause higher health care spending in the United States.

United States versus Canada: Other Comparisons and Conclusions

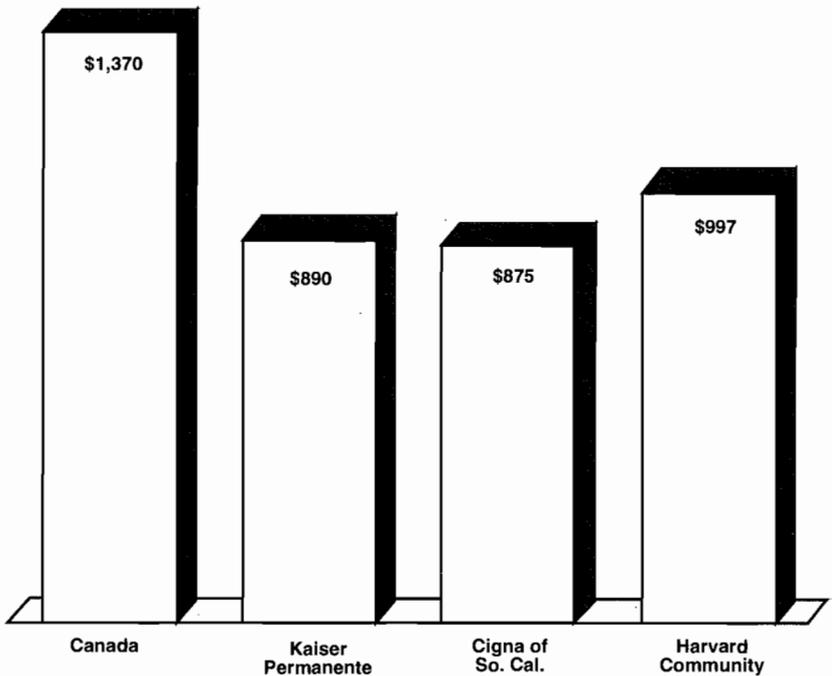
No one has tried to sort out all of the differences in the two systems to arrive at a bottom line. But there is considerable anecdotal evidence that U.S. health care may actually cost less than Canada's. For example, hospitals in British Columbia contract with hospitals across the border in Seattle to perform heart surgery on Canadian patients.⁷ There is a similar arrangement between hospitals in Ontario and those in Detroit. Canadian hospital managers apparently make a profit on these transactions, and at the same time reduce the public outcry over long waiting lists.

Another way of comparing health care costs in the United States and Canada is to compare Canada with some of the largest health maintenance organizations (HMOs) in the United States. The managed care programs of HMOs resemble the cost controls imposed in Canada in their commitment to control spending. Moreover, some HMOs are comparable to Canadian provinces in terms of numbers of people. About half of Canada's provinces have a population of one million or fewer people, whereas seven HMOs in the United States have more than one million subscribers. As Figure 17.3 shows, large HMOs in the United States have lower per capita costs than Canada does. The Harvard Community HMO in Massachusetts spends only 73 percent as much per capita as Canada spends, and both the Kaiser Permanente and Cigna HMOs spend about 65 percent as much.

To summarize, we can draw at least four important conclusions from the comparison of U.S. and Canadian health care spending. First, there is no evidence that Canada has done a better job than the United States of controlling health care spending over time. Second, Canada's spending on health care has equaled about 75 percent of U.S. spending, under both a private and a public system. Third, although international statistics show that the United States spends more per capita on health care than Canada does, such statistics are often misleading. Fourth, U.S. health care may be less expensive when a level playing field is used for making the comparison.

⁷See the discussion in Neuschler, p. 50.

Figure 17.3
**PERSONAL HEALTH EXPENDITURE PER CAPITA,
 CANADA VERSUS U.S. HMOs, 1987**



SOURCE: Alan Guttmacher Institute; reprinted in Jacques Krasny, *The Canadian Health Care System in Perspective* (Morristown, NJ: Bogart Delafield Ferrier, Inc., 1990).

The United States versus Other Developed Countries⁸

In comparing U.S. health care spending with that of other developed countries, the same kinds of difficulties are encountered. In addition, most international statistics on health care spending are produced by the Organization for Economic Cooperation and

⁸This discussion is based on Dale A. Rublee and Markus Schneider, "International Health Spending: Comparisons with the OECD," *Health Affairs* (Fall 1991), pp. 187-98. See, however, a critique of this approach in George J. Schieber and Jean-Pierre Poullier, "Advancing the Debate on International Spending Comparisons," *Health Affairs* (Fall 1991), pp. 199-201.

Development (OECD), but such statistics are not always reliable because of differences in reporting standards among countries.

Table 17.1 shows the results of an attempt to use more precise measuring techniques to develop more accurate health care spending measurements among OECD countries. As shown, the United States spends more of its income on health care than do other countries, but the difference is smaller than is commonly believed. Moreover, during the 1980s, the real growth rate for health care spending was higher in 11 of 15 countries than in the United States. In per capita terms, most countries had real growth rates that were more than double the U.S. rate.

Many believe that, in countries with national health insurance, the government can, in principle, simply limit health care dollars and tell hospital managers to ration the money they are given to spend. But this power turns out to be more apparent than real. Politicians who follow that course risk being replaced by their political competitors. In the political systems of other countries, there is unrelenting pressure to spend more on health care, just as there is pressure to spend more in the United States.

Myth No. 2: Although the United States Spends More on Health Care Than Countries with National Health Insurance, the United States Does Not Have Better Health Care

This myth is often supported by reference to the fact that life expectancy is not much different among the developed countries and that the infant mortality rate in the United States is one of the highest among developed countries. Doctors and hospitals do not control mortality in general, however. The real test of a health care system is life expectancy once under the doctors' care.

Mortality Rates and Health Care

In most developed countries, general population mortality rates tell us almost nothing about the efficacy of health care systems. That is because, throughout the developed world, there is almost no relationship between health care and general mortality, either among or within countries. General mortality rates are far more closely related to socioeconomic factors and lifestyle.

In Sweden, for example, there are striking differences in health outcomes between Stockholm and Hollard, an agricultural area in

Table 17.1
HEALTH CARE SPENDING IN OECD COUNTRIES, 1980 TO 1988
 (Excluding Costs of Administration, Hospital Construction, and Research and Development)

Country	Spending as a Percent of GNP 1988	Annual Real Growth as a Percent of U.S. Rate 1980–1988 ¹	Annual Real Growth per Capita as a Percent of U.S. Rate 1980–1988 ²
Austria	8.05%	114%	207%
Belgium	7.35	101	187
Canada	8.36	185	263
Denmark	8.35	47	86
France	8.50	225	381
Germany	8.44	158	296
Ireland	9.17	81	108
Italy	7.71	229	412
Japan	6.88	172	268
Luxembourg	6.69	155	270
Netherlands	8.31	38	25
Spain	7.11	70	84
Sweden	9.19	50	76
Switzerland	7.84	156	242
United Kingdom	6.35	102	180
United States	10.19	100	100

SOURCE: Dale A. Rublee and Markus Schneider, "International Health Spending: Comparisons with the OECD," *Health Affairs* (Fall 1991), Exhibits 3, 4 (pp. 193, 195).

¹The U.S. rate is 2.13 percent.

²The U.S. rate is 1.13 percent.

the nation's south. Infant mortality in Stockholm is almost twice as high as in rural Hollard, and mortality among 40-year-olds in Stockholm is 50 percent higher. Even the middle-class suburban area outside of Stockholm city (Stockholm county) has an infant mortality rate 71 percent higher than Hollard's. Yet no one seriously claims that these differences are a result of the Swedish health care system.⁹

In Norway, people in the urban areas of Oslo and the adjoining county of Akershus have the most contacts with physicians. But infant mortality in those areas is still higher than in, say, Hordaland, a county in western Norway.¹⁰ In virtually every country, there is a positive relationship between income and health status and between social class and health. Lifestyle also appears to matter. For example, in Norway, children born to unmarried women between 1971 to 1975 had a 55 percent higher (perinatal) mortality rate than children born to married women. Between 1976 and 1980, the rate for unmarried women was 40 percent higher.¹¹

Case Study: Explaining the U.S. Infant Mortality Rate

The United States has the second highest infant mortality rate (behind Belgium) among 16 OECD countries. Is that a result of the U.S. health care system? If we were to radically change the way we deliver health care, would our infant mortality rate be substantially lower?

The answer is no, according to Nicholas Eberstadt, who has completed an exhaustive study of this question.¹² According to Eberstadt, one problem with international comparisons is that countries measure infant mortality differently. Another and larger problem is that most comparisons assume that babies in different countries are born with roughly the same health problems. That, however, turns out not to be the case.

⁹Finn Diderichsen, "Health and Social Inequities in Sweden," *Social Science and Medicine* 31, no. 3 (1990): Table IV (p. 363).

¹⁰Per Maseide, "Health and Social Inequities in Norway," *Social Science and Medicine* 31, no. 3 (1990): 331-42.

¹¹Maseide, Table 1 (p. 333).

¹²Some of the results of the study are published in Nicholas Eberstadt, "Why Are So Many American Babies Dying?" *The American Enterprise*, September/October 1991, pp. 37-45.

Consider the case of Japan, which has the lowest infant mortality rate of all OECD countries. To the degree that the Japanese health care system affects the result at all, it is only through the greater utilization of (low-technology) prenatal care. But if anything goes wrong, and high-technology care is needed, the Japanese are far less able to meet the challenge than the U.S. health care system is. For example, Japan has very little fetal heart rate monitoring and fewer neonatal intensive care units.¹³

Further evidence that the health care system is not responsible for the high infant mortality rate in the United States is the fact that mortality rates among children ages one to four are about the same as in Japan. Evidence that American doctors perform better is the fact that the Japanese maternal mortality rate is twice as high as the U.S. rate. Presumably when mothers get in trouble, the high-technology care available in U.S. hospitals makes a difference.¹⁴

In general, American mothers have more low-weight babies than women in other developed countries, and Eberstadt argues convincingly that neither poverty nor lack of access to health care explains why that is so. Instead, the explanation lies in several factors associated with lifestyle and attitudes. Babies born to single mothers is one factor. The United States has the highest proportion of single-parent families of any major Western country.¹⁵ Another factor is the high proportion of babies born to U.S. teenagers. By contrast, in 1983 there were only 19 women under the age of 15 who gave birth in all of Japan.¹⁶ Yet another factor is the mother's attitude. Although there is a strong correlation between prenatal care and low infant mortality, it is not clear whether this relationship holds because of the prenatal care or because women who get more prenatal care do so because they have a more positive attitude toward the welfare of their children.

¹³Joseph Schulman, "Japan's Healthy Babies—An American Doctor's View," *World Health Forum* 10, no. 4 (1989): 66–69.

¹⁴*Ibid.*

¹⁵Sweden, with the lowest infant mortality rate in all of Europe, has one of the highest rates (50 percent) of births to unwed mothers. But cohabitation is common in Sweden, and only 16.9 percent of families are headed by a single parent. See Eberstadt, p. 43.

¹⁶Schulman.

What about lack of access to health care? First, there is a big gap between having the money to pay for health care and obtaining it. In the United States, the infant mortality rate among blacks is more than twice as high as among whites. But the difference cannot be explained by the inability of black women to purchase prenatal care. The gap between white and black infant mortality holds for all income and educational levels. Families with incomes above \$35,000 a year, for example, can easily pay a physician's fee. But in this group, white children average 5 visits to the doctor per year, compared with 3.3 for blacks. Among families that describe their children as being in fair or poor health, white children have more than twice the number of physician visits.¹⁷

What about the argument that low-income families cannot afford prenatal care? That argument might be persuasive if low-income families were already spending a high proportion of their income on health care, such that any more might mean the inability to pay the rent or purchase groceries. The evidence, however, suggests that that is not the case. Families with incomes of less than \$20,000 a year spend several times more on entertainment, alcohol, and tobacco than they do on health care.¹⁸

As Table 17.2 shows, the United States has always had a high infant mortality rate. In 1929, for example, the U.S. rate exceeded that of the Netherlands, Sweden, Switzerland, Australia, and Norway, even though the U.S. standard of living was higher. Over time, the United States has seen less improvement than have most other developed countries. We could make considerable progress if we were able to change our attitudes and lifestyles. But there is little reason to believe that we could substantially improve the results by changing our health care delivery system.

Where Health Care Makes a Difference

A population's general mortality, then, is affected by many factors over which doctors and hospitals have little control. For those diseases and injuries for which modern medicine can affect the outcome, however, it makes a big difference where a patient lives. Life expectancy is not the same among developed countries for premature babies, for children born with spina bifida, or for people

¹⁷Eberstadt.

¹⁸*Ibid.*

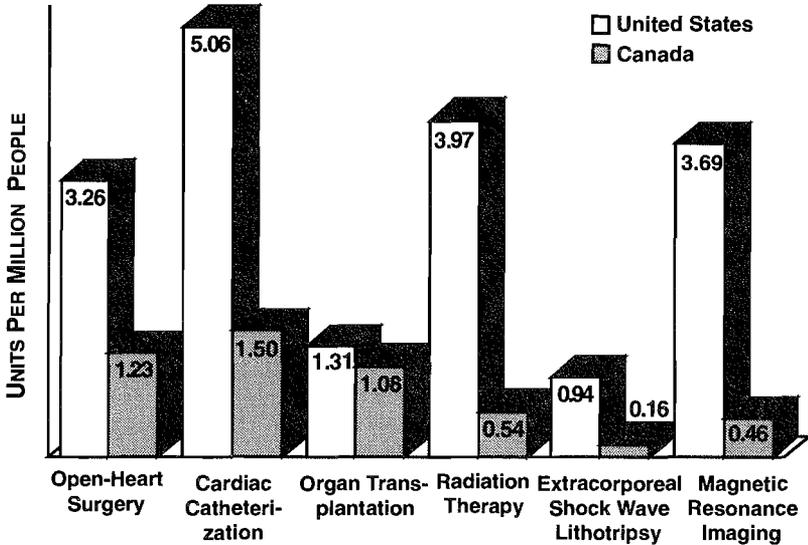
Table 17.2
 INFANT MORTALITY AND PER CAPITA OUTPUT IN OECD COUNTRIES, 1920s AND 1986

Country	Infant Mortality Rate ¹		Per Capita Output	
	1925-29	1986	1929	1986
Japan	140.8	5.2	\$1,162	\$9,756
Italy	122.2	9.8	2,089	9,023
Austria	120.0	10.3	2,118	8,792
Belgium	101.3	16.1	2,882	8,769
Germany	98.1	8.5	1,153	9,964
Canada	93.8	7.9	3,286	12,702
France	91.4	8.0	2,629	9,475
Finland	89.8	5.9	1,667	9,500
Denmark	82.2	8.2	2,913	9,949
Britain	73.3	9.6	3,200	9,178
United States	69.0	10.4	4,909	13,550
Netherlands	57.9	7.8	3,373	9,197
Sweden	57.7	5.9	2,242	10,328
Switzerland	55.5	6.8	3,672	11,907
Australia	53.2	8.9	3,146	9,533
Norway	50.4	8.0	2,184	11,653

SOURCE: Nicholas Eberstadt, "Why Are So Many American Babies Dying?" *The American Enterprise*, September/October 1991, Table 1 (p. 38).

¹Per 1,000 births.

Figure 17.4
ACCESS TO MODERN MEDICAL TECHNOLOGY:
UNITED STATES (1987) VERSUS CANADA (1989)



SOURCE: Dale Rublee, "Medical Technology in Canada, Germany and the United States," *Health Affairs* (Fall 1989), Table 1 (p. 180).

who have cancer, a brain tumor, heart disease, or chronic renal failure. Their chances of survival are best if they live in the United States.

Access to Modern Medical Technology in Canada

Figure 17.4 compares the availability of modern medical technology in the United States and Canada. As the figure shows, on a per capita basis, the United States has eight times more magnetic resonance imaging (MRI) units (sophisticated imaging devices that use magnetism instead of x-rays), seven times more radiation therapy units (to treat cancer), about six times more lithotripsy units (to destroy kidney stones and gallstones with sound waves), and about three times more open-heart surgery units and cardiac catheterization units (for the treatment of heart disease). Note that these figures contrast the United States in 1987 and Canada in 1989.

Comparing the two countries in the same year would reveal an even greater disparity.

Although some people claim that the United States has too much technology, all the evidence suggests that Canada has too little—as a result of the conscious decisions of government officials. Physicians in British Columbia have taken out full-page newspaper ads warning that their patients' lives are in danger because government has refused to purchase lifesaving medical technology. It is easy to understand why these and other Canadian doctors are complaining. Consider what the shortage of diagnostic equipment means for patients:¹⁹

- Seattle, Washington (pop. 490,000), has more CAT scanners (used, for example, to detect brain tumors) than the entire province of neighboring British Columbia (pop. 3 million).
- There are more MRI scanners in Washington state (pop. 4.6 million) than in all of Canada (pop. 26 million).
- The province of Newfoundland (pop. 570,000) has only one CAT scanner, causing patients who need a CAT scan to wait an average of two months.
- Prince Edward Island (pop. 128,000) has no CAT scanner, and patients who need a CAT scan must leave the province to obtain one.
- Because of a shortage of laboratory testing equipment in 1988, women in Newfoundland waited up to five months for a Pap smear (needed to detect cervical cancer) and two months for an "urgent" Pap smear.
- Because of a shortage of equipment, women in Newfoundland wait as long as 2.5 months for a mammogram (used to detect breast cancer).
- Women on Prince Edward Island wait for four to eight months for mammograms, and even emergency patients may have to wait as long as one month.

Access to Medical Technology in Britain

In an extensive study of Britain's National Health Service (NHS), economists at the Brookings Institution estimated the number of

¹⁹Michael Walker, *Why Canada's Health Care System Is No Cure for America's Ills*, Heritage Foundation Issue Briefing no. 19 (November 13, 1989), pp. 7–8.

British patients denied treatment each year, based on U.S. levels of treatment. In most cases, the patients suffered from life-threatening diseases and the denial of treatment meant certain death. Table 17.3 presents the economists' estimates, along with their estimates of what it would cost the NHS to bring British treatment up to U.S. standards. Each year, as the table shows, about 9,000 British kidney patients fail to receive renal dialysis or a kidney transplant—and presumably die as a result. As many as 15,000 cancer patients and 17,000 heart patients in Britain fail to receive the treatment that modern medicine could offer them; furthermore, as many as 1,000 British children facing the threat of death fail to receive total parenteral nutrition (TPN) therapy, and about 7,000 elderly patients living in pain are denied hip replacements.

Willingness to Adopt New Technology

Some people argue that countries with national health insurance delay the purchase of expensive technology to see if it works and is cost-effective. If true, the downside of that approach is that patients are denied access to lifesaving treatment while government bureaucracies evaluate it. During the 1970s, for example, lifesaving innovations were made in renal dialysis, CAT scanning, and pacemaker technology. Yet, as Table 17.4 shows, the rate of implants of cardiac pacemakers in the United States during the mid-1970s was more than four times that of Britain and almost 20 times that of Canada. Furthermore, CAT scanners were more than three times as available in the United States as in Canada and almost six times as available as in Britain, and the treatment rate of kidney patients was more than 60 percent greater in the United States than in Canada or Britain.²⁰

There is considerable evidence that cost-effectiveness is not what drives the bias of other governments against modern medical technology. CAT scan technology was invented in Britain, and until recently Britain exported about half the CAT scanners used in the world—probably with government subsidies. Nevertheless, the British government has purchased only a handful of the devices for

²⁰The treatment for patients with chronic renal failure and the use of CAT scanners continued to rise in virtually every country throughout the 1980s—an acknowledgment of the medical value of those innovations. Some people, though, have argued that the United States went too far in its use of pacemaker implants.

Table 17.3
RATIONING CARE IN THE BRITISH NATIONAL HEALTH SERVICE

Treatment	Number of Patients Denied Treatment Each Year	Added Cost of Treating the Patients (\$ Millions) ¹
Renal dialysis	9,000	\$140
Cancer chemotherapy	10,000–15,000	40
Total parenteral nutrition	450–1,000	45
Coronary artery surgery	4,000–17,000	175
Hip replacement	7,000	50

SOURCE: Authors' calculations based on Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington: Brookings Institution, 1984).

¹In 1984 dollars.

Table 17.4
INTERNATIONAL USE OF MODERN MEDICAL TECHNOLOGY IN THE 1970S

	Pacemakers per 100,000 Population—1976		CAT Scanners per Million Population—1979		Kidney Dialysis and/or Transplants per Million Population—1976 ¹	
	Number	Rank	Number	Rank	Number	Rank
Australia	7.3	6	1.9	4	65.8	7
Canada	2.3	8	1.7	5	73.4 ²	5
France	22.6	3	0.6	7	111.3	2
West Germany	34.6	2	2.6	3	105.0	3
Italy	18.8	4	NA		102.0	4
Japan	2.7	7	4.6	2	NA	
United Kingdom	9.8	5	1.0	6	71.2	6
United States	44.2	1	5.7	1	120.0 ³	1

SOURCE: Pacemaker data from Eli Lilly Co.; CAT scanner data from the National Center for Policy Analysis; treatment of chronic renal failure data from British Office of Health Economics, *Renal Failure: A Priority in Health?* (London: Office of Health Economics, 1978), Table 7 (p. 30); data on Canada from 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), p. 22; U.S. figure estimated from data from U.S. Department of Health, Education, and Welfare (now U.S. Department of Health and Human Services).

¹As of December 31, 1976.

²As of December 31, 1975.

³Excludes transplants. With transplants included, the number would be approximately 170.

