

# **Twenty Myths About National Health Insurance**

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## Executive Summary

Countries with national health insurance make health care “free” to patients and at the same time limit spending and access to modern medical technology. As a result, there is widespread rationing, bureaucratic inefficiency and a lower quality of care.

- A citizen of the United States is twice as likely to have open heart surgery as a Canadian and four times as likely as a Briton.
- Although computer scanning (in place of conventional x-ray) is routine diagnostic procedure in the United States, a patient in Ontario can wait as long as a year and four months for an MRI scan.
- Britain, where the CAT scanner was invented, has one of the lowest rates of CAT scanner use in western Europe.

When access to modern medical technology is rationed, who receives care? Mounting evidence suggests that the wealthy, the powerful and the sophisticated find ways of moving to the head of the waiting lines, while the poor, the elderly, racial minorities and rural residents wait longer.

- Studies show that the Inuits (Eskimos) and Crees in Canada and the Maoris in New Zealand receive less health care and have worse health outcomes than other citizens of those countries.
- The most recent studies of kidney dialysis show that more than a fifth of dialysis centers in Europe and almost half in England have refused to treat patients over 65 years of age.
- Studies in almost every country with national health insurance find that low-income families often have less access to care in relation to their need for it than higher-income families.

Almost every developed country with national health insurance has pledged special efforts to create equal access to health care, and these commitments are periodically and publicly repeated. Yet the rhetoric is very different from the reality.

- Despite 40 years of promises to create regional equity, Britain spends least on hospital services in those areas which are most underserved.
- Despite 40 years of promises to create equality of access to health care, spending per person varies by a factor of two to one across the regions of New Zealand, and the number of surgeries performed varies by more than six to one.
- Despite 20 years of promises in Canada, the distribution of physicians per capita among the provinces varies by almost three to one and within Ontario by a factor of more than four to one.

Canadian provincial governments restrict modern medical technology to hospitals, usually in large cities, and actively discourage outpatient surgery. Rural residents must travel to the cities for the services of most specialists and for most surgical procedures. But considering the inconvenience of travel and the fact that specialized services are rationed by waiting, how often do rural residents actually get care? Consider that:

- Total per capita spending on physicians' services among British Columbia's 30 regional hospital districts varies by a factor of six to one, and spending on the services of specialists varies by a factor of 12 to 1.
- Spending varies by a factor of almost 4 to 1 for obstetrical/gynecological (OB/GYN) services, 8 to 1 for the services of internists and 35 to 1 for the services of psychiatrists.

Despite many recent claims, there is little evidence of efficiency in countries with national health insurance. While people wait for months and even years for hospital admission, hospital managers appear uninterested in admitting more patients.

- While more than 50,000 people wait for surgery in New Zealand, at any point in time one in five hospital beds is empty and one in four is occupied by a chronically ill patient using the hospital as an expensive nursing home.
- While more than one million people wait for surgery in Britain, at any point in time about one-fourth of all beds are empty and another one-fourth are being used by nursing home patients.
- While more than 250,000 people wait for surgery in Canada, at any point in time almost one in five hospital beds is empty and a fourth of all beds is being used by nursing home patients.

Although countries with national health insurance frequently proclaim that health care is a right, available regardless of ability to pay, increasingly the reverse is true. Access is often guaranteed only to those with private health insurance or the ability to pay out-of-pocket.

- Although health care is theoretically free to all in Britain, 10 percent of the population has purchased private health insurance, and one-fifth of all elective surgery is performed in the private sector.
- Although health care is theoretically free to all in New Zealand, one-third of the population has private health insurance, and one-fourth of all surgery is performed in private hospitals.
- As Canadian waiting lists for surgery grow, increasing numbers of Canadians are coming to the United States for health care.

The lessons from other countries teach that America would not be well-served by an expansion of government bureaucracy or by any 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 new opportunities to solve our health care problems.

## INTRODUCTION

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, the reforms being adopted seek to replace socialism in medicine with privatization, competition and market incentives.

- In 1989, the British government introduced radical market-based reforms in health care and began to allow private hospitals to compete against public hospitals for National Health Service funds.<sup>1</sup>
- In 1987, the Netherlands introduced a voucher system which allows consumer choice among private and public insurance funds.<sup>2</sup>
- In 1987, Germany introduced a new policy which encourages competition among hospitals.<sup>3</sup>
- More recently, the government of New Zealand has signaled its intent to end 40 years of socialized medicine by giving people tax incentives to purchase private health insurance and by introducing market-based reforms in the public sector.<sup>4</sup>
- Sweden, along with other European countries, has already introduced some “managed competition” into its national health insurance system, and with the recent change of government those reforms will undoubtedly continue.<sup>5</sup>
- In Canada, pressures mount to allow private health insurance options and to institute user fees, and the father of Quebec’s health care system (the oldest national health insurance scheme in Canada) has called for privatization and competition in the supply of health services.<sup>6</sup>
- The Soviet Union’s new health care reform plan calls for decentralization, “enterprise” and the introduction of financial incentives into health care.<sup>7</sup>
- Chile has given its citizens financial incentives to opt out of national health insurance for the last decade, and most other Latin American countries are seeking ways to partially privatize their health care systems.<sup>8</sup>

*"Most countries with national health insurance are searching for market-based reforms."*

*"Despite official promises, national health insurance usually creates special burdens for the poor, the elderly, minorities and rural citizens."*

As 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. Yet in those countries which have adopted 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 report 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 and explaining 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 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. Those unfamiliar with other systems assume that the United States can control health care costs through national health insurance without any loss of benefits or deterioration of quality. In what follows, we briefly discuss this and other common myths about national health insurance.

### **MYTH NO. 1: Countries with national health insurance have been more successful than the U.S. in controlling health care costs.**

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

As we shall see, international comparisons of health care spending are difficult, not least because of differences in measuring techniques. But 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 that 90 percent of the variation in health care spending among developed countries is based on income alone.<sup>9</sup>

This should give pause to anyone who believes that the United States will significantly lower health care spending by adopting the system or institutions of some other country. Apparently, as people have more income, they spend more on health care, whether their spending takes place through the market, the political system or quasi-public institutions.

*"About 90 percent of the difference in health care spending among developed countries is due to differences in income."*

**United States vs. Canada: Growth in Spending.** 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 U.S. 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). Canada's system of national health insurance was implemented between 1968 and 1971. Since then the U.S. has surged ahead. In 1987, the United States spent about 11.1 percent of its GNP on health care, whereas Canada spent only 9.0 percent.<sup>10</sup>

The problem with those 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). As it turns out, the above differences can be almost totally explained by the behavior of the denominator. Over the 20-year period (1967 to 1987), Canada's real GNP per capita grew 74 percent, while the U.S. figure grew only 38 percent.<sup>11</sup> 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.
- 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. (The increase was 4.38 percent in the United States versus 4.58 percent in Canada.)

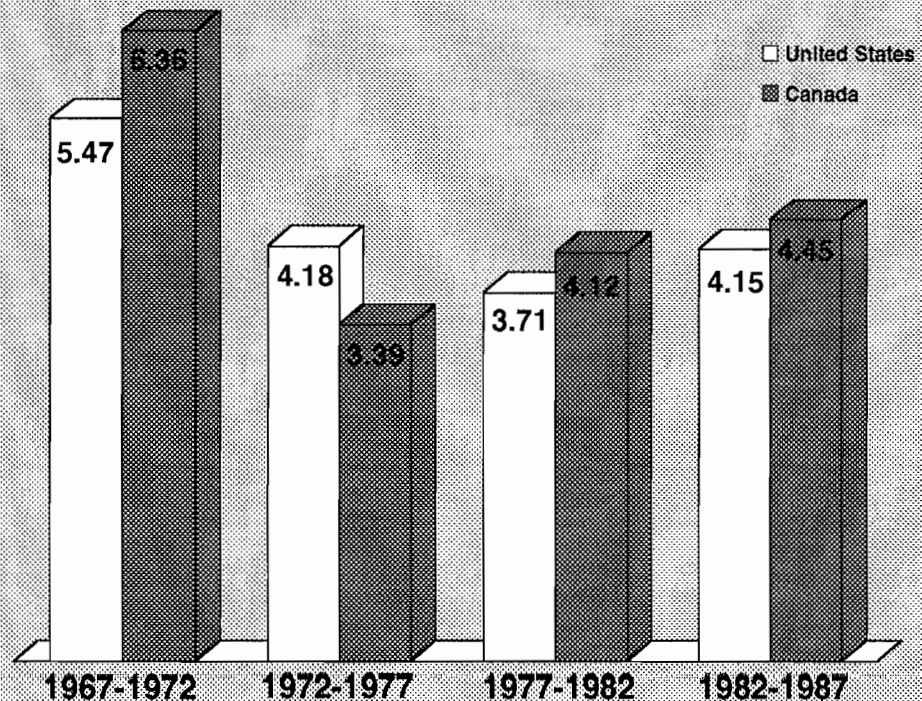
Canada has been no more successful than the United States in controlling health care spending. As Figure I shows, in recent years it has been less successful.<sup>12</sup>

**United States vs. Canada: Levels of Spending.** There are other problems in comparing United States and Canadian health care spending:

- First, the Canadian number doesn't include capital spending to the same extent that the U.S. number includes it.
- Second, the U.S. number includes research and development (R & D) costs. Canada engages in very little R & D spending, while 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 study, correcting for these differences between the two countries cuts the gap in the fraction of GNP spent on health care in half.<sup>13</sup>

*"Health care costs have been increasing faster in Canada than in the United States."*

**FIGURE I**  
**Increase in Real Health Care Spending Per Capita in the United States and Canada**  
Annual Percentage Increase



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

*"Official comparisons of health care spending conceal important differences among countries."*

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 since Canada's public sector is relatively larger than that of the United States, far more of Canada's costs are buried in bureaucratic budgets.