Table 17.5
 KIDNEY PATIENTS¹ TREATED BY DIALYSIS OR TRANSPLANT
 (December 31, 1984)

Country	Patients per Million Population	
	Number	Rank
Australia	263.0	7
Belgium	393.6	2
Canada	287.3	5
Denmark	252.0	8
France	285.7	6
East Germany	117.7	13
West Germany	308.5	4
Israel	356.7	3
Italy	237.9	9
New Zealand	217.0	10
Sweden	197.6	12
United Kingdom	200.2	11
United States	413.7 ²	1

SOURCES: U.S. statistic from *End Stage Renal Disease Quarterly Statistical Summary*. All other data from *Canadian Renal Failure Register* (European data from XXII Proceedings of the European Dialysis and Transplant Association—European Renal Associations; Australian and New Zealand data from the Eighth Report of the Australia and New Zealand Combined Dialysis and Transplant Registry, 1985, Australian Kidney Foundation).

¹Patients suffering from end-stage renal disease.

²As of July 31, 1984.

the NHS and has even discouraged gifts of CAT scanners to the NHS by wealthy donors. Britain also was the codeveloper of kidney dialysis, a lifesaving method of treating patients with chronic renal failure, but Britain has one of the lowest dialysis rates in Europe.²¹

One could argue that the need for technology varies from country to country. For example, the incidence of chronic renal failure may be higher in the United States than in other developed countries. Even if that were true, however, Table 17.5 shows that every country had substantially increased the number of patients being treated

²¹See John C. Goodman, *National Health Care in Great Britain* (Dallas: Fisher Institute, 1980), pp. 96–104.

by 1984—a strong indication that thousands of kidney patients had been denied lifesaving treatment in the 1970s. By 1984, even East Germany was treating more patients than Britain or Canada had been treating only eight years earlier, even though the technology remained essentially the same.

The Politics of Medical Technology

It would be a mistake to think of the U.S. health care system as a model for the world, however. Over the past several decades, the United States has not always been the first to adopt new technology (even technology that works and is cost-effective), has not always purchased the most technology, and has not always made cost-effective choices among competing technologies. In 1970, before a dialysis benefit was extended to the entire population under Medicare, the U.S. treatment rate for patients with renal failure was on a par with Britain's and less than half that of Sweden and Denmark. Only after Medicare provided a virtual blank check did the U.S. treatment rate soar ahead of all others.²²

How we treated kidney patients was also dictated by government reimbursement policies. Studies show that home dialysis is less expensive than dialysis in a hospital or a clinic, and prior to the Medicare expansion, about 40 percent of U.S. dialysis treatment was home-based. But because Medicare gave physicians incentives to avoid home-based dialysis, the rate fell to 12 percent by 1978. There is also evidence that kidney transplants are more cost-effective over the long run than dialysis. But because Medicare reimbursement policy favored dialysis, the United States was 12th among 20 developed countries in the percent of kidney patients treated by transplant in 1985.²³

A more recent technological innovation is extracorporeal shock wave lithotripsy (ESWL) for kidney stones and gallstones. The treatment uses shock waves to disintegrate the stones, eliminating the need for surgery. In 1989, the United States had more lithotripters per capita than most countries, but Germany (where ESWL was invented) and Belgium had still more.²⁴

²²Jönsson, Table 8 (p. 88).

²³*Ibid.*, pp. 88–89.

²⁴*Ibid.*, Table 10 (p. 89).

Overall, the best way to think about government policies toward technology is in terms of the politics of medicine. As the role of government in health care expands, it tends to evolve from a pro-technology phase to an antitechnology phase. In the first stage, government tends to spend on items perceived as being underprovided by the market or by conventional health insurance. Thus, practically every less-developed country has used government funds to build at least one very modern hospital, usually in the largest city, and to stock it with at least one piece of each new type of technology, even though the vast majority of its citizens lack basic medical care and public sanitation. As government's role in medicine begins to expand, however, more and more interest groups must be accommodated. In this stage, government policy tends to be antitechnology because the small number of people who need the technology are so heavily outnumbered. Along the way, these general trends may be violated with respect to any particular technology because of the varied (and even random) ways in which special-interest pressures are exerted. (See chapter 18 for a discussion of the politics of medicine.)

When the United States had a pure cost-plus health care system, technology tended to be adopted quickly because physicians—unconstrained by considerations of cost—found the technology useful. When the role of government was minimal, it was easier to acquire public funds when conventional insurance coverage was lacking (for example, kidney dialysis and organ transplants). Thus, it is not surprising that the United States made greater use of technological innovations. Our experience in the future, though, may be very different. Now that we are well into the cost-control phase of the evolution of cost-plus medicine, more and more obstacles are being created to limit access to technology.

In the United States, we pay more for health care. We also get more. And what we get may save our lives. But increasingly, our health care system is acquiring the characteristics of the health care systems of other countries, in which access to medical technology is determined by rationing and politics.

Myth No. 3: In Countries with National Health Insurance, People Have a Right to Health Care

Virtually every government that has established a system of national insurance has proclaimed health care to be a basic human

right. Yet, far from guaranteeing that right, most national health systems routinely deny care to patients who need it. Not only do citizens have no enforceable right to any particular medical service, they don't even have a right to a place in line when health care is rationed. The 100th person waiting for heart surgery is not entitled to the 100th operation, for example. Other patients can, and do, jump the queue for any number of reasons.

By U.S. standards, one of the cruelest aspects of government-run health care systems is the degree to which these systems engage in nonprice rationing. In Britain, New Zealand, and Canada, for example, hospital services are completely paid for by government. All three countries also have long waiting lists for hospital surgery. In Britain, with a population of about 57 million, the number of people waiting for surgery is more than 1 million.²⁵ In New Zealand, with a population of 3 million, the waiting list is more than 50,000.²⁶ And in Canada, with a population of about 25 million, the waiting list is more than 250,000.²⁷

On the surface, the number of people waiting may seem small relative to the total population—ranging from 1 percent in Canada to almost 2 percent in Britain. However, considering that only 16 percent of the people enter a hospital each year in developed countries²⁸ and that only about 4 percent require most of the serious

²⁵See Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs* (Fall 1991), p. 43. For a discussion of British hospital rationing, see Goodman, *National Health Care in Great Britain*, chapter 6. Enoch Powell, a former minister of health, has argued that waiting lines of this magnitude are inevitable under the NHS, regardless of the resources devoted to health care. See Enoch Powell, *Medicine and Politics, 1975 and After* (New York: Pitman, 1976).

²⁶For an analysis of the waiting list in New Zealand, see *Choices for Health Care: Report of the Health Benefits Review* (Wellington: Health Benefits Review Committee, 1986), pp. 78–79.

²⁷Estimate of the Fraser Institute, based on sampling in five Canadian provinces.

²⁸Hospital admissions as a percent of the total population average 16.1 percent for all OECD countries and are 15.9 percent for the United Kingdom, 13 percent for New Zealand, and 14.5 percent for Canada. See George J. Schieber, Jean-Pierre Pouillier, and Leslie M. Greenwald, "Health Systems in Twenty-four Countries," *Health Affairs* (Fall 1991), Exhibit 4 (p. 27).

(and expensive) procedures,²⁹ these numbers are quite high.³⁰ In New Zealand, for example, there is one person waiting for surgery for every three surgeries performed each year.³¹

In Britain and New Zealand, elderly patients in need of a hip replacement can wait in pain for years, and those awaiting heart surgery often are at risk for their lives. Perhaps because Canada has had a national health care program for only half as long, the rationing problems are not as great as they are in Britain and New Zealand, although all three countries have similar cultures. But because the demand for health care has proved insatiable, and because Canadian provincial governments severely limit hospital budgets, the waiting lines for surgery and diagnostic tests are growing. As Table 17.6 and Figure 17.5 show, patients in British Columbia wait up to a year for routine procedures such as cholecystectomies, prostatectomies, hip replacements, and surgery for hemorrhoids and varicose veins. In Ontario, patients wait up to six months for a CAT scan, up to a year for eye surgery and orthopedic surgery, up to a year and four months for an MRI scan, and up to two years for lithotripsy treatment.³² All over Canada, heart patients wait for coronary bypass surgery, while the Canadian press tells of heart patients dying on the waiting list.³³

Moreover, one of Canada's best kept secrets is that a growing number of Canadians are completely uninsured. For example, to help fund its health plan, British Columbia charges a monthly premium—increased by 11.5 percent in 1991—that amounts to \$840

²⁹Health insurance industry officials in the United States report that about 4 percent of the population consumes about 50 percent of health care costs. See Blue Cross–Blue Shield, *Reforming the Small Group Health Insurance Market* (Chicago, 1991), p. 6.

³⁰For example, the number of people in Ontario waiting for open-heart surgery in 1989 equaled more than 25 percent of the total surgeries performed. Because of special efforts to reduce the waiting lists, Ontario achieved a rate of one person waiting for every seven surgeries by January 1991. See C. David Naylor, "A Different View of Queues in Ontario," *Health Affairs* (Fall 1991), pp. 115–16.

³¹Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand* (Wellington: New Zealand Business Roundtable, 1991), Table 2.3 (p. 26).

³²General Accounting Office, *Canadian Health Insurance: Lessons for the United States* (June 1991), Table 4.1 (p. 55).

³³See, for example, Joan Breckenridge, "Grief, Frustration Left in Wake of Man Who Died on Waiting List," *Globe and Mail* (Ontario), January 25, 1989.

Table 17.6

WAITING TIMES IN CANADA: BRITISH COLUMBIA, 1989-1990

Procedure	Average Wait	Longest Wait
Bypass	5.5 mo.	7 mo.
Other open heart	4.9 mo.	7 mo.
Hernia repair	5.7 mo.	1 yr.
Cholecystectomy	7.3 mo.	1 yr.
Hemorrhoidectomy	6.4 mo.	1 yr.
Varicose veins	8.3 mo.	1 yr.
Hysterectomy	3.7 mo.	7 mo.
Arthroplasty (hips, etc.)	3.9 mo.	1 yr.
Prostatectomy	7.1 mo.	1 yr.

SOURCE: Steven Globerman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute, May 1990).

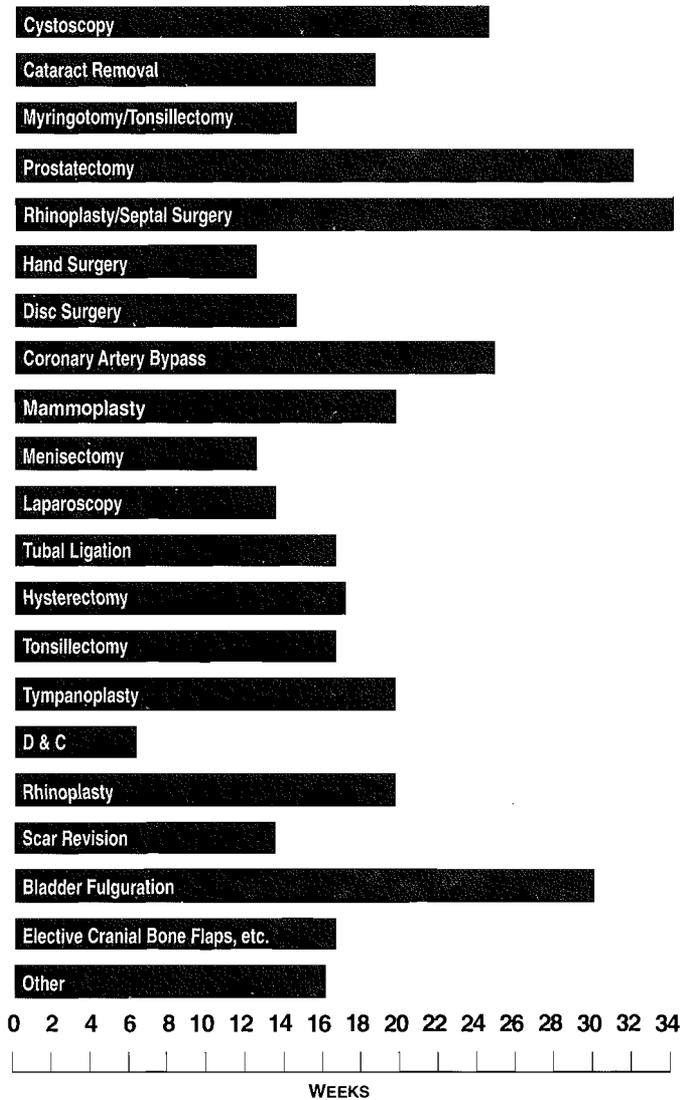
annually for a family, \$744 for a couple, and \$420 for a single person. The number of persons in the province who are uninsured because of failure to pay the premium is estimated at between 2 percent and 5 percent of the population, or 50,000 to 100,000 people. This would be the equivalent of 5 million to 12.5 million Americans. Because the government gives each hospital a fixed annual ("global") budget, hospitals in effect get reimbursed for treating uninsured patients, but the patients must pay physicians for care out-of-pocket or the doctors treating them must absorb the loss. The British Columbia Medical Society estimates that its doctors provide \$15 million to \$50 million in uncompensated care to the uninsured each year.³⁴

Myth No. 4: Countries with National Health Insurance Hold Down Costs by Operating More Efficient Health Care Systems

A widespread international myth holds that the percentage of GNP spent on health care is an indicator of the overall efficiency of a health care system. Thus, defenders of national health insurance often point to the low level of health care spending in their countries as proof of efficient management. Nothing could be further from

³⁴One other province, Alberta, also charges a monthly premium to fund its health care plan but goes ahead and makes reimbursements for uninsured patients anyway. See Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain about Their Health Care System," Heritage Foundation Backgrounder no. 883 (February 19, 1992), pp. 9, 14-15.

Figure 17.5
AVERAGE WAITING TIMES FOR SURGERY IN BRITISH COLUMBIA



SOURCE: Steven Globerman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute, 1990).

the truth. By and large, countries that have succeeded in slowing the growth of health care spending have done so by denying services, not by using resources efficiently.

How much does it cost a hospital to perform an appendectomy? Outside the United States, it is doubtful that any public hospitals could answer that question. Nor do government-run hospitals typically keep computerized records that would allow anyone else to answer it.³⁵ One reason why Margaret Thatcher called for systemic health care reform was that even Britain's best hospitals did not keep computer records, and it was not uncommon for the head of a hospital department to be unaware of how many people the department employed. In organizational skills and managerial efficiency, the public hospitals of other countries cannot begin to match hospitals run by Hospital Corporation of America, Humana, or American Medical International.

More often than not, government-run hospitals in other countries are disastrously inefficient. It is not unusual to find a modern laboratory and an antiquated radiology department in the same hospital. Nor is it unusual to find one hospital with a nursing shortage near another with a nursing surplus. Where excellence exists, it usually is distributed randomly throughout the hospital system—often being a result of the energy and enthusiasm of a few people in isolated departments rather than of any decision by hospital managers.

Moreover, even when specific inefficiencies are acknowledged, it is often impossible to eliminate them because of political pressures. For example, health economist Alain Enthoven reports that "it is more difficult to close an unneeded [British] hospital than an unneeded American military base."³⁶ What about bed management? Consider that, while 50,000 people wait for surgery in New Zealand and 250,000 wait in Canada, at any point in time in these

³⁵For Britain, see the discussion in Alain C. Enthoven, "Internal Market Reform of the British Health Service," *Health Affairs* (Fall 1991). A Canadian observer reports that "Ontario hospitals lag at least a decade behind their U.S. counterparts in expenditure tracking and management information systems." See Naylor, p. 112.

³⁶Enthoven, p. 62.

two countries, one in five hospital beds is empty.³⁷ While one million people wait for surgery in Britain, at any point in time about one in four hospital beds is empty.³⁸ Moreover, in Britain, New Zealand, and Canada, about 25 percent of all acute care beds are occupied by chronically ill patients who are using the hospitals as nursing homes—often at six times the cost of alternative facilities.³⁹

In Canada, hospitalized chronic patients are known as bed blockers, and they are apparently blocking beds with the approval of hospital administrators. Hospital administrators apparently believe that chronic patients are less expensive to care for than acute patients because they use mostly the hotel services of the hospital and cause less of a drain on limited hospital budgets.⁴⁰

One widely used measure of hospital efficiency is average length of stay. By this standard, U.S. hospitals are far in front of their international rivals.⁴¹ As Figure 17.6 shows, the average hospital stay is 39 percent longer in New Zealand, 42 percent longer in Canada, and 61 percent longer in Britain. The average hospital stay in all OECD countries is 76 percent longer than in the United States.⁴²

³⁷For New Zealand, estimate of the New Zealand Department of Health. OECD statistics for 1983 show an occupancy rate of 74.8 percent for New Zealand and 83.3 percent for Canada. See Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris, 1987), Table 29 (p. 67). The most recent OECD statistics are expected to show an occupancy rate of 80.3 percent for acute care hospitals and 82.7 percent for all hospitals in Canada for 1987. See George J. Schieber et al., Exhibits 4, 5 (pp. 27, 29).

³⁸Hospital occupancy rates are 74 percent for acute beds and 82 percent for all beds. See Office of Health Economics, *Compendium of Health Statistics: 7th Edition* (London, 1989), section 3, p. 39. The most recent OECD statistics are expected to show an occupancy rate of 76.4 percent for acute care hospitals and 80.6 percent for all hospitals in 1986. See Schieber, Poullier, and Greenwald, Exhibits 4, 5 (pp. 27, 29).

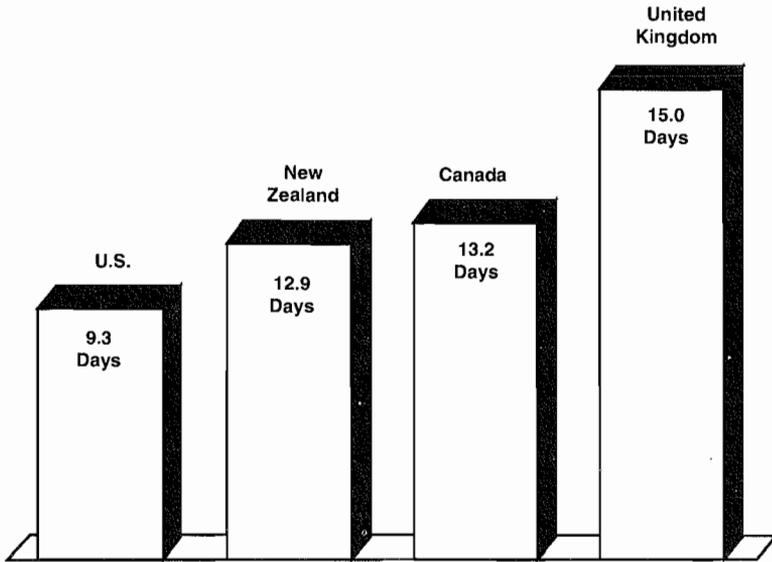
³⁹In Canada, the latest estimate is 23 percent. See Neuschler, p. 18.

⁴⁰See Rosie DiManno, "Hard Choices Facing Health Care System," *Toronto Star*, January 28, 1989; "Ceiling System Needs Radical Surgery," *Toronto Star*, March 27, 1988; and Robert G. Evans et al., "Controlling Health Expenditures: The Canadian Reality," *New England Journal of Medicine* 320, no. 9 (March 2, 1989): 574.

⁴¹For an analysis of international length of stay statistics, see Rita Ricardo-Campbell, *The Economics and Politics of Health* (Chapel Hill: University of North Carolina Press, 1982), Table 3 (p. 85); and Cotton M. Lindsay et al., *National Health Issues: The British Experience* (Nutley, NJ: Hoffmann-LaRoche, Inc., 1980), pp. 74–78.

⁴²See the discussion in Schieber et al., pp. 28–30.

Figure 17.6
AVERAGE LENGTH OF HOSPITAL STAY IN FOUR COUNTRIES*



SOURCE: Based on latest statistics from the Organization for Economic Cooperation and Development. For acute care hospitals, the average length of stay is estimated at 7.2 days for the United States, 8.9 for Canada, and 7.8 for the United Kingdom. See George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in Twenty-four Countries," *Health Affairs* (Fall 1991), Exhibits 4, 5 (pp. 27, 29).

*United States, 1988; New Zealand, 1986; and Canada and Britain, 1987.

Almost all health care economists agree that widespread inefficiencies exist in the U.S. health care system. But we will not improve our efficiency by adopting the practices of other countries.

Myth No. 5: Countries with National Health Insurance Have Established Equality of Access to Health Care

One of the most surprising features of national health care systems is the attention given to the notion and importance of equality. Aneurin Bevan, father of the British NHS, declared that "everyone

should be treated alike in the matter of medical care."⁴³ The Beveridge report, a blueprint for the NHS, promised "a health service providing full preventive and curative treatment of every kind for every citizen without exceptions."⁴⁴ The *British Medical Journal* predicted that the NHS would be "a 100 percent service for 100 percent of the population."⁴⁵ To the founders of the NHS, the goal was to eliminate inequalities in health care based on age, sex, occupation, geographical location, and—most important—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."⁴⁶ Similar statements have been made by politicians in virtually every country that has established a national health insurance program.

Inequality in Britain

Such rhetoric rarely relates to the facts. For over three decades, Britain's ministers of health have assured the British people that they were leaving no stone unturned in a relentless quest to root out and eliminate inequalities in health care. But, after an unofficial government campaign to suppress it, an official task force report (the Black report) concluded that there was little evidence of more equal access to health care in Britain in 1980 than there had been when the NHS was started in 1948.⁴⁷ Virtually every scholarly study of the issue has pointed to a similar conclusion.⁴⁸ One study of

⁴³Quoted in Economic Models, Ltd., *The British Health Care System* (Chicago: American Medical Association, 1976), p. 33.

⁴⁴Quoted in Harry Swartz, "The Infirmity of British Medicine," in Emmett Tyrrell, Jr., ed., *The Future That Doesn't Work: Social Democracy's Failures in Britain* (New York: Doubleday, 1977), p. 24.

⁴⁵*British Medical Journal* (December 12, 1942): 700.

⁴⁶Aneurin Bevan, *In Place of Fear* (London: Heinemann, 1952), p. 76.

⁴⁷*Inequalities in Health* (Black report) (London: Department of Health and Social Security, 1980).

⁴⁸See Julian LeGrande, "The Distribution of Public Expenditure: The Case of Health Care," *Economica* 45, no. 178 (1978); Anthony J. Culyer, *Need and the National Health Service* (Totowa, NJ: Rowman and Littlefield, 1976); Michael H. Cooper, *Rationing Health Care* (New York: Halstead Press, 1975); Michael H. Cooper and Anthony J. Culyer, "Equality in the N.H.S.: Intentions, Performance and Problems in Evaluation," in M. M. Houser, ed., *The Economics of Medical Care* (London: Allen and Unwin, 1972); J. Noyce, A. A. Smith, and A. J. Trickey, "Regional Variations in the Allocation of Financial Resources to the Community Health Services," *The Lancet*, March 30, 1974; and Goodman, *National Health Care in Great Britain*, chapter 9. For a recent update on government failures to make any progress in achieving

Table 17.7
GEOGRAPHICAL VARIATIONS IN HEALTH SERVICES
IN NEW ZEALAND*

Service	Ratio of High to Low
Total spending per capita	190%
Surgeries per capita	630
Day patients per capita	480
Outpatients per capita	220
Number on waiting lists per capita	190
Doctors per occupied hospital bed	580

SOURCE: Patricia Danzon and Susan Begg, *Health Policy in New Zealand: Options for Reform* (Wellington: New Zealand Business Roundtable, 1991), Table 2.3 (p. 26).

*Grouped by area health boards.

health care spending across geographical areas of England found no relationship between any measure of medical need and the amount spent.⁴⁹ Another study of individual medical consumption found that people in Britain's highest social class received 40 percent more medical care (in relation to their need for it) than people in the lowest social class.⁵⁰

Inequality in New Zealand

Other studies have documented widespread inequalities in health care in Sweden,⁵¹ Canada,⁵² New Zealand,⁵³ and elsewhere. For example, New Zealand's health care system is virtually identical to Britain's, and its goal of equal access to health care is just as lofty. Yet, as Table 17.7 shows, among the geographical regions of New

equality of access to health care, see "Dying of Inequality," *The Economist*, April 4, 1987, p. 52.

⁴⁹Noyce, Smith, and Trickey, Table III (p. 556).

⁵⁰LeGrande.

⁵¹See Ingemar Stahl, "Can Equity and Efficiency Be Combined: The Experience of the Planned Swedish Health Care System," in Mancur Olson, ed., *A New Approach to the Economics of Health Care* (Washington: American Enterprise Institute, 1981), pp. 187-90.

⁵²Cotton M. Lindsay, *Canadian National Health Insurance: Lessons for the United States* (Nutley, NJ: Hoffmann-LaRoche, 1979).

⁵³*Choices for Health Care*, pp. 19-22.

Zealand, spending on health care per person varies by a factor of almost two to one. Surgeries per capita vary by more than six to one, doctors per occupied bed by almost six to one, and the number of patients waiting for surgery by almost two to one.

Inequality in Canada

Canada also puts a high premium on equal access to medical care, if the official rhetoric is to be believed. How well have the Canadians done? Table 17.8 compares the amount of spending on the services of physician specialists for two areas in British Columbia: Vancouver, the province's largest city, with a population in excess of one million, and Peace River, a rural area of about 51,000. As the table shows, Vancouver residents receive about three times more specialist services, and this inequality holds for both males and females across all age groups. The differences are even more striking for specific specialties, with an 8-to-1 difference in the services of internists and a 35-to-1 difference in the services of psychiatrists.

One might suppose that the lower level of specialist services in Peace River would be offset by a higher level of general practitioner (GP) services. That is not the case, however. As Figure 17.7 shows, Vancouver residents also enjoy about 50 percent more GP services than do the people who live in Peace River.

Effects on Low-Income Families

There is substantial evidence that when health care is rationed, the poor are pushed to the rear of the waiting line. In general, low-income people in almost every country see physicians less often, spend less time with physicians when they see them, enter the hospital less often, and spend less time in the hospital—especially when the use of medical services is weighted by the incidence of illness. In Canada,⁵⁴ and in every other country with national health insurance, there is no national waiting list and, thus, no way of ensuring that the sickest people get care first. Even in the same hospital, there are instances in which elective patients get surgery while those in much greater need are forced to wait.⁵⁵ Moreover,

⁵⁴General Office of Accounting, p. 53 ff.

⁵⁵A review of the hospital records of open-heart surgery patients in Toronto found that although physicians generally assigned sensible priorities, there were "many instances of relatively short waits for elective cases while more urgent cases waited inappropriately long periods of time." See Naylor, p. 121.

Table 17.8
 PER CAPITA SPENDING ON SERVICES OF SPECIALISTS FOR RESIDENTS OF TWO CANADIAN HOSPITAL DISTRICTS, 1987–1988¹

Age/Specialty	Vancouver (Pop. 1,289,595) ²	Peace River (Pop. 51,252) ³
Child, age 0–4		
Male	145.7	44.0
Female	119.7	32.7
Child, age 5–9		
Male	102.1	32.7
Female	85.7	30.1
Adult, age 40–59		
Male	201.6	86.6
Female	265.2	131.3
Adult, Age 70–79		
Male	522.5	169.6
Female	404.9	204.7
All ages ⁴		
All specialists	214.1	76.0
Internists	26.4	3.1
OB/GYN	11.5	6.4
Psychiatrists	14.0	0.4

SOURCE: Arminée Kazanjian et al., *Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1987–88* (Vancouver: University of British Columbia, 1989), pp. 121–76.

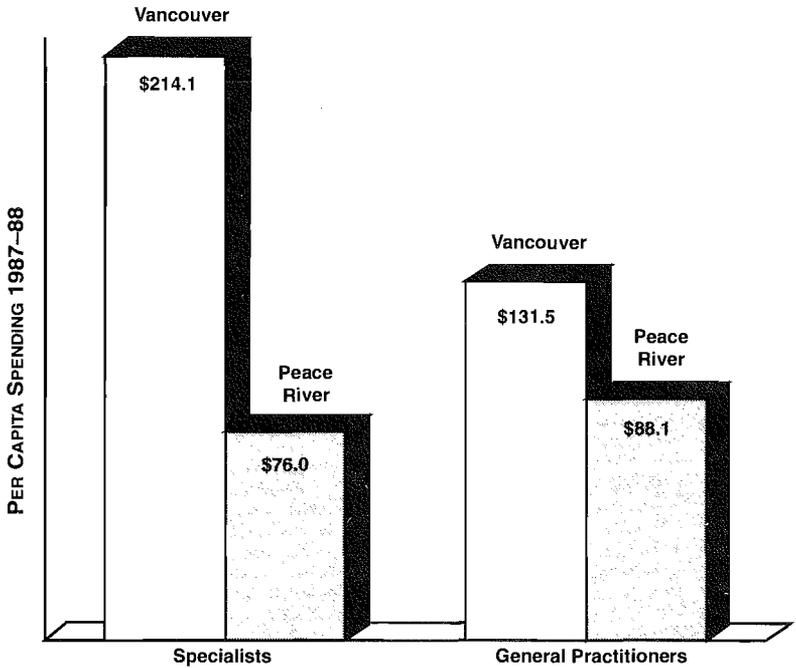
¹Includes all physician fees for services rendered to residents living in the areas indicated, regardless of the area in which the service was received, expressed in Canadian dollars.

²Greater Vancouver Regional Hospital District, British Columbia.

³Peace River Regional Hospital District, British Columbia.

⁴Spending statistics are age/sex standardized.

Figure 17.7
AMOUNT SPENT ON PHYSICIAN SERVICES
FOR RESIDENTS OF TWO CANADIAN HOSPITAL DISTRICTS*



SOURCE: Arminée Kazanjian et al., *Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989), pp. 121-76.

*Data are age/sex standardized and expressed in Canadian dollars.

anecdotal evidence from every country suggests that the wealthy and powerful do not wait as long as others. As one study of the Canadian system noted: "Critics charge that those who are rich, influential, or 'connected' often 'jump the queue,' which changes Canadian health care into a two-tier system—precisely what the government wanted to avoid."⁵⁶

Interestingly, among the patients who jump the queue in Canada are Americans who pay out-of-pocket for care. Because U.S.

⁵⁶House Wednesday Group, *Public Health in the Provinces* (September 22, 1989), p. 14.

patients pay, they add to hospital revenues and are valued by hospital administrators. Because it is illegal for Canadians to pay for care at a national health insurance hospital, the typical Canadian patient must wait in line.⁵⁷

How does access to health care for low-income people in the United States compare with access in countries with national health insurance? Our poorest citizens—those on Medicaid—probably have more access to better health care than low-income citizens do in any other country. Being on Medicaid usually means having access to all the technology the U.S. health care system has to offer, especially because medical technology is more available in the United States and Medicaid will usually pay for it. Even though Medicaid rationing is becoming more prevalent, there is probably far less rationing in the United States than in most other countries.

International opinion surveys show that 7.5 percent of Americans say they do not receive needed health care for financial reasons compared with only 0.6 percent of Canadians and 0.1 percent of Britons. By contrast, a somewhat smaller percent of people in the United States (5.1 percent) but a much larger percent in Canada (3.1 percent) and Britain (4.6 percent) say they cannot get care for nonfinancial reasons, including inability to get an appointment, unavailability of services, and lack of transportation.⁵⁸ However, it is not clear what these responses really mean. In the United States, people are more frequently asked to choose between money and health care. In Britain and Canada, people more frequently must choose between health care and other (rationing) costs. It is not known whether people would have obtained health care if they had perceived their medical needs as being more urgent, but that often must have been the case. Two-thirds of the people in the United States who said they did not get needed care for financial reasons had health insurance.⁵⁹ A different way of comparing the United States and Canada is to look at medical care received by

⁵⁷Walker, *Why Canada's Health Care System Is No Cure for America's Ills*, p. 9.

⁵⁸Robert J. Blendon and Humphrey Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs* (Spring 1989), p. 156.

⁵⁹*Ibid.*

Table 17.9
ACCESS TO MEDICAL CARE IN THE UNITED STATES AND
CANADA BY INCOME

Income Level	United States	Canada
<i>Percent of Citizens Hospitalized One or More Times in the Last Year¹</i>		
Low income ²	23%	22%
Middle and upper income	13	12
<i>Average Number of Physician Visits¹</i>		
Low income ²	6.7	8.7
Middle and upper income	6.6	5.5

SOURCE: Robert J. Blendon and Humphrey Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs* (Spring 1989), Table 7 (p. 155).

¹Data are age adjusted for comparison.

²Income less than \$15,000 per year.

income group. As Table 17.9 shows, the differences are not that great among low-income citizens in both countries. Low-income Canadians see physicians more often, but low-income Americans are slightly more likely to spend time in a hospital.

In every country, some people slip through the social safety net. But for the most part, the United States has largely achieved the goal of socialized medicine: the removal of financial barriers to health care. And, considering the rationing of medical technology in countries with national health insurance, the U.S. health care system may have gone further in removing financial barriers to medical care than any other country in the world.

Myth No. 6: Countries with National Health Insurance Make Health Care Available on the Basis of Need Rather Than Ability to Pay

Most people in Britain, Canada, and in other countries with health care rationing schemes believe that the wealthy, the powerful, and the sophisticated move to the head of the rationing lines. Because government officials have little interest in verifying this fact, few formal studies exist. However, there is considerable evidence that, in the face of health care rationing, those who can pay find ways to obtain health care.

In response to severe rationing by waiting, both Britain and New Zealand have witnessed a growing market in private health insurance, whereby citizens willingly pay for coverage for private surgery, although they are theoretically entitled to free surgery in public hospitals. As a result, the privately insured pay for health care twice—through taxes and through insurance premiums. In Britain, the number of people with private health insurance policies has more than doubled and currently totals about 10 percent of the population, with about one in every five elective surgeries being performed in the private sector.⁶⁰ In New Zealand, one-third of the population is covered by private health insurance, and private hospitals now perform 25 percent of all surgical procedures.⁶¹

Canada does not allow private health insurance. Thus, if Canadians go to private physicians (who account for less than 1 percent of all Canadian physicians) or private hospitals (less than 5 percent of all Canadian hospitals), they must pay the full bill out-of-pocket.⁶² An exception is the small number of outpatient surgery clinics operated by entrepreneurial physicians; the government will pay the surgeon's fee but not other costs. Canadians who receive cataract surgery, for example, must pay from \$900 to \$1,200 out-of-pocket.⁶³

In addition, Canadian citizens are increasingly entering the United States to get the health care they cannot get at home. In some cases, the Canadian province pays the bill; in other cases, patients spend their own money.⁶⁴ In either event, patients must bear the costs of travel. For example, about 100 Canadian heart patients go to a Cleveland clinic each year because they cannot get timely treatment in their own country.⁶⁵ A volunteer organization, Heartbeat Windsor, arranges for Ontario heart patients to get treatment at Detroit hospitals (which accept the Ontario rate as payment in full); Alberta has indicated it will accept a similar arrangement.⁶⁶

⁶⁰Day and Klein, pp. 43–44.

⁶¹*Choices for Health Care*, p. 75.

⁶²Neuschler, pp. 17–18, 20.

⁶³*Ibid.*

⁶⁴DiManno.

⁶⁵Tracey Tyler, "Frustrated Heart Patients Head to Ohio for Surgery," *Toronto Star*, January 22, 1989.

⁶⁶Neuschler, p. 50.

Because there is only one lithotripter in all of Ontario, many lithotripsy patients cross the border; at Buffalo General Hospital in New York, for example, half of the lithotripsy patients are Canadians.⁶⁷ Because of the inadequate facilities in Canada, about half of the in vitro fertilization patients at the University of Washington Medical Center are Canadians, who pay \$5,000 out-of-pocket for each procedure.⁶⁸

In general, the Ontario government will pay 75 percent of the standard U.S. hospital charges and the same physician fee it would have paid had the service been provided in Ontario. Apparently, many U.S. hospitals and physicians believe they can make a profit at those rates. U.S. drug dependency centers are actually marketing their services to Canadian citizens. Although the number of Canadian patients who cross the border is small, it is growing. In 1990, the Ontario Health Insurance Plan paid about \$214 million to U.S. physicians and hospitals—up 45 percent over the previous year. Of that amount, 40 percent went to Florida, 9 percent to New York, 5 percent to Michigan and Minnesota, and 4 percent to California.⁶⁹

Myth No. 7: Countries with National Health Insurance Maintain a High Quality of Health Care

Americans have been repeatedly told that at least the quality of care in Canada's health care system has not suffered because of the imposition of national health insurance. Yet there are increasing reports by physicians and the news media of patient deaths and near-deaths, precisely because of the government's limits on access to technology and the resulting health care rationing. Here is one physician's report of what conditions are like in Quebec:

In my academic practice at a teaching neurologic hospital in Montreal, the wait for the treatment of a "minor" medical problem (e.g., carpal tunnel syndrome) could be half a year or longer. What I considered essential services were unavailable. I recall losing an argument with the radiologist on call over whether a patient with a new stroke should have a CT

⁶⁷Ibid.

⁶⁸John K. Iglehart, "Canada's Health Care System Faces Its Problems," *New England Journal of Medicine* 322, no. 8 (February 22, 1990): 566.

⁶⁹Milan Korcak, "U.S. Cash Registers Humming As Canadian Patients Flock South," *Canadian Medical Association Journal* 144, no. 6 (February 1991): 745-47.

scan at 5:05 p.m.; he judged that the situation was not an emergency serious enough to warrant performing the procedure after regular hours.⁷⁰

Among the victims of Canada's system of health care rationing are the following well-known cases:

- Malcolm Stevens of British Columbia died of a heart attack after two months on the waiting list. Ironically, that same day his doctor bumped another patient from the surgery schedule to make room for Stevens.⁷¹
- Charles Coleman, a 64-year-old man, died shortly after a heart operation in a Toronto hospital. Coleman's operation had been postponed 11 times.⁷²
- Stella Lacroix's death started as a suicide. Moments after she swallowed a quart of cleaning fluid, she raced to the nearest emergency room. Because the hospital wasn't equipped to perform the surgery she needed to stop the internal bleeding, the emergency room physician spent 3.5 hours contacting 14 hospitals in an effort to secure emergency surgery and an available intensive care bed. By the time she arrived at York County Hospital, in Ontario, it was too late. She died that night.⁷³
- In January 1990, two-year-old Joel Bondy needed urgent heart surgery that was repeatedly postponed. Alarmed at their son's deteriorating condition, his parents contacted Heartbeat Windsor, an underground railroad for Canadian heart patients, to arrange for the surgery in Detroit. Embarrassed by media coverage of Joel's situation, Canadian officials promised that Joel would be moved to the top of the waiting list. After a four-hour ambulance ride to a hospital that lacked an available bed,

⁷⁰David Caplan, letter to the editor, *New England Journal of Medicine* 321, no. 2 (July 13, 1989): 115.; reprinted in the House Wednesday Group, p. 12.

⁷¹House Wednesday Group, p. 14.

⁷²"The Crisis in Health Care: Sick to Death," *Maclean's*, February 13, 1989; cited in Iglehart, pp. 565–66.

⁷³"The Crisis in Health Care"; cited in Walker, *Why Canada's Health Care System Is No Cure for America's Ills*, p. 9.

the family had to spend the night in a hotel. The next day, Joel Bondy died.⁷⁴

These examples are far from unique. Indeed, the Canadian press has produced scores of similar stories. The following are some additional examples:

- According to one report, 24 people died in 1989 while waiting for heart surgery in British Columbia.⁷⁵
- At Winnipeg's Health Science Center, Manitoba's largest hospital, six heart patients died in 1988 before they reached the operating room.⁷⁶
- In Toronto, where about 1,000 people are facing waits as long as a year for bypass surgery at three hospitals, two patients died in two months.⁷⁷
- In January 1989, long waiting lists forced Toronto's highly respected Hospital for Sick Children to send home 40 children who needed heart surgery.⁷⁸
- At Moncton Hospital in New Brunswick, some patients were kept in hallways and even in closets, and 2,300 people were on the waiting list for surgery.⁷⁹
- Because of a four-month wait for mammograms at St. Clare's Hospital in Newfoundland in 1988, preventive screening became impossible and the hospital could only handle women who needed an immediate diagnosis.⁸⁰
- Because of budget pressures, patients in the maternity ward of Toronto's North York General Hospital are required to bring their own pillows.⁸¹

⁷⁴"Canadians Cross Border to Save Their Lives," *Wall Street Journal*, December 12, 1990; cited in Michael Tranner, "Canadian Health Care in America: Prescription for Disaster," *American Legislative Exchange Council State Factor* 17, no. 8 (June 1991): 1.

⁷⁵*Ottawa Citizen*, February 4, 1989; cited in House Wednesday Group, p. 15.

⁷⁶"The Crisis in Health Care"; cited in Walker, *Why Canada's Health Care System Is No Cure for America's Ills*, p. 9.

⁷⁷*Ibid.*

⁷⁸*Ibid.*

⁷⁹"The Crisis in Health Care"; cited in Neuschler, p. 49.

⁸⁰*Globe and Mail*, May 28, 1988; cited in Neuschler, p. 48.

⁸¹*Ibid.*

- In some Montreal hospitals, elderly patients are being kept in diapers because nurses do not have time to help them get to the bathroom.⁸²
- In September 1989, Princess Margaret Hospital in Toronto announced it would not accept new cancer patients requiring radiation therapy for a six-week period so it could clear up a 300-patient backlog.⁸³
- In 1990, the only hospital doing cardiovascular surgery in northern Alberta had 210 adults and children on its waiting list, with some patients already having waited for as long as a year.⁸⁴
- In 1989, physicians at Brandon General Hospital (Manitoba) said bed closings had left 91 patients, including cancer victims, waiting for up to six weeks for urgent surgery. Most of the patients had cancer of the breast, large bowel, or lungs.⁸⁵
- In 1989, the health minister of Newfoundland announced that lack of funds would force the closure of more than 400 beds—one-eighth of all beds in public general hospitals in the province.⁸⁶
- In an interview with reporters on a Canadian Broadcasting Company program, ambulance drivers recounted how a patient's condition steadily deteriorated as they traveled from one emergency room to another in search of one that would take him. The patient died.⁸⁷

Myth No. 8: Countries with National Health Insurance Eliminate Unnecessary Medical Care

A frequent criticism of the U.S. health care system is that a great deal of waste exists because a considerable number of procedures

⁸²Ibid.

⁸³*Toronto Sun*, September 14, 1989; cited in Neuschler, p. 93.

⁸⁴*Edmonton Journal*, January 6, 1990; cited in Neuschler, p. 96.

⁸⁵*Winnipeg Free Press*, July 5, 1989; cited in Neuschler, p. 94.

⁸⁶*St. John's Evening Telegram*, June 28, 1989; cited in Neuschler, p. 94.