### **United States vs. Canada: Differences in Health Care Needs.**

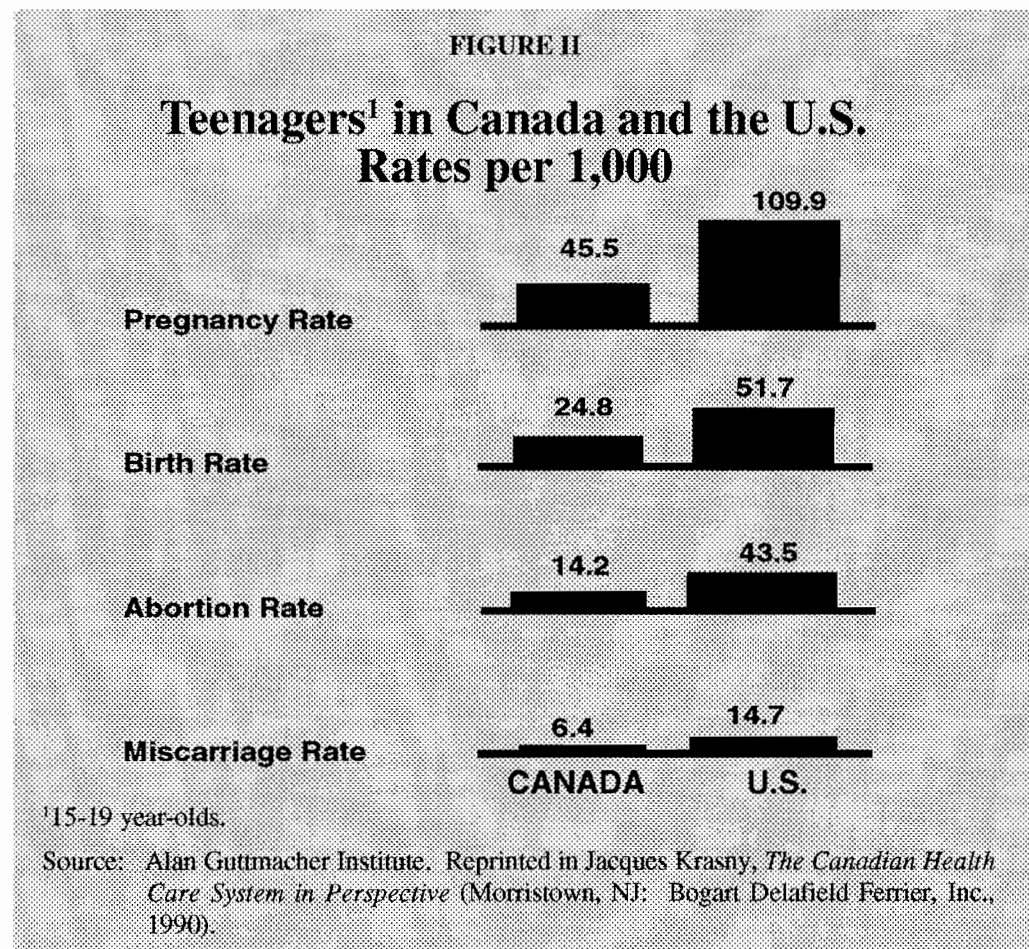
Because of historical and cultural differences between the two countries, the need for health care spending is often higher in the United States than in Canada. For example, the United States has a much higher violent crime rate, heavier illegal drug use and a greater incidence of AIDS — all of which generate more health care spending. According to Leroy Schwartz (Health Policy International):<sup>14</sup>

- 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 incidents 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 due 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 with an average treatment cost of \$63,000 per baby. This problem is negligible in Canada.

The United States also has health care costs related to war injuries (including those of Vietnam veterans), which Canada does not have. And Figure II illustrates another important difference: U.S. teenage women have almost 2 1/2 times the pregnancy rate of teenagers in Canada, 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 other complications, these differences cause higher health care spending in the United States.



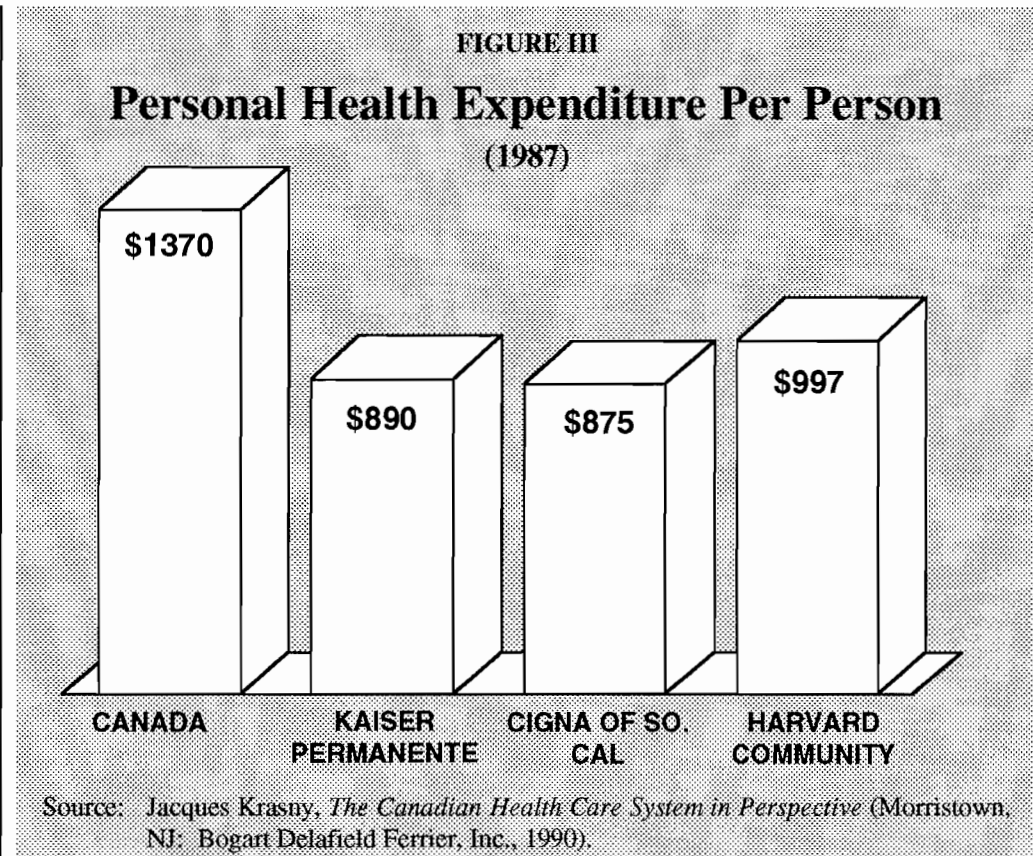
"America's higher rate of teenage pregnancies leads to higher health care costs."



**Other Comparisons.** No one has tried to sort out these differences to arrive at a bottom line. But there is considerable anecdotal evidence that the real cost of U.S. health care may actually be lower than Canada's. For example, hospitals in British Columbia contract with U.S. hospitals across the border in Seattle to perform heart surgery on Canadian patients.<sup>15</sup> There is a similar arrangement between Ontario hospitals and those in Detroit. Canadian hospital managers apparently have concluded they make a "profit" on these transactions, and at the same time reduce the public outcry over long waiting lists.

Another way of comparing the two nations' health care costs is to compare Canada with some of the largest health maintenance organizations (HMOs) in the United States. The "managed care" programs of HMOs, like the cost controls imposed in Canada, demonstrate a commitment to control spending. Moreover, some HMOs are as populous as Canadian provinces. About half of Canada's provinces have a population of one million or fewer people, while seven HMOs in the United States have more than one million. Although people enrolled in HMOs may not be a random sample of the U.S. population, Figure III shows that large HMOs in the United States have lower costs per person than Canada has:

*"America's HMOs control spending better than the Canadian system does."*



- The Harvard Community HMO in Massachusetts spends only 73 percent as much per person as Canada spends.
- Both the Kaiser Permanente and Cigna HMOs spend about 65 percent as much per person.

To summarize, we can draw at least four important conclusions. (1) It is not clear that Canada has done a better job than the United States at controlling health care spending over time. (2) Canada's spending on health care — under both a private and a public system — consistently has been about 75 percent of what the United States spends. (3) Although international statistics show that the United States spends more per capita on health care than Canada, these statistics can be very misleading. (4) There is some evidence that U.S. health care is less expensive when the comparison is made on a more level playing field.