⁸⁷Canadian Broadcasting Company radio show, "As It Appears," January 25, 1989; cited in Neuschler, p. 95.

are “unnecessary.” For example, Robert Brook of the Rand Corporation maintains that “perhaps one-fourth of hospital days and two-fifths of medications could be done without.”⁸⁸

One source of evidence for unnecessary medical care is a series of studies that show wide variations in the rate of treatment among different U.S. communities. Another is a major study conducted by the Rand Corporation, which concluded that 40 percent of medical procedures were “inappropriate” or “questionable.”⁸⁹

One might suppose that in countries where health care is rationed and many medical needs are unmet, doctors would provide only “necessary” care. That turns out not to be the case. As in the United States, there is considerable variation in treatment rates in countries with socialized medicine. In Britain, for example, there are widespread differences in the referral (to specialists) rates of general practitioners and in their prescribing habits. One study found a four-to-one difference in the number of prescriptions per patient among British doctors, and the difference for prescriptions to treat specific diseases was even greater.⁹⁰ The difference in the rate at which British general practitioners refer patients to hospital specialists varies by at least four to one, and according to one study by a factor of 25 to one—and there is a high correlation between referrals and subsequent hospital admissions.⁹¹

Figure 17.8 shows that the practice patterns of physicians vary widely in Canada as well. For example, there is a four-to-one difference among Canadian counties in the rate of cesarean sections. In addition, there is a four-to-one difference in rates of tonsillectomy and hysterectomy, and a two-to-one difference in the rates of mastectomy, prostatectomy, and cholecystectomy. Figures 17.9 and 17.10 compare the rates in three countries for procedures for which it is believed that doctors exercise some discretion. There is no

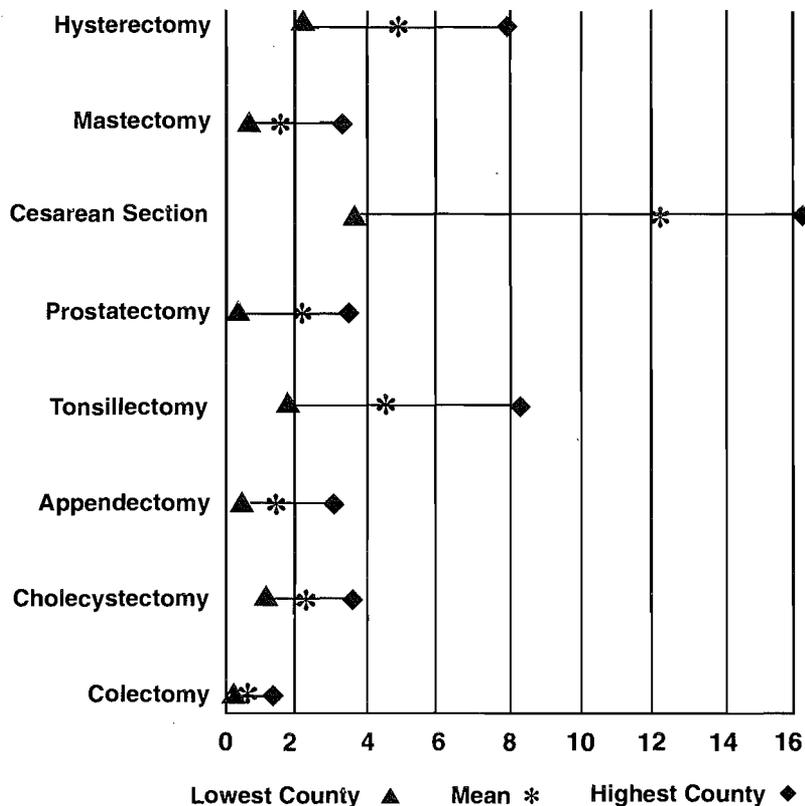
⁸⁸Robert H. Brook, “Practice Guidelines and Practicing Medicine: Are They Compatible?” *Journal of the American Medical Association* 262, no. 21 (December 1, 1989): 3028.

⁸⁹A summary of Rand Corporation research may be found in Mark R. Chassin, ed., *The Approachment of Selected Medical and Surgical Procedures* (Ann Arbor, MI: Health Administration Press, 1989).

⁹⁰George Telling Smith, *Patterns of Prescribing* (London: Office of Health Economics, 1991).

⁹¹Office of Health Economics, *Variations between General Practitioners*, OHE Briefing no. 26 (July 1990).

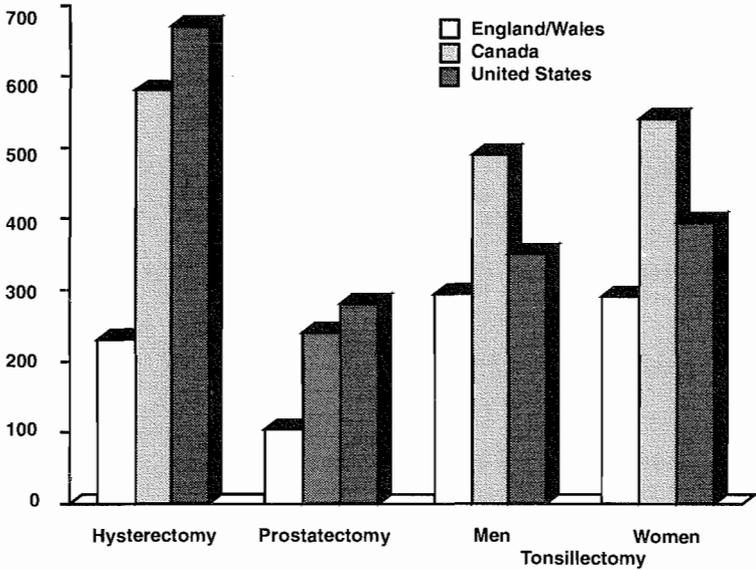
Figure 17.8
SURGERY RATES IN CANADIAN COUNTIES*



SOURCE: E. Vayda et al., "Five-Year Study of Surgical Rates in Ontario's Counties," *Canadian Medical Association Journal* 131 (1985): 111-15, reprinted in K. Lohr and R. Brook, eds., *Geographic Variations in the Use of Medical Services and Surgical Procedures: A Chartbook* (Washington: National Health Policy Forum, 1985); reprinted in Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris, 1987), Chart 3 (p. 20).

*Rates of surgery per 1,000 persons in 44 counties of Ontario, Canada, in 1977.

Figure 17.9
 SURGICAL PROCEDURES PER 100,000 PEOPLE IN THREE
 COUNTRIES*



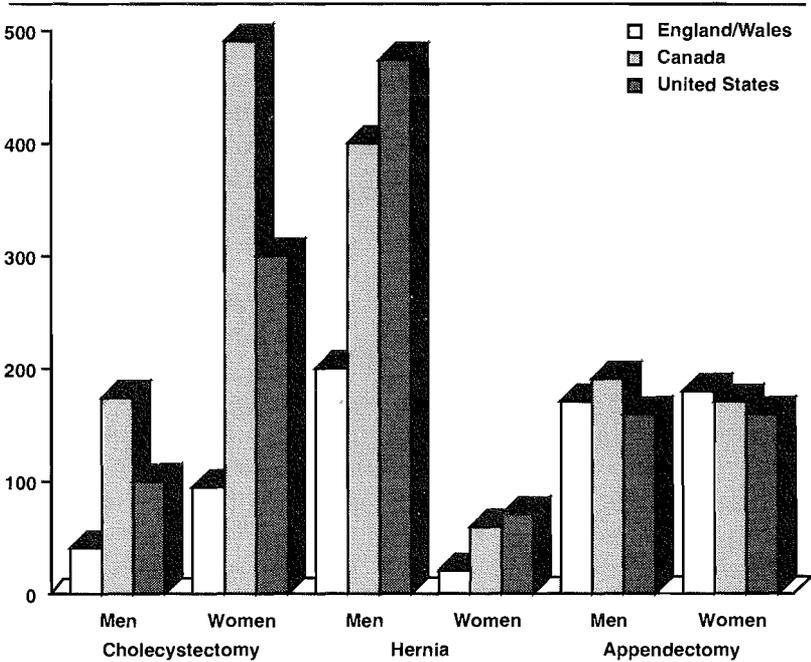
SOURCE: K. McPherson et al., "Regional Variations in the Use of Common Surgical Procedures: Within and between England and Wales, Canada and the United States of America," in *Social Science of Medical Services and Surgical Procedures: A Chartbook* (Washington: National Health Policy Forum, 1985); reprinted in Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris, 1987), Chart 2 (p. 18).

common pattern, except that British surgery rates are generally lower, as they are for almost all types of surgery.

Close inspection of the Rand study in the United States reveals why there are such variations in medical practice: Physicians frequently do not agree on what should be done, and there is often no objective, or "right," answer. Indeed, when the Rand researchers went to great lengths to get consensus, a panel of experts was able to agree on a procedure's appropriateness less than half the time (see chapter 4).⁹² Medicine, it seems, is often more art than

⁹²Brook, p. 3021.

Figure 17.10
SURGICAL PROCEDURES PER 100,000 POPULATION IN THREE COUNTRIES*



SOURCE: K. McPherson et al., "Regional Variations in the Use of Common Surgical Procedures: Within and between England and Wales, Canada and the United States of America," in *Social Science of Medical Services and Surgical Procedures: A Chartbook* (Washington: National Health Policy Forum, 1985); reprinted in Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris, 1987), Chart 2a (p. 19).

science. Interestingly, the panel did agree that certain procedures were clearly inappropriate 12 percent of the time. But the cases studied were in the early 1980s, and undoubtedly less inappropriate medicine is practiced today. The reason is that the United States has devoted considerable resources to monitoring the behavior of physicians to make sure the quality of care is high. Most countries with national health insurance have done little along these lines.⁹³

⁹³See, for example, Adam L. Linton and David K. Peachey, "Guidelines for Medical Practice: The Reasons Why," *Canadian Medical Association Journal* 143, no. 6 (September 24, 1990): 485-90.

Myth No. 9: Under National Health Insurance, Health Care Dollars Are Allocated So That They Have the Greatest Impact on Health

Of all the characteristics of foreign health care systems, the one that strikes American observers as the most bizarre is the way in which limited resources are allocated. Foreign governments do not merely deny patients lifesaving medical technology; they spend millions of dollars to provide services for people who are not seriously ill. Often, those services have little if anything to do with health care.

Spending Priorities in Britain

Britain, once again, exemplifies this behavior. Throughout the NHS, there is a pervasive tendency to divert funds from expensive care for the few who are seriously ill toward the many with minor ills. Take the British ambulance service, for example. English patients take more than 19.5 million ambulance trips each year, about one ride for every two people in England. About 91 percent of the rides are for nonemergency purposes (such as taking an elderly person to a local pharmacy), and they amount to free taxi service.⁹⁴ Yet, for genuine emergencies, the typical British ambulance lacks the modern, lifesaving equipment considered standard in U.S. cities.

While as many as 9,000 people die each year from lack of treatment for kidney failure, the NHS provides comforts for the many chronically ill people whose kidneys are in good working order. Each year about 4.1 million people in England are treated in their homes by "health visitors" and more than 1.1 million by chiropractors, and a meals-on-wheels service delivers almost 33 million meals to people's homes. Social workers attending to the needs of the elderly and the handicapped help with the installation of more than 17,000 telephone and telephone attachments, help arrange more than 93,000 telephone rentals, help more than 49,000 people

⁹⁴These and other statistics presented in this discussion are taken from Department of Health and Social Security, *Health and Personal Social Services for England, 1985 Edition* (London: Her Majesty's Stationery Office, 1985), and from the 1991 edition of the same volume. Note that throughout this book, statistics sometimes refer only to England, sometimes to Britain (England, Scotland, and Wales), and sometimes to the United Kingdom (includes Northern Ireland).

with home alterations, assist in arrangements for 63,000 vacations, and help 346,000 people with other personal appliances and aids.

While tens of thousands classified by their physicians as being in "urgent need" of surgery wait for hospital beds, the NHS spends more than \$90 million each year on tranquilizers, sedatives, and sleeping pills, almost \$32 million on antacids, and about \$11 million on cough medicine. About 9.7 million people receive free eyesight tests every year, and about 2.3 million of these receive free or subsidized eyeglasses.⁹⁵ If the NHS did nothing more than charge patients the full costs of sleeping pills and tranquilizers, it would free enough money to treat 10,000 to 15,000 additional cancer patients each year and save an additional 3,000 kidney patients. But such options are not seriously considered.

A telephone book-sized volume would be needed to describe the many ways in which "caring" takes priority over "curing" within the British National Health Service, and readers may wish to consult other references.⁹⁶ Suffice it to say here that the tendency is pervasive.

Spending Priorities in Canada

Although not as pronounced, similar trends can be observed in Canada, where the government has expanded GP services while tightly controlling access to modern medical technology. For example, in the United States, only 13 percent of all physicians are general practitioners or family practitioners. In Canada, over half of all physicians are GPs, and the percent of physicians who are GPs has been rising over the past two decades. Ontario even requires that 55 percent of its physicians be in general practice.⁹⁷ In general, Canadians have little trouble seeing a GP. But specialist services and sophisticated equipment are increasingly rationed. Canada has actively discouraged outpatient surgery, presumably to control spending, and all over Canada, CAT scanners and other equipment are restricted to hospitals, and Ontario has even made

⁹⁵New out-of-pocket charges for these services were introduced in the spring of 1989, however.

⁹⁶See John C. Goodman, "The Envy of the World?" in Arthur Seldon, ed., *The Litmus Papers: A National Health Disservice* (London: Centre for Policy Studies, 1980), pp. 125–32; and Goodman, *National Health Care in Great Britain*, pp. 192–6.

⁹⁷General Accounting Office, p. 38.

the restriction a law.⁹⁸ In general, the Canadian system encourages routine services for the many over special, critical services for the few. As one Canadian economist observed, "A growing number of operations are triaged because resources are used to continue first-dollar coverage for sniffles and splinters."⁹⁹

Myth No. 10: When Health Care Is Free, Total Health Costs Are Lower because Preventive Health Services Are More Available

A common argument for national health insurance is that it saves money by encouraging use of preventive services, which enable physicians to spot problems before they develop into costly to treat diseases. The argument is wrong for two reasons. First, careful studies show that preventive medicine is economical only when it targets special at-risk groups (see chapter 4). Giving general preventive medical services to the entire population usually costs more than it saves.¹⁰⁰ That does not mean that preventive care is undesirable. Diagnostic tests showing that no disease is present relieve patient anxiety and reassure people of their good health. Preventive care is like a consumer good that creates benefits in return for a cost rather than an investment good that promises a positive rate of return. The second reason is that, under national health insurance, preventive care may actually become less available, precisely because it is free. A comparison of American and British GPs in the 1970s found that British patients saw a GP four times as often. Yet, when Americans did see a doctor, they spent two and a half times as much time with the physician and received far more preventive services.¹⁰¹

Because the services of GPs are free to British patients, an inordinate number of visits are for trivial complaints. To handle the case load, British doctors have reduced the amount of time spent with each patient. Moreover, because of the British government's desire

⁹⁸Neuschler, p. 18.

⁹⁹Michael Walker, "Neighborly Advice on Health Care," *Wall Street Journal*, June 8, 1988; cited in Neuschler, p. 51.

¹⁰⁰See Louise B. Russell, *Is Prevention Better Than Cure?* (Washington: Brookings Institution, 1986).

¹⁰¹Goodman, *National Health Care in Great Britain*, pp. 55–87.

to control costs, British physicians have much less access to diagnostic equipment, and most of them send their patients to a hospital even for chest x-rays and simple blood tests. As a result, preventive medical care is precisely what is slighted in the NHS system. As one study concluded:

Even though GPs receive an extra fee for cervical cytology tests (PAP smears), most will not provide such tests unless patients insist. The attitude is similar for breast checks. Apparently there is a great deal of deterrence going on. In 1976, only 8 percent of eligible females received PAP smears, and most of these were given to middle and upper-middle class patients. (By contrast, in 1973 almost 46 percent of American women age 17 or older had been given a PAP test within the previous 12 months.) GPs also receive extra payments for certain kinds of vaccinations. But again, it appears that the inducement is small. Over the last decade there has been a general decline in the percentage of children vaccinated against every major childhood disease.¹⁰²

One consequence of the lack of preventive care in Britain is that many illnesses are never diagnosed. For example, screenings conducted by the British government several decades ago implied that for every case of diabetes, rheumatism, or epilepsy known to a GP, another case went undiagnosed; for every case of psychiatric illness, bronchitis, high blood pressure, glaucoma, or urinary infection, another five cases went undiagnosed; and for every known case of anemia, another eight went undiagnosed.¹⁰³

The evidence suggests that conditions in Britain may not have improved. A fairly recent study (1989) concluded that for every diabetic being treated under the NHS, there is another case of undiagnosed diabetes, which, if untreated, could damage the retina and lead to total blindness. Another study (1988) suggests that one out of every 20 diabetics in England is first diagnosed by an optometrist (when the disease is in its late stages), who then refers the patient to a GP.¹⁰⁴

¹⁰²*Ibid.*, p. 70.

¹⁰³Cooper, p. 13.

¹⁰⁴See Smith, pp. 21–22.

At one-half the age of the British system, Canadian national health insurance does a better job—but it suffers from similar problems. Although Canadians see their physicians more often than Americans do, a Canadian is not entitled to a routine cholesterol check unless some condition appears to warrant it. Once a test is given, Canadian physicians typically do not pursue further treatment unless the level is above 265, whereas most American physicians treat patients if the level is above 200.¹⁰⁵ Moreover, it is worth noting again that limits on technology in Canada are causing extensive waits for other types of diagnostic services, including Pap smears, mammograms, and CAT scans.

The United States does not necessarily do a better job at delivering preventive medicine. As is the case in Britain, it is believed that one out of every two U.S. diabetics is undiagnosed. And one recent study reported that, between 1980 and 1986, there were 121,560 deaths from disorders that are usually not lethal if discovered and treated early.¹⁰⁶ However, socializing the health care system by no means guarantees that such problems will be solved.

Myth No. 11: National Health Insurance Is the Only Way to Eliminate High Administrative Costs Inherent in a Private Health Care System

The administrative costs of any production system can be reduced by firing all of the administrators and abolishing all reporting requirements. But most systems would perform far less efficiently as a result. The real goal is not to simply slash administrative costs, but to make the system as a whole perform as efficiently as possible. A similar observation holds for marketing costs and other costs of competition. Money could be saved, for example, by abolishing all car dealerships and automobile company advertising. Money could also be saved by producing a single model car and eliminating competition among different models and different producers. We could simply pay taxes and have government provide us with a new automobile every few years. The end result would be decreased

¹⁰⁵Elizabeth Rosenthal, "In Canada, a Government System That Provides Health Care to All," *New York Times*, April 30, 1991.

¹⁰⁶Eugene Schwartz, Vincent Y. Kofie, et al., "Black/White Comparisons of Deaths Preventable by Medical Intervention: United States and the District of Columbia 1980–1986," *International Journal of Epidemiology* 19, no. 3 (September 1990): 592.

efficiency and less consumer satisfaction. After all, if socialism worked, the economies of communist countries would not have collapsed.

Some studies have claimed to show that the administrative costs of the Canadian system are well below those in the United States.¹⁰⁷ One problem with these studies is that government accounting techniques invariably underestimate the real cost of government provision of goods and services.¹⁰⁸ A more basic problem is that the studies have looked at one aspect of administration (for example, administrative salaries or the costs of paperwork) while ignoring the effects of administration (for example, how efficiently the health care system meets consumer needs).

The costs of rationing by waiting and the waste of resources caused by perverse incentives are costs of administering the Canadian system. One cannot legitimately calculate administrative savings in the system without including the adverse effects on patients in the same calculation. Moreover, many of the administrative costs in the U.S. health care system are not incurred merely to oversee the exchange of money between suppliers and third-party payers. They are also incurred to prevent inappropriate care and maintain quality. Even if the United States were to adopt national health

¹⁰⁷For example, one study claimed that administrative costs in the United States were between 19.3 percent and 24.1 percent of total health care spending and accounted for more than half the difference in cost between the U.S. and Canadian systems. See Steffie Woolhandler and David Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine* 324, no. 18 (May 2, 1991): 1253–58. See also the critique of the study's methodology by the Health Insurance Association of America in *Medical Benefits* 8, no. 10 (May 30, 1991): 5. In another study, a national health insurance advocacy group, Citizen Fund, claimed that 33.5 cents of every dollar spent by private health insurance was for overhead expenses. See Richard Koenig, "Insurers' Overhead Dwarfs Medicare's," *Wall Street Journal*, November 15, 1990. The estimates of other studies were discussed in chapter 8. For critiques of these estimates, see "GAO Report on Canadian Health Care Tainted by Charges of Partisanship," *Health Benefits Letter* 1, no. 16 (September 18, 1991); and the letters to the editor in *New England Journal of Medicine* 325, no. 18 (October 31, 1991): 1316–19. A thorough analysis and critique of the claim that administrative costs can be reduced through national health insurance is contained in Patricia M. Danzon, "The Hidden Costs of Budget-Constrained Health Insurance," paper presented to an American Enterprise Institute conference on "Health Policy Reform," Washington, October 3–4, 1991.

¹⁰⁸E. S. Savas, "How Much Do Government Services Really Cost?" *Urban Affairs Quarterly* (September 1979), p. 24.

insurance, it is unlikely that we would follow the Canadian practice of giving hospitals global budgets and forcing physicians to decide how to ration care with few questions asked.

The administrative costs and paperwork burdens of the U.S. health care system are indeed much too high, but that is not a natural consequence of private provision of health care. Rather, it is a result of federal tax policies. Most U.S. employees are overinsured—using third-party payers to pay for routine checkups, diagnostic tests, and many other small medical bills. Too much insurance not only encourages people to be wasteful consumers in the medical marketplace; it also adds to administrative costs.

If the U.S. government gave as much tax encouragement to self-insurance through Medisave accounts as it now gives to third-party insurance (see chapter 8), the administrative costs of the U.S. health care system could easily be cut in half. Whereas the administrative costs of private health insurance average about 11 to 12 percent of premiums, payment of medical bills with Medisave funds could be accomplished by use of health care debit cards, with administrative costs somewhere between 1 and 2 percent. There is no economic reason why the United States cannot move to a system in which most medical bills are paid by patients with health care debit cards, relying on third-party insurance to pay only catastrophic expenses.¹⁰⁹

Myth No. 12: National Health Insurance Will Benefit the Elderly

If the experience of other countries is any guide, the elderly have the most to lose. In general, when lifesaving care is rationed, the young get preferential treatment. Consider chronic kidney failure, for example. Across Europe, 22 percent of the dialysis centers reported that they refused to treat patients over 55 years of age in the late 1970s. In Britain, as Table 17.10 shows, 35 percent of the dialysis centers refused to treat patients over the age of 55 and 45 percent refused to treat those over the age of 65. Those over 75 rarely received treatment at all for this disease.¹¹⁰

¹⁰⁹See John C. Goodman and Gerald L. Musgrave, *Controlling Health Care Costs with Medical Savings Accounts*, NCPA Policy Report no. 109 (Dallas: National Center for Policy Analysis, January 1992).