**The United States vs. Other Developed Countries.** In comparing United States health care spending with that of other developed countries, we encounter the same difficulties. In addition, most international statistics on health care spending are produced by the Organization for Economic Cooperation and Development (OECD). Yet because of differences in reporting standards of different countries, OECD statistics are not always reliable.<sup>16</sup>

Table I shows the results of an attempt to develop more accurate health care spending measurements among OECD countries:

- Using more precise measuring techniques, we find that the United States spends more of its income on health care than other countries — but the difference is smaller than people commonly believe.
- During the 1980s, the real growth rate for health care spending was higher in 11 of 15 countries than in the U.S.
- In per capita terms, most countries had real growth rates that were more than double the U.S. rate.

TABLE I

## International Health Care Spending

(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 <sup>1</sup>	Annual Real Growth Per Capita as a Percent of U.S. Rate 1980-1988 <sup>2</sup>
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

<sup>1</sup>The U.S. rate is 2.13 percent.

<sup>2</sup>The U.S. rate is 1.13 percent.

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

*"The real growth rate for health spending was much higher than the U.S. growth rate in 11 of 15 countries."*

Many believe that countries with national health insurance have an “advantage” the U.S. does not. In those countries the government can, in principle, limit health care dollars and tell hospital managers to ration the money they are given. But that power is more apparent than real, and politicians who exercise it risk being replaced by their competitors. In the political systems of other countries, as in the U.S., there is unrelenting pressure to spend more on health care.

**MYTH NO. 2:      Although the United States spends more on health care per capita than countries with national health insurance, Americans do not get better health care.**

This myth is often supported by reference to two facts: that life expectancy is not much different among the developed countries and that the U.S. infant mortality rate is one of the highest among developed countries.

**Mortality Rates and Health Care.** General population mortality rates tell us almost nothing about the efficacy of health care systems 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.

For example, in Sweden, there are striking differences in health outcomes between Stockholm and Hollard, a rural, agricultural area in the nation’s south:<sup>17</sup>

- 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 has seriously claimed that these differences are the result of the Swedish health care system.

In Norway, people in the urban areas of Oslo and Akershus have the most contacts with physicians. But infant mortality in those areas is still higher than in, say, Hordaland in western Norway.<sup>18</sup> In virtually every country, there is a positive relationship between income and health status and between social

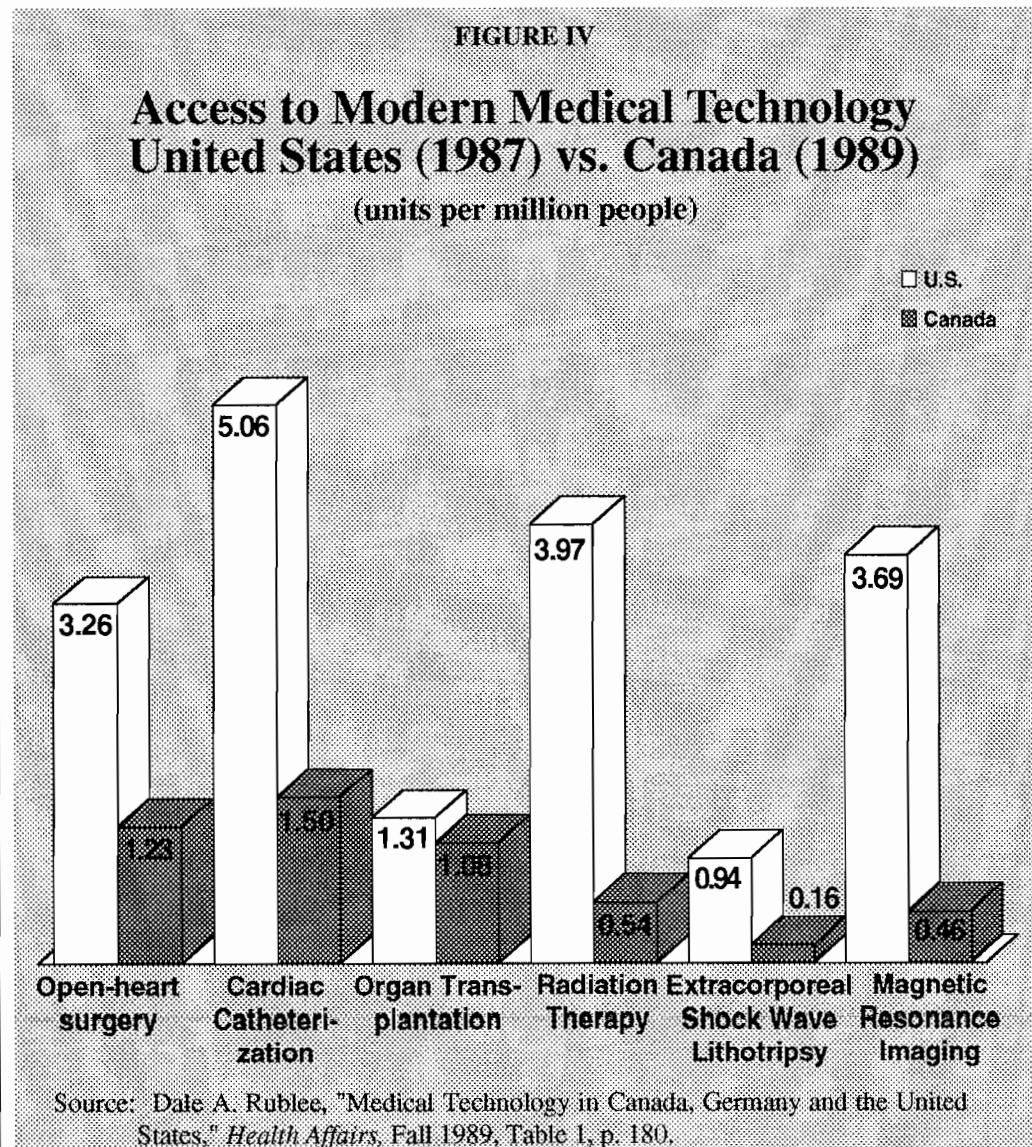
*"In the United States, we spend more, but we also get more."*



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.<sup>19</sup>

**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 modern medicine can affect, however, it makes a big difference where a patient lives. For premature babies, for children born with spina bifida or for people who have cancer, a brain tumor, heart disease or chronic renal failure — the chances of survival are best in the United States.

**Access To Modern Medical Technology in Canada.** Figure IV compares the availability of modern medical technology in the United States and Canada. As the figure shows:



*"American patients have much better access to modern medical technology than Canadian patients."*

*"There are more MRI scanners in Washington state than in all of Canada."*

- On a per capita basis, the United States has eight times as many magnetic resonance imaging (MRI) units — which use magnetism instead of x-rays — as Canada.
- The United States has seven times as many radiation therapy units (to treat cancer) per person.
- The United States also has about six times as many lithotripsy units (to destroy kidney stones and gallstones with sound waves) per person.
- And, per capita, the United States has about three times as many open-heart surgery units and cardiac catheterization units (for the treatment of heart disease).

Note that the figures contrast the United States with Canada two years later. Contrasting the two countries in the same year would reveal an even greater disparity. While critics of the U.S health care system claim that we have too much technology, all the evidence suggests that Canada has too little — as a result of the conscious decisions of government officials. Doctors in British Columbia have taken out full-page newspaper advertisements warning that their patients' lives are endangered by government's refusal 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:<sup>20</sup>

- Seattle, Washington (pop. 490,000) has more computerized axial tomography (CAT) scanners (used, for example, to detect brain tumors) than the entire province of 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 in order to obtain one.
- Because of a shortage of laboratory testing equipment in 1988, women in Newfoundland wait up to five months for a Pap smear (needed to detect cervical cancer) and two months for an "urgent" Pap smear.

- Also because of an equipment shortage, women in Newfoundland waited as long as 2 1/2 months for a mammogram (used to detect breast cancer).
- Women on Prince Edward Island wait from four to eight months for mammograms, and even “emergency” patients can wait as long as one month.

**Access To Modern Medical Technology in Britain.** In an extensive study of Britain’s National Health Service (NHS), Brookings Institution economists estimated the number of British patients denied treatment each year, based on U.S. levels of treatment. Most of the patients suffered from life-threatening diseases and the denial of treatment meant certain death. Table II presents these estimates, along with estimates of what it would cost the NHS to bring British treatment up to U.S. standards. As the table shows:

- Each year, 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 fail to receive the best treatment modern medicine can offer.
- As many as 1,000 British children fail to receive lifesaving total parenteral nutrition (TPN) therapy and about 7,000 elderly patients are denied pain-relieving hip replacements.