¹¹⁰*End-Stage Renal Failure* (London: Office of Health Economics, 1980), pp. 3, 6.

Table 17.10
TREATMENT FOR KIDNEY FAILURE IN FOUR COUNTRIES
(New Patients per Million Population, 1978)

Age	Germany	France	Italy	United Kingdom
Under 15	2.3	3.9	3.5	4.0
15-24	13.1	13.9	12.5	17.7
25-34	22.8	27.6	22.0	26.9
35-44	41.7	34.2	37.2	33.1
45-54	58.8	59.8	55.7	43.5
55-64	71.3	69.5	69.5	22.7
65-74	49.9	56.6	52.2	3.5
75+	8.6	17.6	7.3	0.0
All ages	30.9	30.4	29.0	19.2

SOURCE: *Proceedings of the European Dialysis and Transplant Association*, vol. 16; reported in *End-Stage Renal Failure* (London: Office of Health Economics, 1980), pp. 3, 6.

Table 17.10, which shows treatment rates by age for four European countries, illustrates two pertinent features of nonprice rationing of medical care. First, when resources are limited, middle-aged patients get priority over older patients. In Germany, France, and Italy, the treatment rates were highest among those aged 55 to 64. In Britain, the treatment rates were highest among those aged 45 to 54. Because our kidneys do not get better with age, these treatment rates undoubtedly reflect rationing decisions rather than medical need. Second, the more limited the resources, the worse the degree of discrimination against the elderly. For the population as a whole, for example, the treatment rates in Germany, France, and Italy were 50 percent higher than in Britain. As a result, elderly patients in the first three countries had a much better chance of getting treatment.

These observations are also consistent with more recent evidence on access to heart surgery. On a per capita basis, the United States performs twice as many coronary artery bypass operations on elderly patients as Canada does. Among 75-year-olds, however, the difference between the two countries is four to one.¹¹¹

How serious is the problem of denying the elderly access to lifesaving medical technology? Lacking hard data, one can only speculate. In general, health economists are reluctant to take population mortality rates as an indicator of health care quality because whether a person lives or dies in any given year is more likely to be determined by that person's lifestyle and environment than by anything done by hospitals or doctors. In the United States, for example, some observers believe that as many as 75 percent of all deaths are directly related to lifestyle.¹¹² Despite these caveats, if the life expectancy of any one population group is significantly affected by the health care system, it is likely to be that of the elderly. And international statistics on population mortality are

¹¹¹See G. M. Anderson, J. P. Newhouse, and L. L. Roos, "Hospital Care for Elderly Patients with Diseases of the Circulatory System: A Comparison of Hospital Use in the United States and Canada," *New England Journal of Medicine* 321, no. 21 (November 23, 1989): 1443-48; and the discussion in Naylor, pp. 117-18.

¹¹²Jack A. Meyer and Marion E. Lewin, Introduction in Meyer and Lewin, eds., *Charting the Future of Health Care* (Washington: American Enterprise Institute, 1987), p. 5.

consistent with the proposition that the elderly have the most to lose by nonprice rationing of medical care.

If nonprice rationing results in discrimination against the elderly, then they ought to be better off in those countries that spend more on health care—and thus have less of a rationing problem. To test this proposition, one recent study compared life expectancy at the age of 80 among OECD countries.¹¹³ The study found that, for life expectancy for 80-year-old males, the United States ranked second (behind Iceland), along with Canada, Japan, and Switzerland. For life expectancy for 80-year-old females, the United States was second, after Iceland and Canada. Compared with their counterparts in all other OECD countries, an 80-year-old American male can expect to live a half-year longer and an 80-year-old female can expect to live almost a year longer. Moreover, although there is very little relationship between health care spending and life expectancy at birth (which tends to correlate with per capita GDP), among 80-year-olds, there is a statistically significant correlation between life expectancy and health care spending—on a par with the influence of GDP.

Myth No. 13: National Health Insurance Will Benefit Racial Minorities

Critics of the U.S. health care system often point to the disadvantages faced by minorities. On the average, blacks and Hispanics are less likely than other Americans to have health insurance, see a physician, or enter a hospital. But is national health insurance the answer? Both economic theory and empirical studies show that minorities fare even worse under nonprice rationing.¹¹⁴ What little evidence there is about health care rationing in the United States is consistent with experience in rationing in other fields.

Take the rationing of organ transplants, for example. Whites received 97.6 percent of the pancreases and high percentages of livers, kidneys, and hearts in 1988, according to the United Network for Organ Sharing (see chapter 4).¹¹⁵ The *Pittsburgh Press* found that where the donors were not living relatives, the average wait for a kidney transplant in 1988 and 1989 was 14 months for black patients

¹¹³Schieber et al., pp. 36–37.

¹¹⁴See Walter Williams, *Legislating Black Unemployment*, NCPA Policy Report no. 112 (Dallas: National Center for Policy Analysis, July 1984).

¹¹⁵Associated Press, May 20, 1989.

and only 8.8 months for whites.¹¹⁶ Note that in addition to race, income also matters. A study by the Urban Institute found that, for black and white males, the higher their income, the more likely they are to receive an organ transplant.¹¹⁷

Racial Discrimination in Canada

There have been very few studies of how racial minorities fare under national health insurance in other countries. A study of the Inuit and Cree populations of northern Quebec found that both groups had much less access to health care than did Caucasians in southern Quebec and in other areas of Canada—despite their much greater health needs.¹¹⁸ For example, the age-adjusted mortality rate for the Inuit is almost twice the rate for Canadians as a whole. Infant mortality rates are three times greater than for the rest of Quebec among the Cree and four times greater among the Inuit. Life expectancy at birth in 1978 was only 58.9 years for Inuit males (compared with 72 years for all Canadian males) and 61.6 years for Inuit females (compared with 79 years for all Canadian females).¹¹⁹

About 45 percent of the aboriginal people of Ontario live in the rural, northern part of the province. And, as in Quebec, the northern counties are underserved. In 1986, there were no specialists in allergies and immunology, geriatrics, infectious diseases, or pediatric surgery in all of northern Ontario. There was only one specialist each in dermatology, endocrinology, nephrology, neurology, and rheumatology.¹²⁰ Interestingly, when national health insurance was adopted in 1969, Ontario also adopted a program to encourage physicians to move to rural areas, and that is now one of the longest running programs of its kind in the world. Yet a recent study

¹¹⁶Reported in *Dallas Morning News*, August 19, 1990.

¹¹⁷Phillip J. Held et al., "Access to Kidney Transplantation: Has the United States Eliminated Income and Racial Differences?" *Archives of Internal Medicine* 148 (December 1988): 2594–2600.

¹¹⁸Jean-Pierre Thorrez, Peter Foggin, and Andre Rannou, "Correlates of Health Care Use: Inuit and Cree of Northern Quebec," *Social Science and Medicine* 30, no. 1 (1990): 25–34. See also Clyde H. Farnsworth, "Diabetes Hits Canadian Indians Hard," *New York Times*, December 8, 1991.

¹¹⁹Averages given for all males and all females are for 1982.

¹²⁰Malcolm Anderson and Mark W. Rosenberg, "Ontario's Underserved Area Program Revisited: An Indirect Analysis," *Social Science and Medicine* 30, no. 1 (1990): 35–44.

concluded that “while some change has been made, northern Ontario is as underserved compared to the rest of the province as it was in 1956.”¹²¹

Racial Discrimination in New Zealand

There is both a significant minority population (Maoris) and a comprehensive system of socialized medicine in New Zealand. One study reported that the infant mortality rate for Maoris is 60 percent higher than for non-Maoris. Life expectancy for Maori males and females is, respectively, 7 and 8 years lower than for other New Zealanders.¹²² Only 20 percent of these differences could be explained in terms of socioeconomic factors. There is also evidence that Maoris get significantly less health care—especially in relationship to the need for it—than other New Zealanders. For example, death from coronary artery diseases is significantly higher among Maoris—3.5 times as high, for example, among females age 25 to 44. But Maoris receive only a tiny fraction of the coronary artery bypass operations—well below their percentage of the population.¹²³

Myth No. 14: National Health Insurance Will Be Good for Residents of Rural Areas

Little is known about who gets care and who does not under nonprice rationing schemes. Britain is one of the few countries that even publish hospital waiting lists for each region and for the country as a whole. Nevertheless, in Britain, as in other countries with national health insurance, rationing decisions are made by physicians and hospital personnel at the local level, and there is no national procedure to guarantee that those in greatest need move to the front of the waiting lines.

A study of Norway’s health care system concluded that regional differences in waiting times constitute the most serious inequity in access to health care—more serious, for example, than the distribution of physicians or hospital beds.¹²⁴ What is true of Norway is probably also true of other developed countries. For example, the

¹²¹Ibid., p. 43.

¹²²E. W. Pomare, “Groups with Special Health Care Needs,” *New Zealand Medical Journal* (October 26, 1988), pp. 711–13.

¹²³Ibid.

¹²⁴Maseide, p. 331.

number of British kidney patients receiving dialysis or a transplant in 1989 averaged 305 per million population in the four metropolitan areas in and around London. However, the number was only 239 in the northern region of Yorkshire and 174 in the western region of West Midlands.¹²⁵ These differences are greater than the regional differences in health care spending per person or other measures of health inputs.

There are many reasons to believe that rural patients are at a disadvantage when health care is rationed.¹²⁶ The most serious form of rationing is rationing of access to modern medical technology. Often, such technology is available only at major hospitals in large cities. That need not be a problem if rural patients can purchase care with their own money or through public or private health insurance. Rationing by waiting, on the other hand, discriminates against rural patients.

For one thing, it often means that care is given to patients who are available when an opening appears in the surgery schedule. Urban patients who live close by thus have an advantage over rural patients who may have to travel considerable distances, requiring both time and inconvenience. For another thing, success in obtaining care often depends on the politics of bureaucracy. A patient who is represented by a physician in a rural area will tend to be at a disadvantage vis-à-vis a patient represented by a physician who lives nearby and is a colleague of the hospital staff. Urban patients also have access to political and personal relationships that may be important in dealing with bureaucratic obstacles—opportunities not generally available to rural patients.

Finally, wherever there is nonprice rationing, people will attempt to move to the head of the waiting lines by paying illegal bribes. In Hungary, the practice of "tipping" has become institutionalized, and physicians receive tips equal to about 40 percent of their official annual total income.¹²⁷ In Japan, an illegal "gift" of \$1,000 to \$3,000

¹²⁵Office of Health Economics, *Compendium of Health Statistics, 7th Edition* (1989), Table 3.36(a) (p. 49).

¹²⁶See John C. Goodman and Gerald L. Musgrave, *National Health Insurance and Rural Health Care*, NCPA Policy Report no. 107 (Dallas: National Center for Policy Analysis, October 1991).

¹²⁷Lajos Csaszai, "Interpreting Inequalities in the Hungarian Health System," *Social Science and Medicine* 31, no. 3 (1990): 280.

can get a patient admitted sooner and ensure treatment by a senior specialist at a Tokyo University hospital.¹²⁸ In most countries, rural residents probably know less about the mechanics of currying favor with physicians.

Rural Patients in Britain

The most important philosophical principle advocated by those who established the NHS was equal access to health care. But inequalities persist across Britain and may even have grown worse since the NHS was founded in 1948. For example, the North East Thames region (near London) has 27 percent more doctors and dentists per person, 15 percent more hospital beds, and 12 percent more total health spending than the Trent region (in the more rural northern part of the country). These inequalities do not reflect differences in need. Northerners die younger and are less healthy than southerners.¹²⁹

One way to appreciate the magnitude of these inequalities is to consider them in relation to the growing private health care sector. If the goal of the NHS is to equalize access, one would expect the service to devote more resources to those areas least well served by the private sector. In fact, though, the British government tends to spend the most in the metropolitan areas where private-sector alternatives are most abundant.

Table 17.11 lists the regions of England by the number of private beds available per capita. Although the correlation is not perfect, in general the more private beds a region has, the greater its odds of also enjoying above-average public hospital spending. For example, as Figure 17.11 shows, the North East Thames region, which had the largest number of private beds per capita, also enjoyed the greatest amount of NHS hospital spending, the second highest amount of NHS capital spending, and the third highest growth in NHS capital spending over the past decade. The Northern region, which had the lowest number of private hospital beds per capita, had only average NHS hospital spending, the second lowest amount of NHS capital spending, and the fourth lowest growth in capital spending over the past decade. The Trent region, which had

¹²⁸Naoki Ikegami, "Japanese Health Care: Low Cost through Regulated Fees," *Health Affairs* (Fall 1991), p. 104.

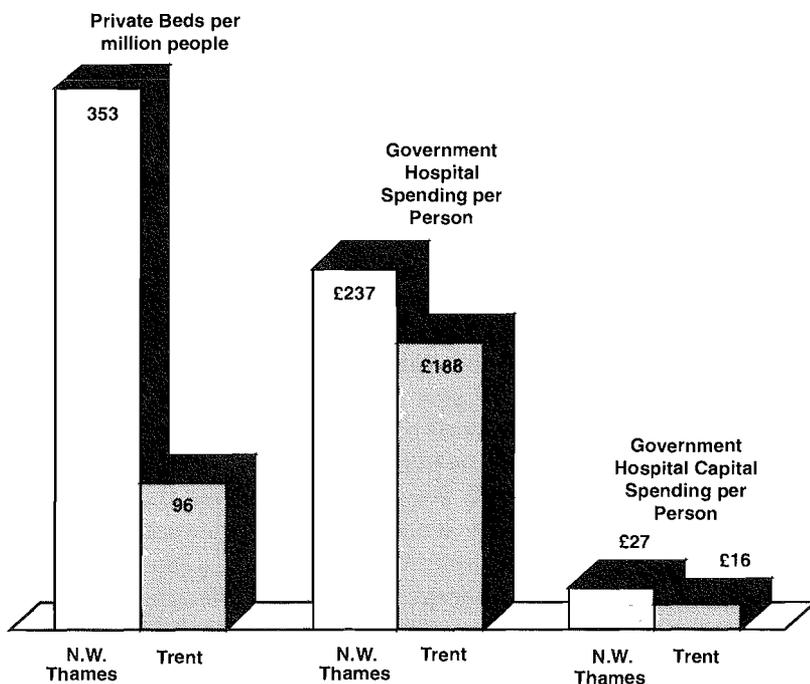
¹²⁹"Dying of Inequality," *The Economist*, April 4, 1987, p. 52.

Table 17.11
REGIONAL INEQUALITIES IN HOSPITAL SPENDING IN ENGLAND

Region	Private Hospital Beds per Million Population (1988)	Total Hospital Spending per Person (1988–89)	Hospital Capital Spending per Person	
			Amount (1988–89)	Percent Increase (1977–88)
N.E. Thames	433	£237	£27	8.6%
N.W. Thames	353	209	27	8.9
S.E. Thames	293	215	28	9.6
S.W. Thames	289	215	26	4.6
Wessex	190	179	24	4.8
Oxford	177	164	17	2.3
Yorkshire	159	195	19	4.3
East Anglia	158	183	15	1.0
N. Western	152	215	19	2.1
Mersey	149	209	23	1.6
S. Western	141	191	23	5.9
W. Midlands	134	193	21	8.3
Trent	96	188	16	–2.0
Northern	51	204	17	2.0

SOURCE: *Compendium of Health Statistics*, 7th ed. (London: Office of Health Economics, 1989), Table 1.3, Box 2.5, Table 3.2(a), Table 3.3(a).

Figure 17.11
HOSPITAL SERVICES IN BRITAIN:
PUBLIC AND PRIVATE CHOICES IN TWO REGIONS



SOURCE: *Compendium of Health Statistics*, 7th ed. (London: Office of Health Economics, 1989), Table 1.3, Table 3.2(a), Table 3.3(a), Box 2.5.

the second lowest number of private beds per capita, had the second lowest amount of NHS hospital spending and the very lowest NHS capital spending, and was the only region to experience a decrease in capital spending over the past decade.

Rural Patients in Canada

Canada, too, has proclaimed equal access to health care to be a national goal. Yet there is little evidence of success in achieving it. Among the Canadian provinces, for example, the number of people per physician ranges from a low of 471 in British Columbia to a high of 1,273 in the Northwest Territories, a difference of almost three to one. Although there are 469 people per physician in Ontario on

the average, there are more than four times that number in each of northern Ontario's rural counties.¹³⁰

Health care in Canada tends to be hospital-based, with modern medical technology often being restricted to teaching hospitals and outpatient surgery discouraged. Moreover, the specialists and the major hospitals tend to be in major cities. As in other countries, residents of rural areas often travel to the larger cities to get medical care. But how often does that happen? A study from the University of British Columbia provides the answer.¹³¹

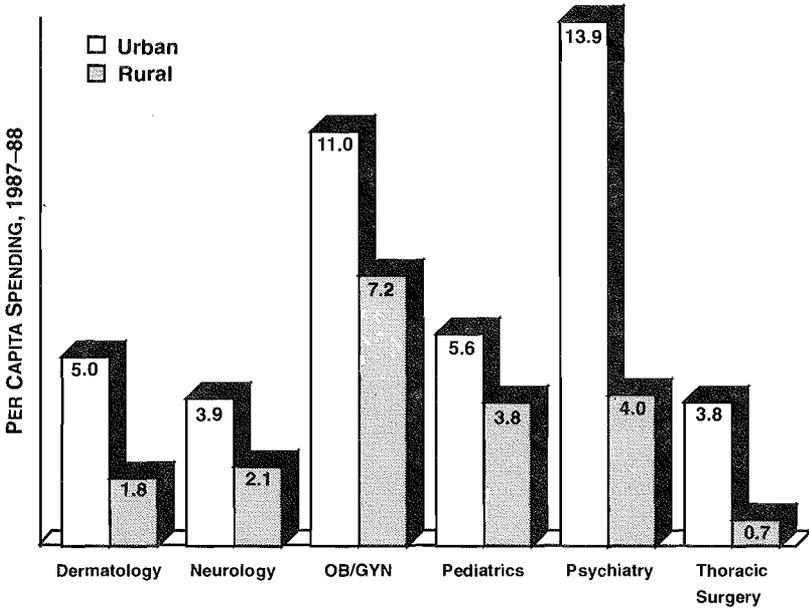
Since doctors are paid on a fee-for-service basis in Canada, fee-for-service income is a good measure of the volume of services actually rendered to patients. By using physician billing data, Canadian researchers determined the regional hospital district in which each patient lived, even if the service was provided in some other district. As Figure 17.12 and Table 17.12 show, people living in British Columbia's two largest cities (Vancouver and Victoria) receive about 37 percent more physician services and 55 percent more services from specialists per capita than those living in the 28 rural districts of the province. For specific specialties, the discrepancies are even greater. On the average, urban residents are 5.5 times more likely to receive services from a thoracic surgeon, 3.5 times more likely to receive the services of a psychiatrist, and about 2.5 times more likely to receive services from a dermatologist, anesthesiologist, or plastic surgeon.

These are the broad averages. The discrepancies are even greater for British Columbia's most underserved areas. Table 17.13 compares spending for selected services in two urban districts with spending in 12 other districts. As the table shows, total spending on physician services per capita among these districts varies by a factor of 6 to 1, and spending on the services of specialists by a factor of 12 to 1. Spending varies by a factor of almost 6 to 1 for OB/GYN services, 15 to 1 for the services of internists, and 140 to 1 for the services of psychiatrists. Even if we ignore the smallest districts and focus only on districts with at least 35,000 people, spending

¹³⁰Anderson and Rosenberg, Table 1 (p. 37), Table 4 (p. 39). Statistics are for 1985-86.

¹³¹Arminée Kazanjian et al., *Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989).

Figure 17.12
 INEQUALITIES IN THE USE OF PHYSICIAN SERVICES
 AMONG URBAN AND RURAL PATIENTS IN BRITISH COLUMBIA*



SOURCE: Arminée Kazanjian et al., *Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989), pp. 121-76.

*Canadian dollars.

varies by a factor of almost 3 to 1 for all specialist services, almost 4 to 1 for OB/GYN services, 8 to 1 for internists, and 35 to 1 for psychiatrists.

The discrepancies among the districts are greater still if one focuses on people in specific age and sex classifications, again ignoring the areas with the smallest populations. Roughly speaking:¹³²

- An 80-year-old man is 524 times more likely to receive the services of an anesthesiologist if he lives in Vancouver rather than in the Sunshine Coast district (pop. 17,049).

¹³²Ibid.

Table 17.12
PER CAPITA SPENDING ON PHYSICIAN SERVICES IN BRITISH COLUMBIA: 1987–1988¹

Service	Urban ²	Rural ³	Ratio (%) Urban/Rural
All physician services	\$347.1	\$253.8	137.0%
General practice	132.1	115.7	114.0
Specialists	214.6	138.1	155.0
Anesthesia	16.6	6.9	241.0
Dermatology	5.0	1.8	278.0
General surgery	11.9	12.4	96.0
Internal medicine	26.3	15.8	167.0
Neurology	3.9	2.1	186.0
Neurosurgery	2.2	1.2	183.0
OB/GYN	11.0	7.2	153.0
Ophthalmology	16.1	8.8	183.0
Orthopedic surgery	8.5	7.1	120.0
Otolaryngology	5.1	3.8	134.0
Pediatrics	5.6	3.8	147.0
Pathology	44.0	35.0	126.0
Plastic surgery	3.2	1.3	246.0
Psychiatry	13.9	4.0	348.0
Radiology	30.9	21.6	143.0
Thoracic surgery	3.8	0.7	543.0
Urology	5.7	4.0	143.0

SOURCE: Arminée Kazanjian et al., *Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1987–88* (Vancouver: University of British Columbia, 1989), pp. 121–76.