TABLE II

### Rationing Care in the British National Health Service

	Number of Patients Denied Treatment <u>Each Year</u>	Added Cost of Treating These Patients <u>(In millions)</u>
<b>Renal Dialysis</b>	9,000	\$140
<b>Cancer Chemotherapy</b>	10,000-15,000	40
<b>Total Parenteral Nutrition</b>	450-1,000	45
<b>Coronary Artery Surgery</b>	4,000-17,000	175
<b>Hip Replacement</b>	7,000	50

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

*"The British system denies treatment to 9,000 kidney patients, and as many as 15,000 cancer and 17,000 heart patients each year."*

**Willingness to Adapt to New Technology.** Some argue that countries with national health insurance delay the purchase of expensive technology in order to see if it works and is cost-effective. If true, the downside of this 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 kidney dialysis, CAT scanning and pacemaker technology. Yet as Table III shows:<sup>21</sup>

**TABLE III**  
**Use of Modern Medical Technology in the 1970s**

	Pacemakers per 100,000 <u>Population-1976</u>		CAT Scanners per Million <u>Population-1979</u>		Kidney Dialysis and/or Transplants per Million <u>Population-1976</u>	
	<u>Number</u>	<u>Rank</u>	<u>Number</u>	<u>Rank</u>	<u>Number</u>	<u>Rank</u>
Australia	7.3	6	1.9	4	65.8	7
Canada	2.3	8	1.7	5	73.4 <sup>2</sup>	5
France	22.6	3	0.6	7	111.3	2
W. 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 <sup>3</sup>	1

<sup>1</sup>As of December 31, 1976.

<sup>2</sup>As of December 31, 1975.

<sup>3</sup>Excludes transplants. With transplants included, the number would be approximately 170.

Sources: Pacemaker data supplied by Eli Lilly Company. CAT scanner data from the National Center for Policy Analysis. Treatment of chronic renal failure data from the Office of Health Economics, *Renal Failure: A Priority in Health?* (London: Office of Health Economics, 1978), Table 7, p. 30. Data on Canada taken 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 provided by the Department of Health, Education and Welfare.

"The United States adopts lifesaving medical technology more rapidly than most other countries."



*"Although Britain invented the CAT scanner and codeveloped renal dialysis, its use of both technologies is one of the lowest in Europe."*

- The rate of implants of pacemakers in the United States during the mid-1970s was more than four times that of Britain and almost 20 times that of Canada.
- CAT scanners in the United States were more than three times as available in the United States as in Canada and almost six times as available as in Britain.
- The treatment rate of kidney patients in the United States was more than 60 percent greater than in Canada and Britain.

There is considerable evidence, however, that cost-effectiveness is not what drives the bias of other governments against modern medical technology:<sup>22</sup>

- CAT scan technology was invented in Britain, and until recently Britain exported (probably with government subsidies) about half the CAT scanners used in the world. Yet the British government has purchased only a handful of the devices for the National Health Service and has even discouraged private gifts of CAT scanners to the NHS.
- Britain also was the codeveloper of kidney dialysis, a lifesaving method of treating patients with chronic renal failure; yet Britain has one of the lowest dialysis rates in Europe.

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 this were true, however, a comparison of Tables III and IV shows that every country had substantially increased the number of patients being treated by 1984, when even East Germany was treating more patients than Britain or Canada had treated eight years earlier.

**The Politics of Medical Technology.** It would be a mistake, however, to think of the current U.S. health care system as ideal. The United States has not always been the first country to adopt new technology (even technology that works and is cost-effective). We do not always purchase the most technology. And we have 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.<sup>23</sup>

TABLE IV

# **Kidney Patients<sup>1</sup> Treated by Dialysis or Transplant**

(December 31, 1984)

<u>Country</u>	<u>Number</u>	<u>Patients Per Million Population</u>
		<u>Rank</u>
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 <sup>2</sup>	1

<sup>1</sup>End stage renal disease.

<sup>2</sup>As of July 31, 1984.

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

"Kidney patients who do not receive dialysis or a transplant presumably die."

How we treat kidney patients was also dictated by government reimbursement policies. Studies show that home dialysis is less expensive than dialysis in a hospital or 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 of 20 developed countries in the percent of kidney patients treated by transplant in 1985.<sup>24</sup>

A more recent technological innovation is extracorporeal shock wave lithotripsy (ESWL) to disintegrate kidney stones and gallstones and eliminate the need for surgery. In 1989, the U.S. rate of lithotripters per capita was exceeded by rates in Germany (where ESWL was invented) and Belgium.<sup>25</sup>

Overall, the best way to think about government policies toward technology is in terms of the politics of medicine. As the role of government expands, health care tends to evolve from a pro-technology phase to an antitechnology phase. In the first stage, government tends to spend on items perceived as under-provided by the market or by conventional health insurance. Thus, practically every less-developed country has used government funds to build at least one modern hospital, usually in the largest city, and to stock it with at least one example of each new technology — even though the vast majority of citizens lack basic medical care and public sanitation.

As government's role in medicine expands, 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, even random, ways in which special interest pressures are exerted. We analyze the politics of medicine in more detail below.

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 where conventional insurance coverage was lacking (e.g., kidney dialysis and organ transplants). It is not surprising that the United States made great use of technological innovations.

Our experience in the future may be very different, however. 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.<sup>26</sup>

*"Because of the politics of medicine, governments have a bias against modern medical technology."*

### **MYTH NO. 3      In countries with national health insurance, people have a “right” to health care.**

*"People waiting for surgery: 25,000 in New Zealand, 250,000 in Canada and more than one million in Britain."*

Virtually every government which has established a system of national health 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 those 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 one hundredth surgery, 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 non-price rationing. Take the health care systems of Britain and New Zealand, for example. In both countries, hospital services are completely paid by government. Both 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 one million.<sup>27</sup>
- In New Zealand, with a population of about three million, the waiting list is more than 50,000.<sup>28</sup>
- In Canada, with a population of about 25 million, the waiting list is more than 250,000.<sup>29</sup>

*"Patients can wait in pain or discomfort for years, and the wait for many is risking their lives."*

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 countries<sup>30</sup> and that only about 4 percent require most of the serious (and expensive) procedures,<sup>31</sup> these numbers are quite high.<sup>32</sup> In New Zealand, for example, there is one person waiting for surgery for every three surgeries performed each year.<sup>33</sup>

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 of 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:

"Patients in British Columbia can wait up to a year for routine procedures."

TABLE V

### Waiting Times in Canada: British Columbia, 1989-1990

<u>Procedure</u>	<u>Average Wait</u>	<u>Longest Wait</u>
Bypass	5.5 mo.	7 mo.
Other open-heart surgery	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.)

- As Table V and Figure V 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.<sup>34</sup>
- All over Canada, patients wait for coronary bypass surgery, while the Canadian press tells of heart patients dying on the waiting list.<sup>35</sup>

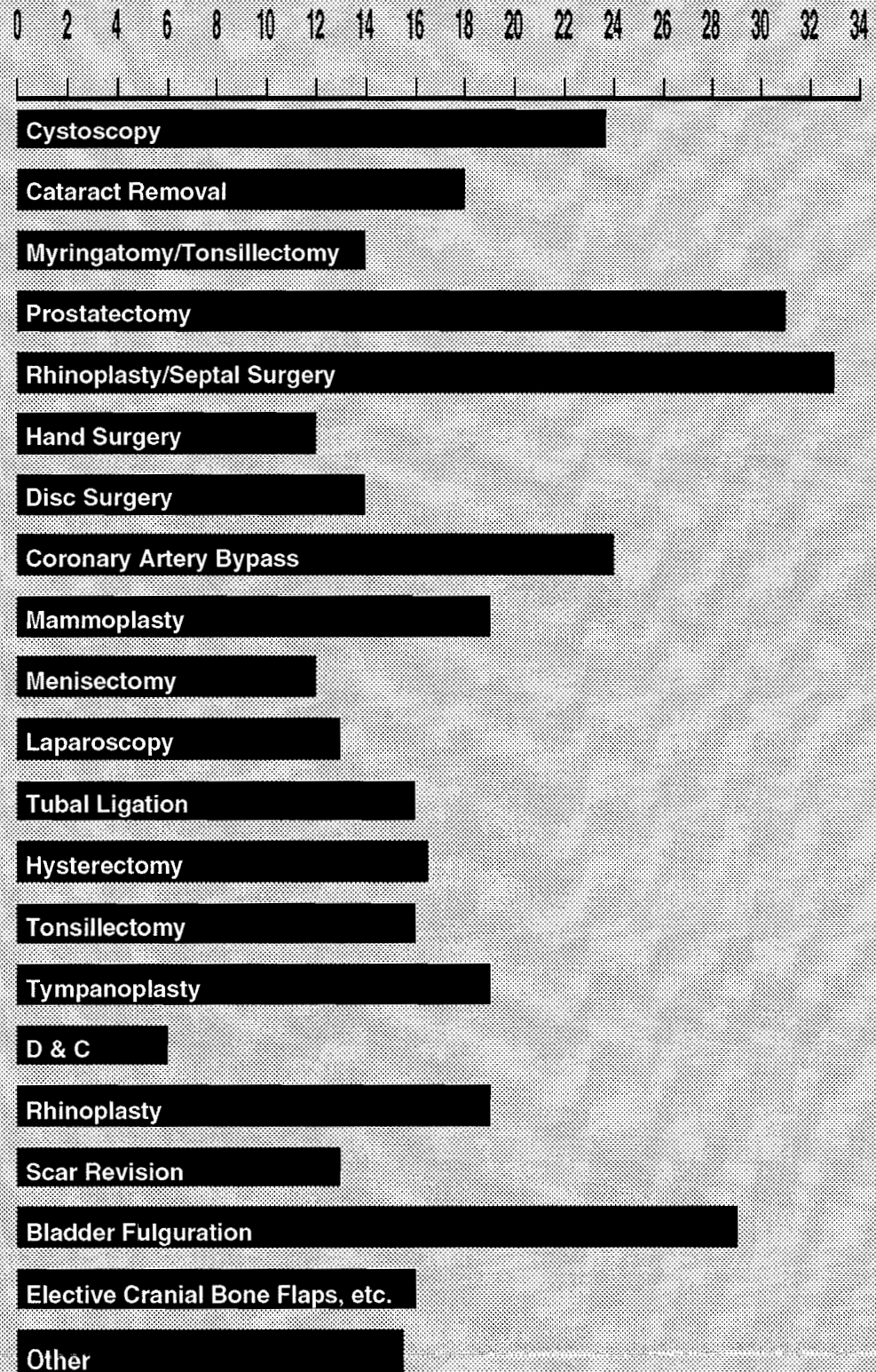
#### **MYTH NO. 4: Countries with national health insurance hold down costs by operating more efficient health care systems.**