¹Based on fees paid to physicians for rendering services to patients living in the areas indicated, regardless of the area in which service was performed. All data are age/sex standardized and expressed in Canadian dollars.

²Greater Vancouver and Victoria regional hospital districts.

³Twenty-seven nonmetropolitan hospital districts.

Table 17.13
SPENDING ON PHYSICIAN SERVICES BY HOSPITAL DISTRICT IN BRITISH COLUMBIA*

District	Total Spending	Per Capita Spending by Category of Service			
		Specialist	OB/GYN	Psychiatrist	Internist
Urban districts					
Vancouver	\$345.6	\$214.0	\$11.5	\$14.0	\$26.4
Victoria	348.4	211.8	8.5	13.2	25.6
Selected rural districts					
Bulkley-Nechako	211.0	95.9	3.5	0.7	11.2
Cariboo	203.9	96.9	5.8	1.0	9.2
Central Coast	105.4	89.3	4.9	0.5	6.7
Columbia-Shuswap	188.0	88.3	3.5	3.4	9.5
East Kootenay	224.7	99.9	3.1	0.4	7.7
Kitimat-Stikine	193.2	103.9	5.8	0.3	10.0
Mount Waddington	167.2	75.6	6.5	0.9	5.2
Peace River	164.1	76.0	6.4	0.4	3.1
Skeena-Queen Charlotte	188.5	84.8	3.9	0.4	7.8
Squamish-Lillooet	205.9	89.5	6.3	2.0	8.8
Stikine	58.2	17.5	2.0	0.1	2.5
Fort Nelson-Laird	169.3	37.1	2.1	0.3	1.7
Average for all rural districts	253.8	138.1	7.2	4.0	7.0

SOURCE: Arminée Kazanjian et al., *Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989), pp. 121-76.

*Based on fees paid to physicians rendering services to patients living in the district indicated, regardless of the area in which service was performed. All data are age/sex standardized by regional hospital districts and expressed in Canadian dollars for 1987-88.

- A baby girl with a skin rash is 22 times more likely to see a dermatologist if she lives in Vancouver rather than in the East Kootenay district (pop. 50,660).
- A 30-year-old woman is more than 3 times more likely to see a gynecologist if she lives in Vancouver rather than in Columbia-Shuswap (pop. 39,367).
- A baby girl is 10 times more likely to see a pediatrician for any reason if she lives in Vancouver rather than in Peace River (pop. 51,252).

Rural Patients in Latin America

Although this book is focused primarily on developed countries, it is worth noting that many of the same principles apply to people living in less-developed countries. For example, people in the urban areas of Brazil are far more successful in getting government benefits than are those in rural areas. By most measures, the need for health care is greater in the northern and northeastern (rural) areas than in the southern and central (urban) areas of the country. Life expectancy at birth, for example, is about three years longer for both men and women in the cities. Yet, although most health care spending flows through government, and several government programs have been designed to create equal access to care, the spending is concentrated in the cities, and about one-third of the population lacks regular access to medical care.¹³³ Although more than half of Brazil's population lives in rural areas, residents of urban areas experience 9 times more medical visits, 15 times more related services, 2.7 times more dental visits, and 4.5 times more hospitalizations. Overall, the Brazilian government spends 5 times less on inpatient care and 13 times less on outpatient care in rural areas.¹³⁴

Brazil is not unique. In neighboring Venezuela, government-provided health care is theoretically free to everyone.¹³⁵ Yet the

¹³³Marlow Kivitko and Elenterio Rodriguez Neto, "Brazil," in Richard B. Saltman, ed., *The International Handbook of Health Care Systems* (New York: Greenwood Press, 1988), p. 33-55.

¹³⁴Ibid.

¹³⁵In Brazil, about 75 percent of hospital beds are in private institutions, although the public sector pays for most hospital care. In Venezuela, public-sector care is provided only in public hospitals.

vast majority of health care services are provided in the cities.¹³⁶ Similarly, a doctor in Bolivia is seven times more likely to practice in an urban area (where less than half the population resides) than in the countryside.¹³⁷ And in Mexico—where health care is a constitutional right—35 percent of the population (mainly in the cities) consumes 85 percent of the country's health care resources.¹³⁸

Rural Patients in Communist Countries.

It is worth noting that many of the same principles apply to nondemocratic countries. Within communist or formerly communist countries, the variation in rural/urban characteristics is enormous. Throughout the former Soviet Union and Eastern Europe, for example, inequality between urban and rural health care is widespread. In general, the urban populations are healthier and have better access to health care. In the former Soviet Union, health care resources appear to matter a great deal. Indeed, the availability of doctors, nurses, and hospital beds explains 55 percent of the variation in infant mortality there. For Bulgaria, Czechoslovakia, Hungary, and Poland, the relationships between health care resources and health outcomes are less clear.¹³⁹

Despite the fact that the Soviet Union was committed to the principle of equal access to health care for over 70 years, there is considerable evidence of inequality in access to medical resources and health outcomes. In the 1960s, infant mortality rates were virtually the same, on the average, among urban and rural areas. In the 1970s and 1980s, however, infant mortality rates continued to fall in the cities but began to rise in rural areas. Between 1960 and 1987, life expectancy at birth fell so much in rural areas that by

¹³⁶Jesus E. Rodriguez and Carlos Sabino, *Social Security in Venezuela* (Caracas: Cedice), forthcoming.

¹³⁷Joseph Bastien, "Community Health Workers in Bolivia: Adapting to Traditional Roles in the Andean Community," *Social Science and Medicine* 30, no. 3 (1990): 281–87.

¹³⁸Kenyon Rainier Stebbins, "Curative Medicine, Preventative Medicine, and Health Status: The Influence of Politics on Health Status in a Rural Mexican Village," *Social Science and Medicine* 23, no. 2 (1986): 139–48.

¹³⁹See Edmund Wnuk-Lipinski and Raymond Illsley, "International Comparative Analysis: Main Findings and Conclusions," *Social Science and Medicine* 31, no. 8 (1991): 879–89.

1986–87 there was a two-year difference in life expectancy between urban and rural areas.¹⁴⁰

Myth No. 15: National Health Insurance Will Be Good for Organized Labor

Traditionally, the leaders of America's largest labor unions have advocated national health insurance, mistakenly believing that they can turn over the cost of employee health care to the U.S. taxpayer. What they forget is that union members also pay taxes. Under national health insurance, the employees of the nation's largest companies would pay more in national health insurance taxes than they currently pay for private health insurance. For example, in manufacturing (one of the most heavily unionized sectors of the economy), they would pay 50 percent more.¹⁴¹ A national health insurance program similar to Canada's would require at least \$339 billion in new taxes¹⁴²—which would double the payroll tax rate, increase the income tax rate by 16 percentage points, or increase the prices of goods by approximately 10 percent through a consumption tax (see chapter 16). Under each of these broad-based taxes, the amount of taxes paid would rise with income. Thus, under national health insurance, the high-wage industries would pay above-average taxes, even though the workers would receive only the average national health insurance benefit.

Myth No. 16: National Health Insurance Will Improve America's International Competitiveness

Many people argue that America's health care costs make American products less competitive in the international marketplace. An example of this view is the dual assertion that health care costs add \$700 to the price of every U.S. automobile and that national health insurance would solve this problem. Both assertions are wrong.¹⁴³

¹⁴⁰Ibid., p. 884. See also Elena Mezentseva and Natalia Rimachevskaya, "The Soviet Country Profile: Health of the U.S.S.R. Population in the 70s and 80s: An Approach to a Comprehensive Analysis," *Social Science and Medicine* 31, no. 8 (1991): 867–77.

¹⁴¹Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care System Would Cost U.S. Employers and Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

¹⁴²Ibid.

¹⁴³See Robbins and Robbins, pp. 20–22.

There is no evidence that private health insurance adds to the price of an automobile or of any other product. Health insurance is simply one element in the total compensation package of auto workers, a fringe benefit provided in lieu of money wages. Over the last two decades, fringe benefits for most American workers have grown steadily in real terms, while money wages have grown little, reflecting the preference of employees for nontaxed benefits over taxed money wages.

What workers are paid depends on what they produce, not what they consume. The fact that Americans spend a greater proportion of their income on health care and a smaller proportion on other goods and services does not put us at a disadvantage relative to other countries.¹⁴⁴ For example, the Japanese spend a greater proportion of their income on food, but food consumption does not add to the price of a Japanese car. The Canadians spend a greater proportion of their income on education, but education does not add to the price of Canadian lumber. These differences in consumption patterns merely reflect differences in consumer preferences and the relative prices of consumer products.

Although health care expenditures do not affect U.S. competitiveness, national health insurance would. That is because national health insurance involves not only the purchase of health care but also a redistribution of income among producers in different industries. On the whole, a national health insurance system would impose extra taxes on U.S. exporting industries and use the proceeds to subsidize other industries. The industries that would receive subsidies contribute mostly to domestic markets, whereas the manufacturing industries that would be penalized provide most of the nation's exports. National health insurance would raise the costs of our export goods and lower marketing costs in the United States for foreign competitors. Far from making auto producers more competitive in international markets, national health insurance would raise auto production costs relative to those of foreign rivals and would make the domestic industry less competitive.

Despite the fact that one-third of our federal budget goes to defense spending, a burden not equaled by our country's trading

¹⁴⁴See Uwe Reinhardt, "Health Care Spending and American Competitiveness," *Health Affairs* (Winter 1989), pp. 5-21.

Table 17.14
TAXES IN THE UNITED STATES AND ITS MAJOR TRADING
PARTNERS, 1986

Country	Taxes as Percent of GDP
Canada	33%
Japan	29
United Kingdom	39
West Germany	38
United States	29
United States with national health insurance	36

SOURCE: Organization for Economic Cooperation and Development.

partners, taxes are lower in the United States than in most other developed countries. As Table 17.14 shows, only Japan has a tax burden as low as ours. Were we to adopt a program of national health insurance, the U.S. tax burden would approach that of Britain and Germany and would be higher than that of most of our trading partners. That additional burden would have a major impact on our ability to compete.

*Myth No. 17: The Defects of National Health Insurance Schemes in
Other Countries Could Be Easily Remedied by a Few
Reforms*

The characteristics of national health insurance described above are not accidental by-products of government-run health care systems. They are the natural and inevitable consequences of the politics of medicine. Why are low-income and elderly patients so frequently discriminated against under national health insurance? Because national health insurance is always and everywhere 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. National health insurance extends the free ride to those who pay taxes to support it. Such systems are created in response to the political demands of the middle-class working population, and they are designed to serve the interests of that population.

Why do national health insurance schemes skimp on expensive services for the seriously ill while providing many inexpensive services for the marginally ill? Because those inexpensive services create benefits for millions of people (read: millions of voters), while acute, intensive care services concentrate large sums on a handful of patients (read: small number of voters). Democratic political pressures in this case dictate the redistribution of resources from the few to the many.

Why are sensitive rationing decisions and other issues of hospital management left to the hospital bureaucracies? Because the alternative is politically impossible. As a practical matter, no government can afford to make it a national policy that 9,000 people will die every year because they will be denied treatment for chronic kidney failure. Nor can any government announce that some people must wait for surgery so that elderly patients can use hospitals as surrogate nursing homes or that elderly patients must be moved so that surgery can proceed.

These decisions are so emotionally loaded that elected officials cannot afford the responsibility of making them. Decisions on who will receive care, who will not, and how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.

Myth No. 18: Public Opinion Polls Show That People in All Developed Countries, Including the United States, Prefer National Health Insurance

True enough, as far back as the presidency of Richard Nixon, polls showed up to 61 percent of the people favoring national health insurance.¹⁴⁵ And only 3 percent of Canadians and 12 percent of the British say they would be willing to trade their own system for the U.S. health care system.¹⁴⁶ But close analysis of the polls reveals that what most people prefer is a free lunch.

Polls in Britain show that most people there believe the cost to them of national health insurance is about 1/20th of what it actually is (see chapter 18). At 1/20th of its real costs, the British health care system may well look attractive to most people. Because health

¹⁴⁵Jon Gabel, Howard Cohen, and Steven Fink, "Americans' Views on Health Care: Foolish Inconsistencies?" *Health Affairs* (Spring 1989), p. 111.

¹⁴⁶Blendon and Taylor, p. 153.

care taxes are also disguised in Canada, Canadians probably are unaware of their individual contribution to national health insurance. Thus, most people in other countries think they get a lot more than they pay for. And given the international publicity about U.S. health care costs, it's not surprising that people prefer something for nothing to something better but more expensive.

When asked to compare benefits with costs, the people participating in polls are much more revealing in their answers. Roughly speaking, people prefer to see government spend more on health care, provided their own taxes are not increased to finance the spending. For example, by a margin of 71 to 26 percent, Americans agree that "health insurance should pay for any treatments that will save lives even if it costs one million dollars to save a life."¹⁴⁷ At a time when the United States was actually spending 8.2 percent of GNP on health care, most respondents thought the nation was spending 13 to 15 percent and identified 16 to 20 percent as the appropriate amount.¹⁴⁸ Although a majority favor covering the uninsured through employer mandates or expanded Medicare,¹⁴⁹ when asked about paying for expanded health insurance coverage, people were unwilling to pay higher income taxes and supported the proposal only if it were financed by "sin taxes" (for example, taxes on alcohol and tobacco) or taxes on employers.¹⁵⁰

Thus, polling data give no indication that people are willing to pay 15 percent of their income to finance national health insurance. Nor do the polls indicate that Americans are willing to accept the negative aspects of national health insurance in other countries. For example, the U.S. public overwhelmingly disapproves of any cost-containment measure that translates into a lower quality of care; and by a margin of 81 to 18 percent, the public is unwilling to accept longer waits for doctor's appointments or elective surgery.¹⁵¹

Myth No. 19: Since National Health Insurance Is Very Popular in Other Countries, It Will Also Be Popular in the United States

The reason national health insurance "works" in other countries, and remains popular, is precisely because it does not function the

¹⁴⁷Gabel, Cohen, and Fink.

¹⁴⁸Ibid., p. 110.

¹⁴⁹Ibid., pp. 109-10.

¹⁵⁰Ibid., p. 112.

¹⁵¹Ibid., p. 114.

way its advocates believe it should. National health insurance works in other countries for three reasons. First, the wealthy, the powerful, and the sophisticated—those most skilled at articulating their complaints—find ways to maneuver to the front of the rationing lines. Second, those pushed to the end of the lines are generally unaware of the medical technologies they are being denied. Third, there are no contingency fees (or contingency arrangements are severely limited), no generally recognized right of due process with regard to health benefits, and no cadre of lawyers willing to represent those who are systematically discriminated against. National health insurance works in other countries because those who could change the system are the ones best served by it. If a member of the British Parliament, the chief executive officer of a large British company, or the head of a major British trade union had no greater opportunity to obtain renal dialysis than any other British citizen, the NHS would not survive for a week.

“Don’t push me around” is a distinctively American phrase. In Europe, people have been pushed around for centuries. In the United States, we have widespread access to information about modern medical technology, a legal system that protects the rights of those without political power or money, and a strong devotion to due process. National health insurance, as it operates in other countries, simply would not survive in the U.S. cultural and legal system.

*Myth No. 20: Adopting the Health Care Programs of Other Countries
Requires Government Action*

Lee Iacocca (chairman of the Chrysler Corporation), the United Auto Workers, and many others have looked longingly at the health care systems of other countries and called for a government solution to our health care problems. But do the workers at Chrysler really need government in order to adopt the health care programs of other countries? It is not at all clear that they do.

The primary way in which other developed countries control health care costs is through “global budgets.” Hospitals, physicians, or area health authorities are told by government how much money they have to spend, and the rationing of funds is handled by the health care bureaucracy.¹⁵² There is nothing mysterious about

¹⁵²See the discussion in Jönsson, pp. 84–86.

this process, and there is no reason why Chrysler needs government in order to copy it. For example, Chrysler workers or any other large group could form their own HMO, called a national health insurance HMO (NHI HMO). The total amount of money given to NHI HMO each year could be 75 percent—or even 50 percent—of what Chrysler now spends on employee health care, and the NHI HMO managers could be instructed to ration care to Chrysler employees.

If Chrysler workers wanted to exert more direct control, they could elect the chief executive officer of the NHI HMO in annual balloting, and candidacy could be open to all health care bureaucrats or restricted to those possessing certain qualifications. The most obvious obstacle Chrysler would face would be U.S. tort law. If NHI HMO physicians rationed medical care the way the British do, there would be many potential malpractice suits. But if Chrysler workers owned their own HMO and if enough legal documents were signed, it is possible that even that obstacle could be overcome.

In short, Chrysler employees could realize all of the purported benefits of national health insurance through private action, provided that that is their sincere objective. On the other hand, if the rhetoric coming from Chrysler is merely a ruse to get taxpayers to pay Chrysler's annual health care bill, coercion by the federal government would be required.

Lessons

Our survey of national health insurance in countries around the world provides convincing evidence that government control of health care usually makes citizens worse off. When health care is made free at the point of consumption, rationing by waiting is inevitable. Government control of the health care system makes the rationing problem worse as governments attempt to limit access to modern medical technology. Under government management, both efficiency and quality of patient care steadily deteriorate.

The lesson from other countries is that the United States would not be well served by an expansion of government bureaucracy or by greater government control over the U.S. health care system. Instead, what is needed is to limit the role of government and allow the private sector to solve the nation's health care problems.

18. The Politics of Medicine

Public choice is the name of a relatively new discipline that attempts to integrate economics and political science.¹ Its chief goal is to explain political phenomena in terms of fundamental principles, in much the same way that economists explain purely economic phenomena. The name, however, is potentially misleading. The new discipline could just as 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. Consider 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 ultimate outcome—efficient production—is independent of any particular producer's wishes or desires.

In a similar way, political competition inexorably leads candidates to adopt a specific position called the winning platform. 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. A politician who wants to be elected or reelected has every incentive

¹The 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: 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; and Gary S. Becker, "A Theory of Competition among Pressure Groups for Political Influence," *Quarterly Journal of Economics* 98, no. 3 (August 1983): 371–400.

to endorse the winning platform. If he does not, he becomes vulnerable; for if his opponent adopts the winning platform, the opponent will win.

In the real world, of course, things are rarely so simple. Voters are influenced by many factors other than substantive political issues—a candidate's religion, general appearance, speaking ability, or party affiliation. Even when voters are influenced by real political issues, politicians don't 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. Candidates who do not do so are unlikely to survive the political competition.

This line of reasoning leads to a remarkable conclusion: In democratic systems with two major political parties, both parties tend to adopt the same policies. They do so not because the party leaders think alike or share the same ideological preferences, but because each party's 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 it will work. Indeed, the more accurate the 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 for 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 the factors that determine the nature of the winning platform.

This second corollary is critical to an understanding of national health insurance. A great many British health economists who support socialized medicine are quick to concede that the British National Health Service (NHS) has defects. But the defects, in their view, are not those of socialism; they merely represent a failure of

political will, or the fact that the wrong politicians were 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 the policies that govern national health insurance programs are the natural and 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 once ran the NHS, seems to have appreciated this fact. Powell wrote that "whatever is entrusted to politicians becomes political even if it is not political anyhow"² 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.³

Explaining the British National Health Service

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.⁴ That is, far from being the consequence of the preferences of politicians (who could be replaced by different politicians with different preferences in the next election), the major features 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 Total 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. That was a major reason many

²Enoch Powell, *Medicine and Politics, 1975 and After* (New York: Pitman, 1976), p. 5.

³Ibid., p. 67.

⁴John C. Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980), ch. 10.

middle-class 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 1948.⁵ Many expected that, under socialized medical care, more total dollars would be spent on health care than would otherwise have been the case. In fact, it is not clear that socialized medicine in Britain has increased overall spending on health care. It may have even led to the opposite result. That is the contention of Dennis Lees, a 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."⁶ The same may be true in other countries with national health insurance programs.

To see why this is so, let us first imagine a situation in which a politician is trying to win over a single voter. To keep the example simple, assume that the politician has access to \$10 to spend on the voter's behalf. To maximize his chance of winning, the politician should spend the \$10 precisely as the voter wants it spent. If the voter's choice is to spend \$5 on medical care, \$3 on a retirement pension, and \$2 on a rent subsidy, that should also be the choice of the vote-maximizing politician. If the politician does not choose to spend the \$10 in that way, he risks losing this particular voter to a clever opponent. Now, it may seem that if the voter wants \$5 spent on medical care, it is appropriate to conclude that he would have spent the \$5 on medical care himself if he were spending \$10 of his own money. But that is not quite true. State-provided medical care has one feature that is generally missing from private medical markets and from other government spending programs as well—nonprice rationing. Nonprice rationing 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, \$5 of spending on government health care will be less valuable to the average voter than \$5 of spending in a private medical marketplace.

⁵Dennis Lees, "An Economist Considers Other Alternatives," in Helmut Schoeck, ed., *Financing Medical Care: An Appraisal of Foreign Programs* (Caldwell, ID: Caxton Printers, 1963), p. 80.

⁶Dennis Lees, "Economics and Non-economics of Health Services," *Three Banks Review* 110 (June 1976): 9.

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 one would expect even less spending on health care under a completely free service like the NHS than under a health service that charges patients more user fees.