The defenders of national health insurance often point to the low level of health care spending in other countries as "proof" of efficient management. Nothing could be further from the truth. By and large, countries that have slowed the growth of health care spending have done so by *denying services*, not by using resources efficiently.



FIGURE V

## Average Waiting Times in British Columbia (Weeks)



*"Canadians wait as long as five months for a Pap smear, eight months for a mammogram and a year and four months for an MRI scan."*

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

*"In Britain, New Zealand and Canada, from one-fifth to one-fourth of all hospital beds sit empty and another 25 percent are used by nursing home patients."*

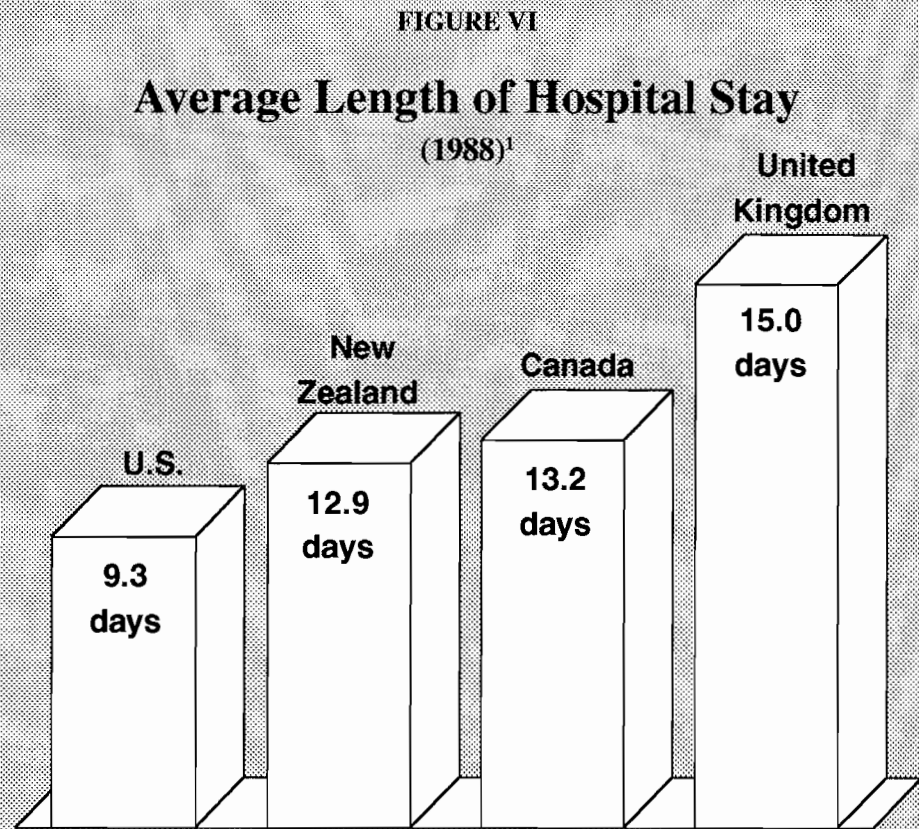
How much does it cost a hospital to perform an appendectomy? Outside the United States, it is doubtful that any public hospital knows. Nor do government-run hospitals typically keep records that would allow anyone else to find out.<sup>36</sup> One reason why Margaret Thatcher called for systematic health care reform was that even Britain's best hospitals did not have computerized 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 are far behind 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 — often the result of the energy and enthusiasm of a few isolated individuals rather than decisions by hospital managements. 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."<sup>37</sup> 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 one in five hospital beds is empty.<sup>38</sup>
- While one million people wait for surgery in Britain, at any point in time about one in four hospital beds is empty.<sup>39</sup>
- 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.<sup>40</sup>

In Canada, hospitalized chronic patients are known as "bed blockers," and they are apparently blocking beds with the approval of hospital administrators — who may believe that such patients, because they use mostly the "hotel" services of the hospital, are less draining to limited hospital budgets.<sup>41</sup>

*"American hospitals are far more efficient in treating and releasing patients than their international counterparts."*



<sup>1</sup>1986 for New Zealand and 1987 for Canada and the United Kingdom.

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 and 5, pp. 27, 29.

One widely used measure of hospital efficiency is average length of stay. In general, the more efficient the hospital, the more quickly it will admit and discharge patients. By this standard, U.S. hospitals are far in front of most of their international rivals.<sup>42</sup> As Figure VI shows:<sup>43</sup>

- 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 among all OECD countries is 76 percent longer than in the United States.

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: In countries with national health insurance, all people have equal access to health care.**

One of the most surprising features of European health care systems is the enormous amount of attention given to the notion of equality and the importance of achieving it. Aneurin Bevan, father of the NHS, declared that “everyone should be treated alike in the matter of medical care.”<sup>44</sup> 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.”<sup>45</sup> The *British Medical Journal* predicted that the NHS would be “a 100 percent service for 100 percent of the population.”<sup>46</sup> The goal of NHS founders was to eliminate inequalities in health care based on age, sex, occupation, geographical location and — most importantly — income and social class. As Bevan put it, “the essence of a satisfactory health service is that rich and poor are treated alike, that poverty is not a disability and wealth is not advantaged.”<sup>47</sup> Similar statements have been made by politicians in virtually every country that has established a national health insurance program.

*"Access to health care in Britain may be as unequal today as it was in 1948 — when national health insurance was adopted."*

**Inequality in Britain.** Such rhetoric rarely relates to the facts. Britain’s ministers of health have long assured Britons that they were leaving no stone unturned in a relentless quest to root out and eliminate inequalities in health care. But, although an unofficial government campaign tried 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 when the NHS was started in 1948.<sup>48</sup> Virtually every scholarly study of the issue has pointed to a similar conclusion.<sup>49</sup> For example:

- One study of health care spending across geographical areas of England found no relationship between any measure of medical need and the amount spent.<sup>50</sup>
- Another study 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 Britain’s lowest social class.<sup>51</sup>

**Inequality in New Zealand.** Other studies have documented widespread inequalities in health care in Sweden,<sup>52</sup> Canada,<sup>53</sup> New Zealand<sup>54</sup> and elsewhere. For example, New Zealand’s health care system is virtually identical to Britain’s and the goal of equal access to health care ranks just as high. Yet as Table VI shows:

TABLE VI  
**Geographical Variations in Health Services  
 in New Zealand<sup>1</sup>**

<u>Measure of Service</u>	<u>Ratio of High to Low</u>
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%

<sup>1</sup>Grouped by Area Health Boards.

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

"The number of surgeries per capita varies by more than six to one among the health regions of New Zealand."

- Among the geographical regions of New Zealand, spending on health care per person varies by a factor of almost two to one.
- Surgeries per capita vary by a factor of 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 is another country that puts a high premium on equality of access to medical care, if the official rhetoric is to be believed. How well have the Canadians done? Table VII compares the amount of spending on the services of physician specialists for two areas in British Columbia: Vancouver, the largest city with a population in excess of one million, and Peace River, a rural area of about 51,000. As the table shows:

- Residents of Vancouver receive about three times more specialist services per person than residents of Peace River, and this inequality holds for both males and females across all age groups.
- The differences are even more striking for specific specialties, with an eight-to-one difference in the services of internists and a 35-to-one difference in the services of psychiatrists.

"Among the health regions of British Columbia, spending on specialists' services varies by as much as 35 to one."

TABLE VII

## Services of Specialists for Residents of Two Areas in Canada

(Spending per person, 1987-88)<sup>1</sup>

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

<sup>1</sup>Includes all physicians' fees for services rendered to residents living in the areas indicated, regardless of the area in which the service was received. Spending figures are age/sex standardized and are expressed in Canadian dollars.