In the real world, politicians rarely have the opportunity to tailor their spending purely to the desires of a specific voter. Generally, they must allocate spending among programs that affect thousands of voters at the same time. New spending for a hospital, for example, provides benefits for everyone in the surrounding community. No matter what level of spending is chosen, some voters will prefer more, and others less. Often, in such cases, 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 also inherently political. A major argument in favor of national health insurance is that private medical care allows geographical inequalities to occur in levels of provision. Yet, those inequalities continue under socialized medicine, and many argue that the levels of provision in regions of Britain, Canada, and New Zealand are just as unequal today 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 regions that are relatively deprived and less in regions that are relatively well endowed. But most governments have not done this. Why? Public choice theory supplies a possible answer. Policymakers must make two choices about spending in a particular 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 regions. For example, per capita spending may differ across voting districts for numerous reasons. Voter turnout may be higher

in some districts than in others, which suggests 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 of a politician trying to win over a voter, suppose that \$10 is going to be spent in a certain city. If a majority of residents want \$2 spent on health services and \$8 spent on other programs, political competition will tend to produce that result. Yet, if the residents of some other city want \$8 spent on health services and \$2 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 regions 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 there is 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 NHS emphasizes caring rather than curing (see chapter 17), and it is that feature of the NHS that marks a radical difference between British and American health care. There can be no doubt that the British choice is a result of conscious political decisions. American economist Mary-Ann Rozbicki once asked some 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.⁷ Commenting on this response, Rozbicki wrote:

⁷Mary-Ann Rozbicki, *Rationing British Health Care: The Cost/Benefit Approach*, Executive Seminar in National and International Affairs, U.S. Department of State, April, 1978, p. 17.

It is difficult for an American observer to comprehend that view. He has been impressed by the support services already afforded the non-acute 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 foregone 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.⁸

What political pressures lead decisionmakers to prefer caring over curing? Rozbicki believes it is a matter of numbers—numbers of votes. Money spent on caring is spread out over far more people than money spent on curing. Rozbicki wrote:

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.*⁹

Although Rozbicki's explanation may be correct, it cannot be complete. It is true that the number of potential beneficiaries of home visiting far exceeds those of radiation therapy. But all Britons are potentially ill, so all have an interest in the spending priorities of the NHS. A complete explanation of these priorities requires an explanation of why the average citizen would approve of them.

Like the citizens of other countries, most Britons know little about medical technology. Their ignorance, moreover, is quite rational. Information is costly. Rational people have an incentive to expand their knowledge about any subject only up to the point where the

⁸Ibid.

⁹Ibid., p. 18. Emphasis added.

cost of an additional bit of information is equal to its benefit. That is the economic explanation for the commonly observed fact that the average person does not become an expert in medical science. The average Briton, however, has much less incentive to become knowledgeable about medicine than the average American does. Precisely because the medical market in the United States is largely private, a better informed person becomes a better consumer. But within the confines of 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. That knowledge is of almost no value unless the citizen can inform millions of other voters, persuade them to "throw the rascals out of office," and achieve a change of policy. Such a campaign would be enormously expensive, undoubtedly costing the citizen far more than could be recovered from any potential personal benefit.

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 in medicine. Such information increases the demand for new services and thereby promises to enhance the income of those who supply them. Under the NHS, however, the suppliers of medical care have no such incentives. Physicians, 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.

Economic theory, then, would predict that in a socialized medical scheme, people will acquire less knowledge about medical care than they would have acquired in a private system. The evidence confirms this prediction. Numerous commentators have observed that British patients know far less about medical care than American patients. Rozbicki, for example, noted that "the British populace appears much less sophisticated in its medical demands than the American populace."¹⁰

The general ignorance about medical science that prevails among British voters has a profound impact on NHS policies. Other things

¹⁰Ibid., p. 17.

being equal, people will always place a higher value on those services with which they are more 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. But that voter is probably unfamiliar with, and uncertain about, the personal value of advanced services for acute ailments. Thus the voter will tend to approve of NHS spending priorities.

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 for quantity. Unlike American physicians, British general practitioners (GPs) have greatly reduced the time spent with each patient and the quality of service rendered. Nonetheless, this type of adjustment allows the typical patient to actually visit his GP within two or three days of making an appointment. The quality of treatment may have deteriorated, 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 as easy to sacrifice quality for quantity in, for example, CAT scans, organ transplants, and renal dialysis. Patients tend to 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 of 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 the 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 become more valuable relative to the latter. Thus, to a certain extent, the priority given to nonacute treatment is perfectly rational.

Spending Priorities: Current Expenditure versus Capital Expenditure

Closely related to the distinction between caring and curing in Britain is the distinction between current and capital expenditures.

Despite the fact that the NHS inherited a deteriorating capital stock, only one new hospital was built in the first 15 years of NHS operation. Today, more than 50 percent of the hospital beds are in 19th-century buildings. Moreover, despite one million people on the hospital waiting lists, there are fewer hospital beds today than there were when the NHS was founded in 1948.

Capital expenditure creates a flow of long-term benefits whereas current expenditure, by definition, creates short-term benefits. The distinction between the two types of expenditure is largely a distinction between benefits later and benefits now. Clearly, the political preference of the British is for benefits now. Can public choice theory help explain this preference? Indeed it can. To see how, it is necessary to first consider how decisions about capital spending are made in the free market.

Very few of us know how our consumption of, say, coffee varies over the seasons of the year. Most of us simply buy coffee when we want it and, except for the influence of general inflation or an occasional coffee tree blight in Brazil, we pay about the same price regardless of the season. The reason is that the suppliers of coffee are balancing our demand for coffee in the future against our demand for coffee right now. The free market furnishes suppliers with powerful incentives to give us precisely what we want—the ability to buy as much coffee as we like for roughly the same price at any time of the year.

The decision on the part of business firms to make capital investments is similar. Firms that make capital investments today are betting on a consumer demand for their products in the future. Once private decisionmaking is replaced by public decisionmaking, however, things are very different. In a democracy, voters are forced to decide how much capital spending there should be. And precisely because voters are rationally ignorant about such matters, these are decisions they are ill-prepared to make. Socialism in the coffee market, for example, might work something like this: Candidates competing in September might woo voters by promising lower and lower prices for coffee. Because the voters are uninformed about the future consequences of a low price of coffee today, they are naturally attracted to the candidate who promises the lowest price. For politicians to have good incentives, they must anticipate that they will be around in the spring, and that voters will make the connection between fall's policy and spring's disaster.

Yet, because voters are usually ignorant of the connection between capital spending and specific benefits, politicians cannot look forward to realizing the full costs or the full benefits of their decisions. Further, because a politician is not likely to be in office for very many years, long-term penalties and rewards are largely irrelevant. Finally, because politicians have no property rights in their decisions, the worst that can happen is that they fail to be reelected. And that may be an acceptable price to pay for the opportunity to hold office today.

John and Sylvia Jewkes, two British economists who were long-time students of the NHS, argued on numerous occasions that NHS's lack of capital spending was solely the result of the political pressures just described. Successive chancellors of the exchequer, according to the Jewkeses, skimmed on "those items where the consequences in the short period would be least noticeable and least likely to arouse protest."¹¹ They went on to write:

Governments followed the line of least resistance. They laid emphasis on those medical items which constituted pressing day-to-day demand, yielded their results quickly and with some certainty, made something of a public splash and conformed with the doctrine of equality. Conversely, they tended to neglect those items where spending would bring only slowly maturing results, where economy would not be quickly noticed and therefore would be less likely to arouse public opposition. . . .

These were the conditions under which preventive medicine, new hospitals and medical schools, occupational health services and medical research were likely to give way to a free supply of drugs, of doctors' services and of hospital care. However anxious a government might be to take a longer view, its resolve was likely to be weakened by the pressure of immediate demands; and by the hope that easier times were coming; that perhaps next year defense expenditures would be smaller, or investment needed for other purposes would be less, or the national income would rise sharply.¹²

¹¹John and Sylvia Jewkes, *Value for Money in Medicine* (Oxford: Basil Blackwell, 1963), p. 55.

¹²*Ibid.*, pp. 59-60.

Administrative Controls

One of the most remarkable features of national health insurance is the enormous amount of decisionmaking power left in the hands of physicians. 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,¹³ Anthony Culyer,¹⁴ and many others, this discretion is the principal reason for many of the gross inefficiencies found in Britain's NHS.

In addition to GPs and consultants, other producer interest groups also have obtained power and influence. Within the NHS, they 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 observed:

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 by-product, depending on how conflicts between the groups and between them and government happen to shake down at any particular time.¹⁵

Government production of goods and services always tends to be less efficient than private production. Nonetheless, the NHS could be run more efficiently than it actually is. 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. Over 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

¹³Michael Cooper, *Rationing Health Care* (London: Croom Helm, 1975), p. 73.

¹⁴Anthony Culyer, "Health: The Social Cost of Doctors' Discretion," *New Society*, February 27, 1975.

¹⁵Lees, "Economics and Non-economics of Health Services," p. 12.

welfare of consumers.¹⁶ Why should we expect the NHS to be different?

Are these phenomena consistent with public choice theory? At first glance it may seem that they are not. Given that consumers outnumber producers, it might seem that, with democratic voting, consumers would always have the upper hand. If sheer voting power were the only power, that might be so. But two additional factors put consumers at a disadvantage: costs of information and costs of political organization.

To achieve any fundamental change of policy, voters must be informed about what kinds of changes they specifically seek. They must also 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 information is costly. Organizing a political coalition is also costly. And the incentives for any single individual to bear those costs are extremely weak.

Producers are in a different position. Because 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 each producer's personal stake 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. The 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 30 years ago:

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

¹⁶A representative sample of such studies is contained in Paul W. MacAvoy, ed., *Crisis of the Regulatory Commissions* (New York: Norton, 1970).

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 barbering. 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.¹⁷

Public choice theory, then, predicts that administrative inefficiencies caused by producer interest groups within health care bureaucracies will 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?"¹⁸ That British patients do like the NHS has been confirmed repeatedly by public opinion polls. The same can be said of Canadians about their health care system. The most recent surveys show that only 3 percent of Canadians and 12 percent of the Britons would trade the U.S. system for their own.¹⁹ Why are British patients so satisfied with the NHS? There appear to be two major reasons: (1) the typical British patient has far lower expectations and much less knowledge about medicine than the typical American patient; and (2) most British patients apparently believe that they are getting something for nothing.

¹⁷Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), p. 143.

¹⁸John J. Fisher, "If Britain's Health Care Is So Bad, Why Do Patients Like It?" *Medical Economics* (August 21, 1978).

¹⁹See Robert J. Blendon and Humphrey Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs* (Spring 1989), pp. 149-57.

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."²⁰ 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."²¹ Another doctor summarized the difference in British and American attitudes this way:

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.²²

The expectations and the level of knowledge of British patients, however, are only part of the explanation for the popularity of the NHS. More basic is the fact that most British patients grossly underestimate the taxes they pay to finance the NHS. Public opinion polls have found that 60 percent of the British people believe that the entire cost of the NHS is met, not from general taxes, but from the weekly payroll tax (called the insurance stamp).²³ In fact, in 1972, when the opinion polls were taken, the payroll tax represented only 8.5 percent of the total cost of the NHS. Moreover, the worker's nominal share of the weekly payroll tax is only two-thirds, with the remainder being nominally paid by employers. Although most economists believe that the employers' share of the payroll tax ultimately comes out of wages that would have been paid to

²⁰Derek Robinson, "Primary Medical Practice in the United Kingdom and the United States," *New England Journal of Medicine* 297, no. 4 (July 28, 1977): 189.

²¹Rozbicki, p. 18.

²²Quoted in Harry Swartz, "The Infirmary of British Medicine," in R. Emmett Tyrrell, Jr., ed., *The Future That Doesn't Work: Social Democracy's Failures in Britain* (New York: Doubleday, 1977), p. 31.

²³Cooper, p. 87.

workers, very few workers believe that. A loose way of interpreting these results is as follows: Most people in Britain believe that the total tax they pay to finance the NHS is about 1/20th of what it actually is. Given this perception, no wonder the British public looks upon the NHS as a good bargain.

Just how this perception affects British attitudes toward what most Americans would regard as intolerable defects in the health service was vividly illustrated by the experience of Rep. Bob Bauman on a trip to England in 1975. Traveling with a group of congressmen to examine the NHS firsthand, Bauman met a young woman with substantial facial scars received in an accident. Although the woman wanted plastic surgery for her face, she related, "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 Bauman 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, and 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 physicians—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

²⁴Quoted by Lew Rockwell in *World Research Inc.*, March 1979, p. 5.

²⁵*Ibid.*, p. 6.

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 but they also resisted Margaret Thatcher's proposals to open it to minimal competition.

In almost every country with national health insurance, disinterested, knowledgeable observers agree on the need for substantial reform. For example, Claude Castonguay, considered the father of national health insurance in Quebec, now recommends the establishment of private health care centers to compete with public ones and a voucher system to encourage competition among suppliers.²⁷ Even Sweden is searching for ways to introduce the discipline of the competitive marketplace into its public system.

There have been successful attempts to privatize public health care programs (for example, in Singapore and Chile), and among less-developed countries there will probably be more (for example, in Colombia and Venezuela) (see chapter 20). But in developed countries, all serious attempts at fundamental reform have been blocked by the politics of medicine. Any public-sector retreat on health care is more likely to come about as people seek private-sector alternatives rather than through changes at the ballot box.

The Politics of Medicine in the United States

The U.S. health care system differs from the systems of other developed countries in two important respects. First, government spending on health care is largely confined to the poor and elderly. The vast majority of the middle-class working population participates in the private health care marketplace, although they shoulder the increasing tax burden of medical expenses for the poor and elderly. Second, through both public and private health insurance, the U.S. system has been a cost-plus system for almost half a century and, until recently, there has not been any significant health care rationing. If anything, Americans have experienced the reverse phenomenon; hospitals and doctors have felt free to utilize virtually every new technique offered by medical science, secure in the knowledge that someone would always pay the bill.

²⁶John Walsh, "Britain's National Health Service: The Doctors' Dilemmas," *Science* 201 (July 28, 1979): 329.

²⁷Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington: Health Insurance Association of America, 1989), p. 52.

However, now that the U.S. system has evolved into a cost-plus system in its cost-control stage, with government more involved in paying for medical care, political pressures in the United States are leading to the same kinds of decisions that have been made in many European countries. Evidence of that can be seen in virtually every government-funded health care program.

Health Care Rationing under Medicare

Under Medicare, the federal government now pays hospitals a fixed sum for each of 492 categories of illness called diagnosis-related groups (DRGs). As a result, the federal government is attempting to set prices and monitor quality for 28 million potential patients and as many as 5,000 hospitals. It is an impossible mission. No matter what reimbursement rules are adopted, the medical marketplace is so complex that health care providers will find literally thousands of ways to exploit the rules for financial gain. Moreover, there is an inevitable conflict between price and quality of care. In the early years of the Medicare program, quality took precedence. Under the new reimbursement rules, the reverse is beginning to occur.

The federal government is resisting cost pressures by making DRG reimbursement rates increasingly stingy. Yet this attempt to control costs is adversely affecting patient care. As the DRG system is now structured, it can be used (and to some extent is being used) as a health care rationing device—an eventuality that some have argued is inevitable. The following is a brief account of some of the ways in which Medicare is taking on characteristics of national health insurance.

Bias against Modern Medical Technology

One way that Medicare can avoid paying for expensive technology is by refusing to pay hospitals enough money to buy the technology in the first place. That is, Medicare's hospital reimbursement rate for a particular procedure may be high enough to reimburse the hospital for one level of care but too low to cover a higher level. In other cases (under Medicare Part B), Medicare specifically refuses to pay for a higher quality treatment. For example, Medicare reimbursement rates have denied elderly patients with hearing loss access to cochlear implants and may be endangering the lives of kidney dialysis patients (see chapter 10).

Another way in which Medicare encourages health care rationing is by refusing to pay at all. For example, despite the fact that Medicare theoretically pays for heart and liver transplants, it often will not pay for lifesaving drugs for the thousands of elderly people who die of cancer each year. In general, Medicare will not pay for physician-injected drugs unless the purpose for which the drug is being used has been approved by the federal Food and Drug Administration (FDA). But a physician guided by the medical literature will discover that many effective uses of prescription drugs have not been approved.

Physicians who treat cancer patients, for example, will normally turn to one of three bibles of drug prescribing—the *American Medical Association Drug Evaluations*, the *Hospital Formulary Service Drug Information Book*, or the *United States Pharmacopoeia*. The consensus is that once a drug's effectiveness in treating a disease is listed in one of these publications, it is no longer experimental, but instead is accepted therapy.²⁸ Nevertheless, about 60 percent of all chemotherapy listed in these publications is currently for "off-label" indications; that is, for uses not yet approved by the FDA. Medicare insists that pharmaceutical companies go through the expensive and laborious process of having each use "added to the label" by the FDA before they will pay for it. Effectively, that means that patients with life-threatening illnesses are often denied treatments that might save their lives.²⁹ Many private insurers, including the national Blue Cross and Blue Shield Association, have adopted the same policy—under the protective umbrella of Medicare's respectability and authority. Thus, Medicare's policies are indirectly affecting the nonelderly as well.

The excuse given for these practices is that insurers are trying to protect patients from false hopes about unproven or experimental therapies, such as Laetril. But the real issue is money. As Lee E. Mortenson, executive director of the Association of Community Cancer Centers, has explained, patients are being denied access to improvements in cancer therapy by third-party payers "hiding

²⁸See Elizabeth Rosenthal, "Rules on Approved Uses of Drugs Could Bar Help for Some Patients," *New York Times*, August 11, 1991.

²⁹See "Oncology Forum," *COPE* (April/May 1989): 17 ff.

behind concerns for patient safety but in fact struggling to keep costs down."³⁰

For example, injections of the drug 5-Fluorouracil (5-FU) is one way to treat colon cancer patients, at a cost of about \$9 per week. This drug, however, is effective only about 11 percent of the time. By contrast, a weekly injection of 5-FU plus Leucovorin is effective in about 48 percent of cases, but at a weekly cost of \$250.³¹ Until 1989, Medicare refused to pay for the higher priced drug.³² Similarly, interferon is FDA-approved for hairy cell leukemia (a very rare form of cancer), and Medicare will pay the \$1,000 a month it costs. However, Medicare will not pay for the drug's use in treating five other types of cancer for which the medical literature shows it is often indicated.³³

Moreover, things are likely to get worse. Despite the continued protests of doctors and cancer patients, the FDA commissioner, David Kessler, has announced his intention to "crack down" on drug companies, and perhaps physicians, who promote drugs for uses not on the FDA label. That's bad news for the 500,000 Americans who will die of cancer this year.

Medicare also refuses to pay for certain higher quality medical devices. For example, Medicare refuses to pay for dual-chamber pacemakers, insisting instead that single-chamber pacemakers be used in the first implant. Medicare will pay for the higher quality pacemaker only if the lower quality device doesn't work. Medicare also refuses to pay for (pacemaker) defibrillators, which also are of higher quality and more expensive.

Bias in Favor of Caring over Curing

When politicians allocate health care resources, they face strong pressures to spend money on simple services for the many, rather

³⁰Quoted in the *Wall Street Journal*, May 12, 1989.

³¹Nicholas Petrulli et al., "A Prospective Randomized Trial of 5-Fluorouracil versus 5-Fluorouracil and High-Dose Leucovorin versus 5-Fluorouracil and Methotrexate in Previously Untreated Patients with Advanced Colorectal Carcinoma," *Journal of Clinical Oncology* 5, no. 10 (October 1987): 1559-65.

³²For California doctors, Medicare denied reimbursement until January 19, 1989—about three years after the treatment was known to be effective.

³³For a review of the literature on the effectiveness of interferon in treating various types of cancer, see Jeffrey W. Clark and Dan L. Longo, "Interferons in Cancer Therapy," *Updates to Vincent T. DeVita, Jr., Samuel Hellman, and Stephen A. Rosenberg, Principles and Practice of Oncology* 1, no. 4 (April 1987).

than on expensive services for the few. Despite the fact that Medicare has had access to huge sums (growing from annual expenditures of \$3.2 billion in 1967 to \$128 billion in 1992), those political pressures have affected Medicare since its inception. Medicare has always paid a great many small medical bills while leaving the elderly exposed for large ones, and Congress has forced private Medigap insurers to follow similar practices (see chapter 15). The same pressures emerged in the battle over catastrophic care for the elderly. Congress was unable to approve any version of catastrophic coverage that did not also include more coverage for the small bills that most Medicare enrollees incur.

Moreover, the Medicare reforms of the 1980s left intact the practice of paying for physician visits for any and all complaints, and the most likely victims of the DRG system will be the sickest patients with the most complicated medical problems.

Political pressures have also affected Medicare in the area of preventive medicine. When the British NHS was founded, a common argument for socialized medicine centered around the value of prevention. If medical care were free at the point of consumption, it was argued, people would have an incentive to seek preventive care; thus, in many cases, diseases would be caught in their early stages, and that would save lives and maybe money as well. British patients do see physicians often. But because of the politics of medicine, access to preventive medical services is much lower in Britain than in the United States.³⁴

Because of similar political pressures in the United States, Medicare patients can see physicians for almost any reason. But diagnostic tests are more rigorously controlled. To receive a mammogram, chest x-ray, Pap smear, or cholesterol test, a Medicare patient must have a very specific symptom. Of course, if the patient does display a symptom, it may be too late.

Bias against Rural Communities

One way in which inequalities in access to health care are perpetuated under national health insurance is through the bias against rural areas (see chapter 17). When the government's health care budget gets tight, rural communities are among the first to suffer.

³⁴Goodman, *National Health Care in Great Britain: Lessons for the USA*, pp. 89–92.

The same is occurring under Medicare. In general, Medicare reimbursement to rural hospitals is 33 percent less than the reimbursement to urban hospitals for similar services.³⁵ This policy, adopted during the 1980s, is having a major impact—for example, in Texas, which has led the nation in hospital closings in recent years. Between 1984 and 1989, 66 rural hospitals serving three million people in Texas were closed. The care given in those hospitals was primarily to elderly, Medicare patients.³⁶

The closing of rural hospitals is occurring because of a relationship between bureaucracies, not because of normal market forces. If the market will not support a rural hospital and the rural community does not want to subsidize one, there is nothing wrong with closing the hospital. But rural Medicare patients are effectively given less money to spend on health care, even though they (and the other members of the communities) pay the same tax rates as everyone else. Moreover, elderly patients are forbidden to add their own money to Medicare money. If patients controlled Medicare's funds and if the market were allowed to work, many rural hospitals now closed might have remained open.