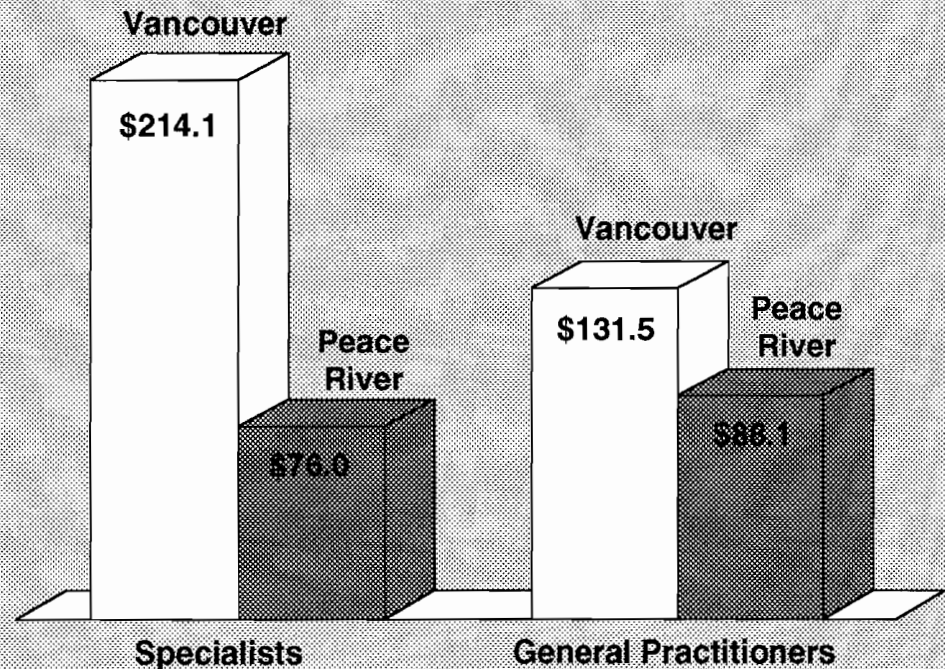
<sup>2</sup>Greater Vancouver Regional Hospital District, British Columbia.

<sup>3</sup>Peace River Regional Hospital District, British Columbia.

Source: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989), pp. 121-176.

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. As Figure VII shows, Vancouver residents also enjoy about 50 percent more GP services.

FIGURE VII  
**Amounts Spent on Physician Services for  
 Residents of Two Canadian Hospital Districts<sup>1</sup>**  
 (Per capita spending, 1987-88)



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

Source: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989), pp. 121-176.

*"Residents of Vancouver receive about three times more special services and 50 percent more services from general practitioners."*

**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 them, enter the hospital less often and spend less time there — when the use of medical services is weighted by the incidence of illness. In Canada<sup>55</sup> and other countries with national health insurance, there is no national waiting list to assure that the sickest people get care first. Even in the same hospital there are instances where elective patients get surgery while those in much greater need are forced to wait.<sup>56</sup> Moreover, anecdotal evidence suggests that the wealthy and powerful do not wait as long as others. As one study of the Canadian system noted:



*"The United States may have gone further in creating access to medical care than any country in the world."*

"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."<sup>57</sup>

Interestingly, among the patients who jump the queue in Canada are Americans who pay out-of-pocket for care. U.S. patients add to hospital revenues, so hospital administrators value them. Since Canadians cannot legally pay for care at a national health insurance hospital, the typical Canadian patient must wait in line.<sup>58</sup>

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 in any other country. Being on Medicaid usually means access to all the technology of the U.S. health care system; such technology is more available in the United States, and Medicaid will usually pay for it. Even though Medicaid rationing is becoming more prevalent, the U.S. probably has far less rationing than most other countries.

International opinion surveys show that, in the U.S., 7.5 percent of people say they do not receive needed care for financial reasons compared to only 0.6 percent in Canada and 0.1 percent in Britain. 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, lack of transportation, etc.<sup>59</sup>

It is not clear what these responses mean. In the United States we more frequently ask people to choose between money and health care. In Britain and Canada, people more frequently must choose between health care and other (rationing) costs. We do not know if those surveyed would have obtained health care if they had perceived their medical needs as being more urgent, but that must often 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.<sup>60</sup>

A different way of comparing the United States and Canada is to look at medical care received by income group. As Table VIII shows, the differences are not that great. Low-income Canadians make more trips to physicians, but low-income Americans are slightly more likely to spend time in a hospital.

*"Low-income families use more health care services in both the United States and Canada."*

TABLE VIII

## Access to Medical Care in the U.S. and Canada

### Percent of Citizens Hospitalized One or More Times in the Last Year<sup>1</sup>

	<u>U.S.</u>	<u>Canada</u>
Low-Income <sup>2</sup>	23%	22%
Middle-Upper Income	13%	12%

### Average Number of Physician Visits<sup>1</sup>

	<u>U.S.</u>	<u>Canada</u>
Low-Income <sup>2</sup>	6.7	8.7
Middle-Upper Income	6.6	5.5

<sup>1</sup>Data are age-adjusted for comparison.

<sup>2</sup>Income less than \$15,000.

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

In every country, some people slip through the social safety net. But for the most part, the United States has already made considerable progress toward 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 United States may have gone further in removing 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 other countries that ration health care 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. There is considerable evidence, however, that in the face of health care rationing those who can pay find other ways to obtain health care.

In response to severe rationing by waiting, both Britain and New Zealand have a growing market in private health insurance — where 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.

*"Canadians increasingly enter the United States to get care they cannot get at home."*

- In Britain, the number of people with private health insurance policies has more than doubled in the last ten years, currently totaling about 10 percent of the population with about one in every five elective surgeries performed in the private sector.<sup>61</sup>
- 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.<sup>62</sup>

Since Canada does not allow private health insurance, if Canadians go to the less than 1 percent of the private physicians or less than 5 percent of private hospitals, they must pay the full bill out-of-pocket.<sup>63</sup> An exception is the small number of outpatient surgery clinics operated by entrepreneurial physicians. Government will pay the surgeon's fee but not other costs. Canadians who receive cataract surgery on an outpatient basis, for example, must pay from \$900 to \$1,200 out of pocket.<sup>64</sup>

In addition, Canadian citizens are increasingly entering the United States to get health care they cannot get at home. In some cases, the Canadian province pays the bill. In other cases, patients spend their own money.<sup>65</sup> In either event, patients must bear the costs of travel. For example:

- About 100 Canadian heart patients go to the Cleveland clinic each year because they cannot get timely treatment in their own country.<sup>66</sup>
- 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), and Alberta has indicated it will accept a similar arrangement.<sup>67</sup>
- 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.<sup>68</sup>
- Because of the inadequate facilities in Canada, about half of the *in vitro* fertilization patients at the University of Washington Medical Center are Canadians, paying \$5,000 out of pocket for each procedure.<sup>69</sup>

In general, the Ontario government will pay 75 percent of the standard U.S. hospital charges and the same physician's fee it would have paid had the service been provided in Ontario. Apparently, many American 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:<sup>70</sup>

- In 1990, the Ontario Health Insurance Plan paid about \$214 million to U.S. doctors 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.

### **MYTH NO. 7: Countries with national health insurance maintain a high quality of health care.**

Americans repeatedly have been told that the quality of care in Canada has not suffered because of national health insurance. Yet there are increasing reports by doctors 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 doctor'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 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."<sup>71</sup>

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 in order to make room for Stevens.<sup>72</sup>
- Charles Coleman, a 64-year-old man, died shortly after a heart operation at Toronto's St. Michael's Hospital. Coleman's operation had been postponed 11 times.<sup>73</sup>

*"A Canadian patient died after his heart operation had been postponed 11 times."*



*"At one Canadian hospital, patients were kept in hallways and even in closets."*

- 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 1/2 hours contacting 14 hospitals in an effort to secure emergency surgery and an available intensive care bed. By the time she arrived at Ontario's York County Hospital, it was too late. She died that night.<sup>74</sup>
- 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 Joel would be moved to the top of the waiting list. After a four-hour ambulance ride to a hospital which lacked an available bed, the family had to spend the night in a hotel. The next day Joel Bondy died.<sup>75</sup>

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.<sup>76</sup>
- At Winnipeg's Health Science Center, Manitoba's largest hospital, six heart patients died in 1988 before they reached the operating room.<sup>77</sup>
- 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.<sup>78</sup>
- In January 1989, long waiting lists forced Toronto's highly respected Hospital for Sick Children to send home 40 children who needed heart surgery.<sup>79</sup>
- At Moncton Hospital in New Brunswick, some patients were kept in hallways and even in closets, while 2,300 people were on the waiting list for surgery.<sup>80</sup>
- 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 handle only women who needed an immediate diagnosis.<sup>81</sup>

- In September 1989, Princess Margaret Hospital in Toronto announced it would not accept new cancer patients requiring radiation therapy for a six-week period in order to clear up a 300-patient backlog.<sup>82</sup>
- In 1990, the only hospital doing cardiovascular surgery in northern Alberta had 210 adults and children on its waiting list — with some patients waiting as long as a year.<sup>83</sup>
- In 1989, doctors at Brandon General Hospital said bed closings had left 91 patients, including cancer victims, waiting up to six weeks for urgent surgery. Most of the patients had cancer of the breast, bowel or lungs.<sup>84</sup>
- In 1989, the Health Minister of Newfoundland announced the closure of more than 400 beds due to lack of funds — one-eighth of all beds in public general hospitals in the province.<sup>85</sup>
- 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.<sup>86</sup>