Delegating Rationing Decisions to Providers

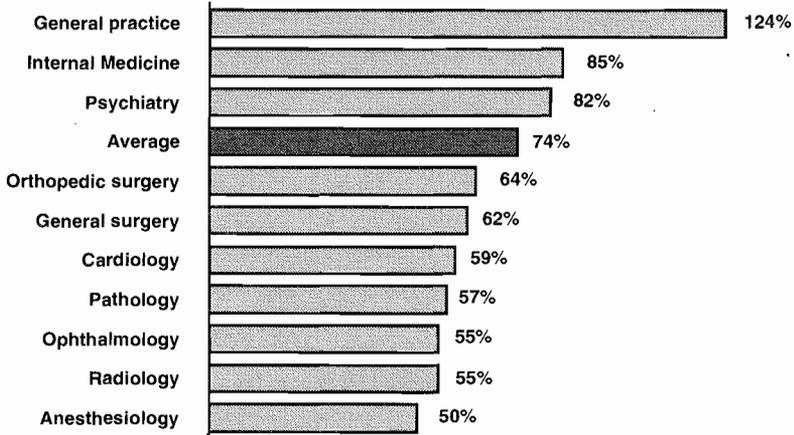
National governments usually go to great lengths to avoid being accused of denying lifesaving medical care to patients. The most common practice is to limit resources and leave the rationing decisions (along with the blame) to hospital administrators and physicians. Under Medicare, the DRG program adopts the European strategy. That is, under Medicare Part A, rationing decisions are forced on hospitals by limiting the amount of money Medicare pays, not by telling hospitals how to treat patients.

By contrast, under Medicare Part B, the Medicare bureaucracy tells physicians what drugs they can inject and how much time they can spend with patients. In this case, specific rationing decisions (choices about the level of care) are made in Washington. Given the politics of medicine, it should come as no surprise that there is

³⁵U.S. Congress, Office of Technology Assessment, *Health Care in Rural America*, OTA-H-434 (Washington: U.S. Government Printing Office, September 1990), Table 5-22 (p. 193).

³⁶Texas Bureau of State Data and Policy Analysis, *Special Task Force on Rural Health Care Delivery*, a report to the 71st Texas legislature (Austin, February 1989).

Figure 18.1
MEDICARE PHYSICIAN FEES: WINNERS AND LOSERS
 (Cumulative Increases from 1991 to 1996 in Medicare
 Payments to Physicians)



SOURCE: U.S. Department of Health and Human Services; reprinted in the *New York Times*, November 16, 1991.

considerable pressure to extend the DRG method of payment to Medicare Part B, thus fixing a total price for all services. Were this proposal adopted, Medicare could enforce all rationing decisions simply by controlling the purse strings.

Extending Price Controls to Physicians

A step in the direction of a general DRG system is a new formula for setting physician fees, adopted by the Bush administration in the fall of 1991.³⁷ Under the system, the physician's fee for a particular service will be determined by the following formula:

$$\text{Physician's fee} = (\text{RVU}_{w_s} \times \text{GPCI}_{w_a}) + (\text{RVU}_{p_e_s} \times \text{GPCI}_{p_e_a}) + (\text{RVU}_{m_s} \times \text{GPCI}_{m_a}) \times \text{CF}$$

We won't bother to define the variables because that would shed very little light on the bottom line, which is depicted in Figure 18.1.

³⁷See Robert E. Moffit, *Comparable Worth for Doctors: A Severe Case of Government Malpractice*, Heritage Foundation Backgrounder no. 855 (September 23, 1991).

As the figure shows, the formula is designed to shift money away from physicians who perform surgical specialties to those who engage in family practice.³⁸ Although it may be true that GPs and internists were underpaid under the old system, the new fee schedule is consistent with political pressure to favor caring over curing. It will discourage medical students from becoming surgeons, it will discourage surgery, and it may discourage a wide range of other services. That is not mere speculation; the federal government's U.S. Physician Payment Review Commission came to the same conclusion in criticizing the proposed fee schedule when it was published in the summer of 1991.³⁹ The logical next step is to force physicians to accept the Medicare fee as "payment in full," which almost half of all physicians already do. Once that is done, the federal government will be able to control physician behavior in the same way it is increasingly determining the behavior of hospitals.

Health Care Rationing under Medicaid

The politics of medicine also influences public policy on health care for the poor, including patients on Medicaid. Not too long ago, a person on Medicaid had a free ticket to all that the American health care system had to offer. Today, that is less and less true.

The 33 million elderly and disabled people who participate in the Medicare program are competing for resources against beneficiaries of every other government program. Those others include the 27 million low-income families, including 13 million children that participate in Medicaid. In general, the elderly have been far more successful as a political force.

Implicit Rationing

In principle, people on Medicaid still are entitled to virtually any services. In practice, care to Medicaid patients is rationed by the terms under which Medicaid reimburses medical providers. Medicaid patients do not control the medical dollars that are spent. Nor can they add to Medicaid reimbursements with their own funds. As a consequence, the principal customer of medical providers is not the patient but the bureaucracy. Moreover, through its policy

³⁸Robert Pear, "U.S. Makes a Major Change in Medicare Fees for Doctors," *New York Times*, November 16, 1991.

³⁹*New York Times* News Service, August 1, 1991.

of setting reimbursement rates, Medicaid increasingly determines the type and quality of care that Medicaid patients receive.

In most states, Medicaid payments for medical services are well below the payments made by other third-party payers. For example, Table 18.1 shows the difference between Medicare and Medicaid payments to physicians for similar services. As the table shows, in only four states is the Medicaid payment as high as, or higher than, the payment made by Medicare. In New York, the Medicaid payment is only 30 percent of the Medicare payment. In West Virginia, it's only 35 percent. As a result, many physicians who used to accept Medicaid patients no longer do so.⁴⁰ By choosing to pay low prices, the Medicaid bureaucracy is ensuring that the quality of care is reduced.

A similar phenomenon is occurring in the hospital and nursing home industries. According to the American Hospital Association, Medicaid paid more than 90 percent of the cost of hospital care for Medicaid patients in 1980. But by 1988, that figure had dropped to 78 percent. One consequence is that many hospitals no longer want to accept Medicaid patients.⁴¹

Things would be even worse were it not for the intervention of the federal courts (which are somewhat insulated from political pressures). In response to lawsuits filed by nursing homes in 20 states and hospitals in 21 states, the courts are ruling that Medicaid payments do not meet the standards of "reasonable and adequate" compensation and are ordering higher reimbursement levels.⁴² There is nothing wrong with paying lower prices in return for taking a hospital bed when it becomes available, rather than paying top dollar for immediate services. The trouble is that these decisions are not being made by patients. They are being made by the bureaucracy.

Explicit Rationing

At least two political entities have announced their intentions to explicitly ration medical care for patients using public dollars: the

⁴⁰Robert Pear, "Low Medicaid Fees Seen as Depriving the Poor of Care," *New York Times*, April 2, 1991.

⁴¹Robert Pear, "Suits Force U.S. and States to Pay More for Medicaid," *New York Times*, October 29, 1991.

⁴²*Ibid.*

Table 18.1
 MEDICAID VERSUS MEDICARE—THE PAYMENT GAP

State	Medicaid to Medicare Ratio	State	Medicaid to Medicare Ratio
Alabama	.72	Montana	.74
Alaska	1.06	Nebraska	.99
Arkansas	1.20	Nevada	.79
California	.54	New Hampshire	.67
Colorado	.81	New Jersey	.40
Connecticut	.56	New Mexico	.69
Delaware	.50	New York	.30
District of Columbia	.51	North Carolina	.93
Florida	.71	North Dakota	.75
Georgia	1.12	Ohio	.60
Hawaii	.79	Oklahoma	.78
Idaho	.76	Oregon	.66

Illinois	.48	Pennsylvania	.51
Indiana	1.02	Rhode Island	.55
Iowa	.91	South Carolina	.81
Kansas	.79	South Dakota	.85
Kentucky	.63	Tennessee	.92
Louisiana	.66	Texas	.77
Maine	.62	Utah	.89
Maryland	.51	Vermont	.71
Massachusetts	.94	Virginia	.73
Michigan	.62	Washington	.69
Minnesota	.86	West Virginia	.35
Mississippi	.66	Wisconsin	.76
Missouri	.57		

SOURCE: U.S. Physician Payment Review Commission; reprinted in the *New York Times*, April 2, 1991.

NOTE: Index of Medicaid payments as compared with Medicare payments for the same physician services in 1989. Arizona and Wyoming did not respond to the survey.

state of Oregon and Alameda County in California. Oregon has announced, for example, that it will cease using Medicaid money for heart, liver, bone marrow, and pancreas transplants, and that it will spend the money instead on prenatal care and other medical services. This decision is consistent with two characteristics of rationing in other countries: discrimination against the elderly and the provision of less-expensive services for the many rather than expensive, lifesaving care for the few.⁴³ Although Oregon is the only state that has officially announced a policy of health care rationing, others—including Alabama, Arizona, Texas, and Virginia—have set limits on what they will pay for organ transplants.

Case Study: Prenatal Care

One of the strangest features of the modern welfare state is the contrast between the extraordinary amount of money that is spent and the failure to solve what appear to be relatively simple, not very expensive to fix problems. At the federal level, means-tested welfare spending is about \$400 billion per year—enough to turn poverty families into upper-income families overnight. But the welfare state seems unable to provide inexpensive shelters for the homeless and prenatal care for poor, pregnant women; in real terms, the amount of cash given to poor people has barely changed since 1965.⁴⁴

A pregnant woman on Medicaid has very few options (see chapter 4). Because Medicaid reimbursement rates are so low, few physicians will see her for any medical problem. Under Medicaid rules, the woman is not permitted to add her own money to Medicaid's reimbursement and purchase care in the marketplace. Because of yet another bureaucracy, the tort system, the shrinking number of physicians who give prenatal care often avoid Medicaid patients, who are the patients most likely to have medical problems that could give rise to tort claims. Moreover, a woman on Medicaid has no opportunity to waive malpractice claims or in any other way

⁴³Victoria von Biel, "Rationing in Alameda: Much to Do with Nothing," *California Physician* (August 1989): 30–33. See also William Raspberry, "If We Have to Ration Medical Care . . .," *Washington Post*, October 23, 1989, p. A15.

⁴⁴See John C. Goodman, *Welfare and Poverty*, NCPA Policy Report no. 107 (Dallas: National Center for Policy Analysis, October 1983); and John C. Goodman and Michael Stroup, *Privatizing the Welfare State*, NCPA Policy Report no. 123 (Dallas: National Center for Policy Analysis, June 1986).

Table 18.2

PERCENT OF U.S. WOMEN WHO RECEIVE PRENATAL CARE IN THE FIRST THREE MONTHS OF PREGNANCY

Race or Ethnic Origin	Percent
White	79%
Black	62
Asian	76
American Indian	61
Puerto Rican	57

SOURCE: U.S. Department of Health and Human Services, "Health, United States" (March 15, 1989).

reach a voluntary agreement to circumvent the costly intrusion of the tort system.

When prenatal care is available, it is often rationed by waiting. The people who provide the care see Medicaid, not the patients, as their primary customer. In America, prenatal care for low-income women is rationed not by ability to pay but by bureaucracy. Table 18.2 shows the percentage of women who receive prenatal care in the first three months of pregnancy, by race or ethnic origin. As the table shows, there are considerable disparities. These disparities are reflected in the infant mortality rate, which is twice as high for blacks (17.9 percent), for example, as for whites (8.6 percent).⁴⁵ This result is not unique to the United States. In Britain, there are vast differences in infant mortality rates among regions of the country and even among parts of the same city, despite the fact that prenatal care is free.⁴⁶

Health Care Rationing in Other Government Health Programs

In addition to Medicare and Medicaid, other government health care programs are also turning to health care rationing under the pressures of the politics of medicine. The following are a few examples.

⁴⁵National Center for Health Statistics, *Monthly Vital Statistics Report* (September 26, 1989).

⁴⁶Infant mortality among the regions of Britain varies by at least one-third. See Office of Health Economics, *Compendium of Health Statistics: 7th Edition*, 1989 (London, 1989), section 1, p. 17. In urban areas, the differences among population groups are even more striking.

Emergency Rooms of Public Hospitals

Just as the Canadian health care system discourages outpatient surgery and attempts to restrict all sophisticated treatment to large city hospitals, care for low-income patients in the United States is increasingly being restricted to urban hospitals. Unable to obtain treatment elsewhere, low-income patients are turning to the emergency rooms of public hospitals in inner cities, for both primary care (ear infections, sprained ankles, etc.) and other care.⁴⁷ But as the demand increases, the supply is decreasing as more hospitals close their emergency rooms.⁴⁸ "Overwhelmed and understaffed," these facilities are taking on many of the characteristics of hospital emergency rooms in countries with national health insurance.⁴⁹

As a consequence, rationing problems are becoming acute. According to one study, the wait to see a physician in a typical emergency room ranges from 15 minutes to 17 hours. Another study—of the UCLA Harbor Medical Center—found that almost 10 percent of the patients left before seeing a physician. Of those patients who left and were later located, 45 percent were found to be in "urgent" need of medical attention, and 29 percent needed to be seen by a physician within 24 hours.⁵⁰

Admission to a hospital through an emergency room also is increasingly rationed. According to the National Association of Public Hospitals, the average emergency room wait for a hospital bed in a public hospital is now 5.5 hours. In the worst cases, the wait can range from 3 to 10 days.⁵¹ Public clinics outside hospitals are experiencing similar problems. For example, in the case of a Chicago clinic, a pregnant woman had to wait 125 days for an appointment with a physician.⁵²

⁴⁷Robert S. Stern, Joel S. Weissman, and Arnold M. Epstein, "The Emergency Department as a Pathway to Admission for Poor and High-Cost Patients," *Journal of the American Medical Association* 266, no. 16 (October 23/30, 1991): 2238 ff.

⁴⁸Lisa Belkin, "Why Emergency Rooms Are on the Critical List," *New York Times*, October 6, 1991.

⁴⁹"Do You Want to Die?" *Time*, May 28, 1990, p. 58 ff.

⁵⁰Philip J. Hilts, "Many Leave Emergency Rooms Needing Care," *New York Times*, August 27, 1991.

⁵¹Philip J. Hilts, "Public Hospital Wait for Bed Can Be Days, U.S. Study Says," *New York Times*, January 30, 1991.

⁵²*Chicago Tribune*, November 25, 1990; cited in Emily Friedman, "The Uninsured: From Dilemma to Crisis," *Journal of the American Medical Association* 265, no. 19 (May 15, 1991): 2494.

The Military Medical System and Veterans Hospitals

At \$14 billion a year, the Pentagon's military medical system has been described as "riddled with waste" and poorly managed. Serving nine million active duty personnel, military retirees, and their dependents, special interests within the system are aggressively fighting budget cuts, whereas some project that—in a few years—the military may be spending half as much on health care as on new weapons systems.⁵³

Some have suggested combining the Pentagon's health care system with that of the Department of Veterans Affairs (VA). There are reasons for the military to resist. An investigator for the General Accounting Office told Congress that VA hospitals administer shoddy care and that patient neglect has caused avoidable deaths. In one case, a man lost a leg because he had not been checked regularly. In another case, a bladder cancer victim died because he had not been treated for 45 days. The investigator, Mary Ann Curran, testified that

I examined chart after chart where attending physicians rarely examined patients or did not examine them at all. . . . Nurses allowed patients with life-threatening illnesses to languish for hours, even days without monitoring.⁵⁴

Community Mental Health Clinics

About 600 community mental health centers, built with federal money, were designed to provide free or low-cost services for people who have been released from mental institutions. Yet, according to an inspector general's report, nearly half are not doing so and are catering to paying patients instead. Some experts believe that this failure is contributing to the number of people who are homeless and mentally ill.⁵⁵

⁵³Andy Pasztor, "Military Medical System, Beset by Budgetary Ills and Riddled with Waste, Needs Some Doctoring," *Wall Street Journal*, August 26, 1991.

⁵⁴Investigator Cites Poor Health at Veterans Hospitals," *New York Times*, November 22, 1991.

⁵⁵Philip J. Hilts, "Report Faults Community Mental Health Clinics," *New York Times*, October 6, 1991.

The Politics of Catastrophic Health Insurance

Most health care economists and employee benefits managers strongly encourage policies that leave patients responsible for small bills, while making the insurance company responsible for bills so large that they would financially devastate most families (see chapter 8). But Medicare pays too many of the small bills while leaving the elderly at risk for the very large ones. Medicare currently pays 80 percent of physician fees for a patient who suffers from a headache or a common cold. Yet elderly patients with acute problems requiring hospital stays face increasingly costly bills—not paid by Medicare—which rise with the duration of the illness (see chapter 15).

How can one explain a federal Medicare plan designed so that those with the most severe health problems face the greatest financial burdens? Only one explanation is possible: politics. Consider that, in 1983, about 90 percent of all Medicare beneficiaries spent less than \$1,000 for medical expenses partly covered by Medicare; by contrast, only 0.4 percent of all Medicare beneficiaries had expenses of \$5,000 or more.⁵⁶ Clearly, Medicare is structured for the convenience of the vast majority of patients incurring minor medical expenses, not the small minority facing catastrophic health care bills.

Private Health Insurance

In response to the gaps created under Medicare, a thriving market emerged in Medigap insurance—insurance designed to pay expenses not paid by Medicare. Yet Congress has forced Medigap policies, like Medicare itself, to cover a great many small medical bills while leaving coverage of the large bills discretionary (see chapter 15).

Reagan's First Reform Proposal

During Ronald Reagan's first term, his administration attempted to restructure Medicare to conform to generally accepted insurance principles. Under the proposal, Medicare patients would have incurred greater out-of-pocket expenses for short hospital stays,

⁵⁶About 70 percent of Medicare beneficiaries had medical expenses falling in the range of \$1 to \$999. See U.S. Department of Health and Human Services, *Catastrophic Illness Expenses* (November 1986), Table 3.1 (p. 27).

and the savings would have been used to finance catastrophic coverage for lengthy stays. The proposal went nowhere. It is not hard to understand why. As one political scientist explained it:

White House proposals to enhance health care benefits for catastrophic illness by reducing benefits for short-term care have fallen on deaf ears in Congress. No matter how sensible this trade-off might be on ethical and analytical grounds, it would force Congress to disadvantage the many so that the few should gain.⁵⁷

Reagan's Second Reform Proposal

On February 24, 1987, President Reagan sent another proposal to Congress.⁵⁸ Unlike the administration's original approach, it involved increasing the flow of money under the direct control of politicians. Under the new proposal, Medicare coverage would have been expanded to cover catastrophic costs (in excess of \$2,000) and would have been financed by an increased premium of \$60 per year paid by Medicare beneficiaries.⁵⁹ The proposal was made at a time when there was considerable criticism of Medigap policies, and it was accompanied by the claim that the federal government could provide catastrophic care more cheaply than the private sector. It took Congress no time at all to think of other, more politically popular variations on the proposal.

The Medicare Catastrophic Coverage Act, 1988–89

The approach adopted by Congress became law in 1988 but was repealed one year later in one of the most remarkable legislative turnarounds in this century. Responding to the pressures of the

⁵⁷Allen Schick, "Controlling the 'Uncontrollables': Budgeting for Health Care in an Age of Megadeficits," in Jack A. Meyer and Marion E. Lewin, eds., *Charting the Future of Health Care* (Washington: American Enterprise Institute, 1987), p. 31. Emphasis added.

⁵⁸The details of the proposal are outlined in U.S. Department of Health and Human Services, *Catastrophic Illness Expenses*.

⁵⁹In theory, the coverage offered was to be optional. The \$60 premium would be tacked onto the current premium for Medicare Part B coverage, which is optional for Medicare patients. However, because such coverage is about 75 percent subsidized by general revenues, the option to pay for coverage would have been an offer that few elderly citizens could afford to refuse.

Table 18.3
 PERCENT OF OUT-OF-POCKET MEDICAL EXPENSES PAID BY
 THE ELDERLY IN EXCESS OF \$2,000 PER YEAR

Type of Expense	Percent
Nursing home	81.0%
Hospital	10.0
Physician services	6.0
Dental	1.7
Drugs	1.2

SOURCE: Jon Gabel and Timothy Rice, "Protecting the Elderly against High Health Costs," *Health Affairs* 5 (Fall 1986), p. 12. Cited in the Task Force on Long-Term Care Policies, *Report to the Congress and the Secretary* (Washington: U.S. Department of Health and Human Services, 1987), p. 17.

politics of Medicare, Congress included in the Medicare Catastrophic Coverage Act many items that had nothing to do with catastrophic medical bills. Visible benefits were added, such as respite home health care benefits and coverage for mammograms.

At the same time, Congress avoided addressing the most serious catastrophic problem of Medicare enrollees—the threat of an expensive nursing home stay (see Table 18.3). The catastrophic hospital expenses covered in the bill were benefits that about 85 percent of the elderly were already entitled to under previous health insurance arrangements. Many elderly voters were deluded into thinking that the Medicare Catastrophic Coverage Act would help them with financial burdens created by a medical disaster, such as Alzheimer's disease, when, in fact, the new program barely put a dent in the cost of such care.

The political mistake behind the catastrophic coverage program was the decision to make Medicare beneficiaries pay the full cost of the new program and to make those costs highly visible. That decision enabled each Medicare enrollee to compare personal benefits with personal costs under the program. Once that was done, the program was dismantled even before most of its major provisions had become effective.