#### **MYTH NO. 8: Countries with national health insurance eliminate unnecessary medical care.**

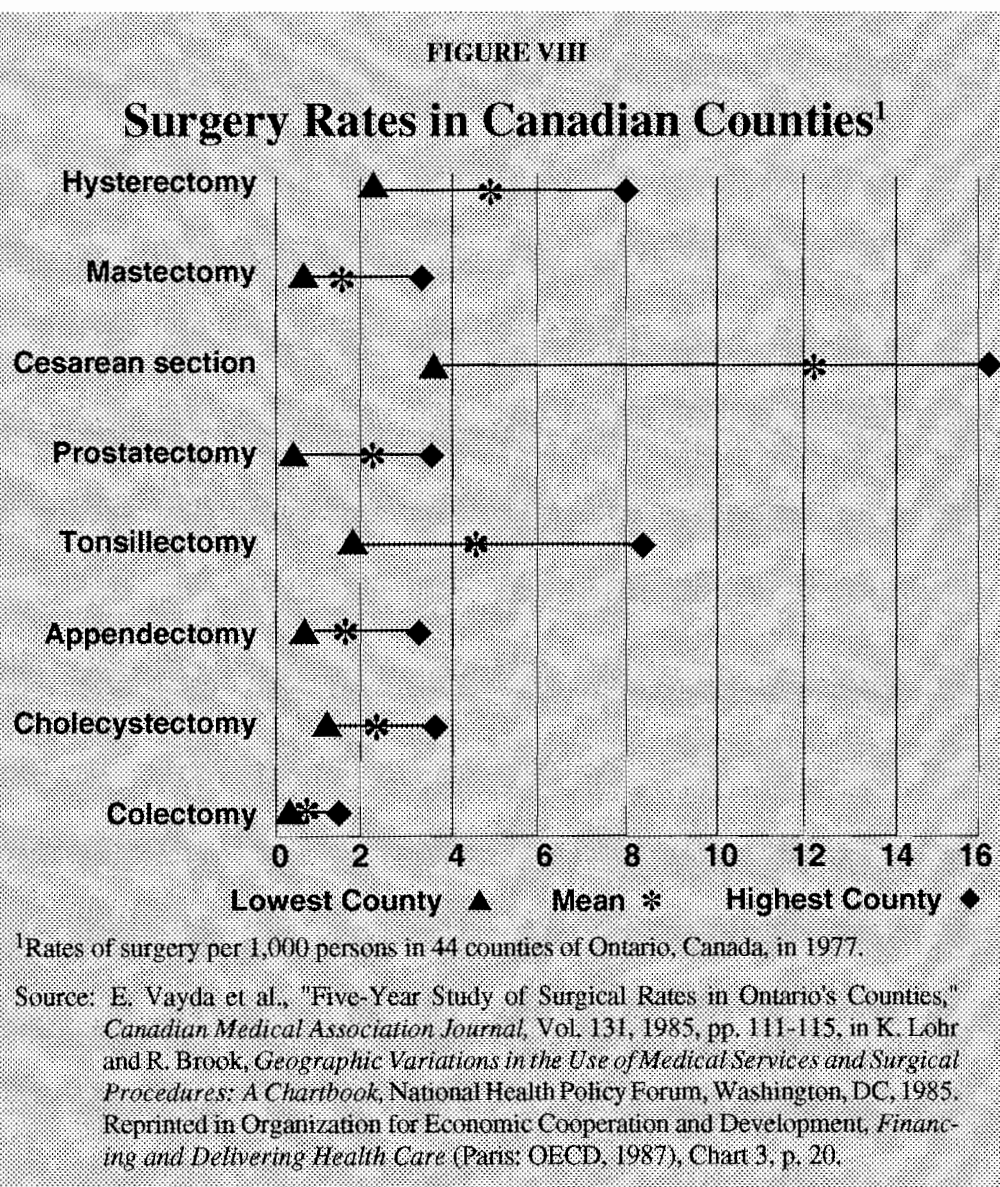
*"The number of prescriptions per patient and referrals to specialists differs by at least four to one among British general practitioners."*

A frequent criticism of the U.S. health care system is that it is wasteful because a considerable number of procedures are "unnecessary." For example, Dr. Robert Brook of the Rand Corporation maintains that "perhaps one-fourth of hospital days and two-fifths of medications could be done without."<sup>87</sup>

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, with no apparent justification. Another major study, conducted by the Rand Corporation, concluded that 40 percent of medical procedures were "inappropriate" or "questionable."<sup>88</sup>

One might suppose that in countries where health care is rationed and many medical needs are unmet, doctors would tend to provide only "necessary" care. That turns out not to be the case. As in the United States, considerable variation in treatment rates exists. For example, in Britain there are

"There is a four-to-one difference among Canadian counties in the rate of cesarean sections."

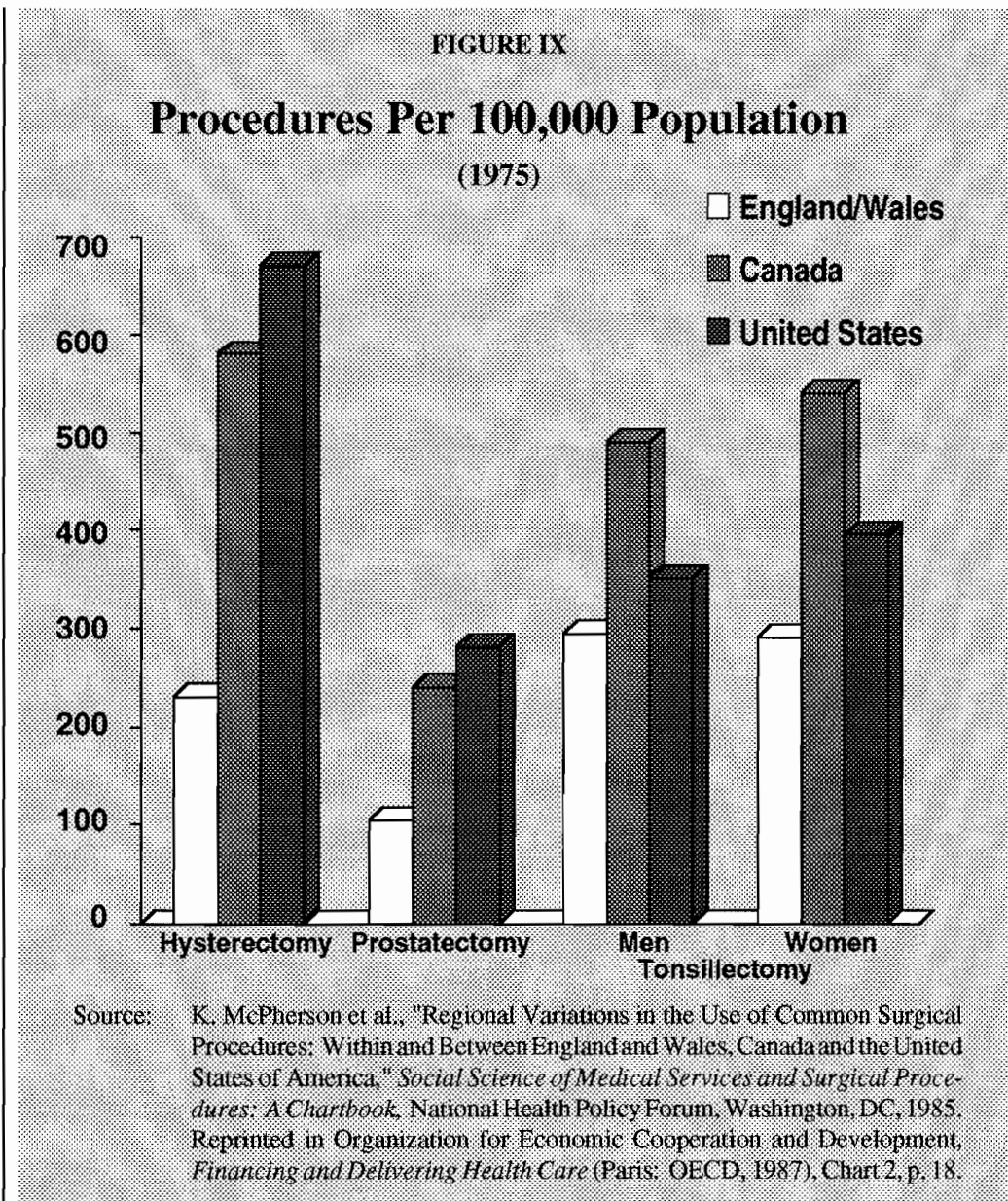


widespread differences in the referral (to specialists) rates of general practitioners and in their prescribing habits:

- One study found a four-to-one difference in the number of prescriptions per patient among British doctors, and for prescriptions to treat specific diseases the differences were even greater.<sup>89</sup>
- The difference in the rate at which British general practitioners refer patients to hospital specialists varies by at least four to one — according to one study by 25 to one — and there is a high correlation between referrals and subsequent hospital admissions.<sup>90</sup>

Figure VIII shows that the practice patterns of physicians vary widely in Canada as well. For example:

"There are wide differences among countries, as well as within countries, in rates of surgical procedures."



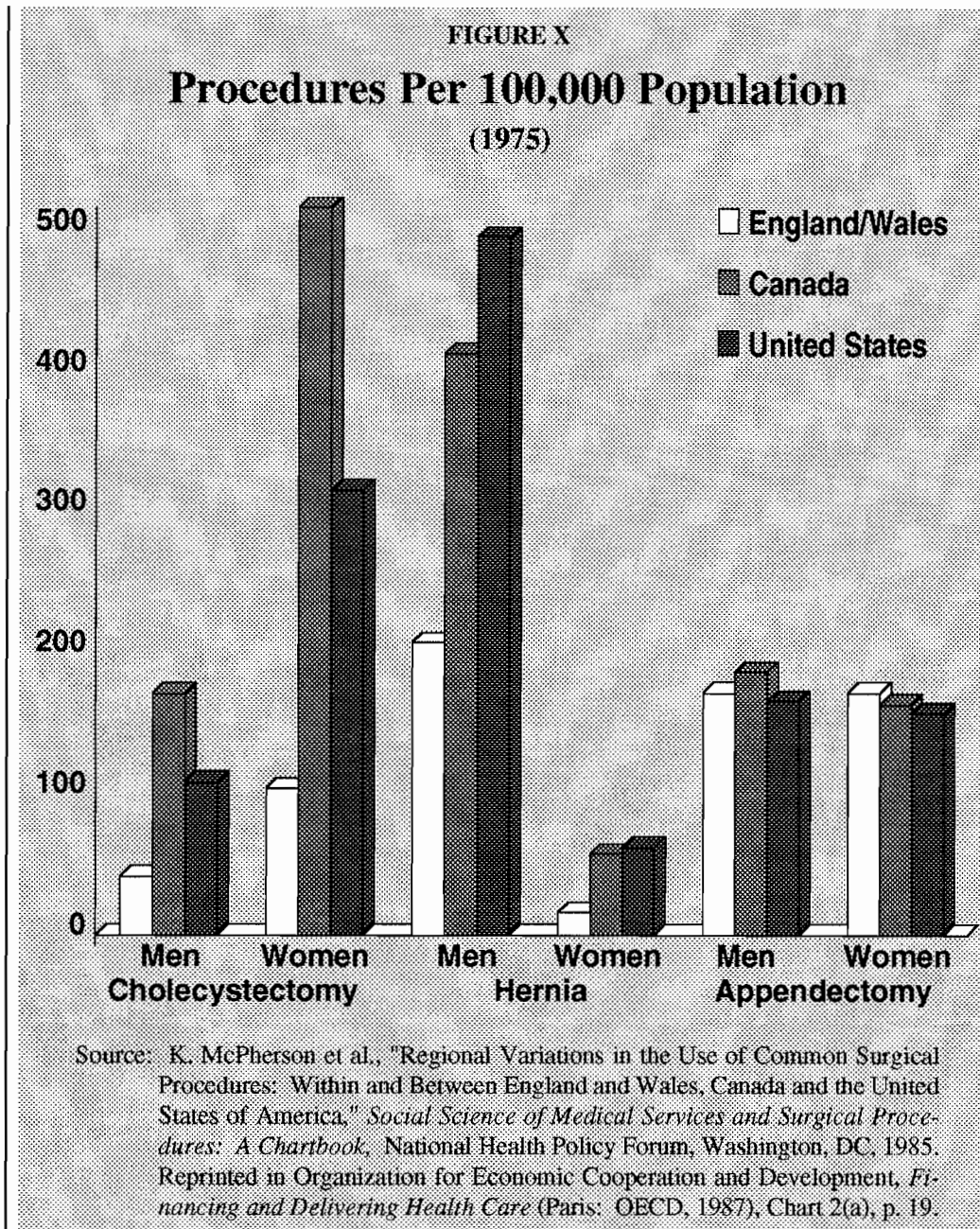
- There is a four-to-one difference among Canadian counties in the rate of cesarean sections.
- There is a four-to-one difference in rates of tonsillectomy and hysterectomy and a two-to-one difference in the rates of mastectomy, prostatectomy and cholecystectomy.

Figures IX and X compare the rates for surgeries over which doctors exercise a great deal of discretion. There is no common pattern except that British rates are generally lower — as they are for almost all types of surgery.

Close inspection of the Rand study reveals the major reason why there are such variations in medical practice in the United States: doctors frequently do not agree on what should be done and there is often no objective, "right"



*"One reason why surgery rates differ so much: medicine is more of an art than a science."*



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.<sup>91</sup> Medicine, it seems, is often more art than science.

Interestingly, the panel did agree that 12 percent of the time certain procedures were clearly inappropriate. 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 insure high-quality care. Most countries with national health insurance have done little along these lines.<sup>92</sup>

**MYTH NO. 9: National health insurance would reduce the administrative costs of the U.S. 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 get administrative costs as low as possible but to make the system as a whole perform as efficiently as possible.

A similar observation holds for marketing and other costs of competition. Money could be saved by, for example, abolishing all car dealerships and all advertising by auto producers. 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. But the end result would be decreased efficiency and less consumer satisfaction. If socialism worked, the economies of communist countries would not have collapsed.

A number of studies have claimed to show that the administrative costs of the Canadian system are well below those in the United States.<sup>93</sup> One problem with these studies is that government accounting techniques invariably underestimate the real cost of government provision of goods and services.<sup>94</sup> A more basic problem is that the studies look only at one aspect of administration (e.g., administrative salaries, costs of paperwork, etc.) while ignoring the effects of administration (e.g., 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 can not legitimately calculate administrative savings in the system without including the adverse effects on patients.

Moreover, many administrative costs in the U.S. system exist not merely to oversee the exchange of money between suppliers and third-party payers, but also to prevent inappropriate care and maintain quality. Even if the United States adopted a program of national health insurance, it is unlikely that we would follow the Canadian practice of giving hospitals global budgets and forcing physicians to ration care with few questions asked.

*"In the United States, we make a much greater effort to ensure that medical care is appropriate."*

### **How the U.S. Tax System Encourages High Administrative**

**Costs.** The administrative costs and paperwork burdens of our system are much too high. That is a consequence not of private provision of health care but of federal policy. Under our tax system, employees (through their employers) can spend unlimited amounts on third-party health insurance. At the same time, any funds employees set aside as self-insurance for small medical bills face a 28 percent income tax, a 15.3 percent FICA tax and, usually, a 4, 5 or 6 percent state and local income tax.<sup>95</sup>

As a result of federal tax policies, most employees are overinsured — using third parties to pay for routine checkups, diagnostic tests and other small medical bills. Not only does too much insurance encourage people to be wasteful consumers in the medical marketplace, it also adds to administrative costs:

- Studies show that physicians spend about \$8 to process a single insurance claim.<sup>96</sup>
- Most third-party payers spend another \$8 for every check they write, and if the insurer makes an additional effort to verify the claim, the costs can be much higher.
- Thus, a \$25 physician's fee can easily become \$50 of total costs when third-party payment is involved — effectively doubling the cost of health care.

### **Reducing Administrative Costs With Medical Savings Ac-**

**counts.** A different approach is used in Singapore, where people are required to deposit 6 percent of their salaries each year in personal medical savings accounts, called Medisave accounts. When Singapore residents are hospitalized, they pay the bills from their Medisave funds and avoid many of the administrative burdens of health insurance.<sup>97</sup>

If the U.S. government gave as much tax encouragement to self-insurance through Medisave accounts as it now gives to third-party insurance for the employers and employees of large companies, the administrative costs of U.S. health care could be cut in half.

*"Using third-party payers to pay small medical bills can double the cost of health care."*

"It is unlikely that the United States will follow the Canadian practice of forcing doctors to ration care with few questions asked."

TABLE IX

## Estimates of the Economic Effects of Adopting the Canadian System in the United States

(\$ billions)

	Lewin/ICF	Physicians for a National Health Program	General Accounting Office
<b>Change in Administrative Costs:</b>			
Insurance Overhead	-\$22	-\$27	-\$34
Physician Administrative Expenses	-1	-9	-15
Hospital Administrative Expenses	<u>-11</u>	<u>-31</u>	<u>-18</u>
Total	-\$34	-\$67	-\$67
<b>Expansion of Coverage for the Currently Insured (Based on Rand estimate)<sup>1</sup></b>			
	+\$54	+\$54	+\$54
<b>Expansion of Coverage for the Currently Uninsured (Based on Rand estimate)</b>			
	<u>+\$19</u>	<u>+\$19</u>	<u>+\$19</u>
<b>TOTAL EFFECT</b>	<b>+\$39</b>	<b>+\$6</b>	<b>+\$6</b>

<sup>1</sup>Based on GAO estimates for increased hospital spending and GAO estimates increased to reflect the Rand results for physician spending.

Sources: General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, June 1991, pp. 62-67; L.S. Lewin and J. Sheils, *National Health Spending Under Alternative Universal Access Proposals* (Washington, DC: Lewin/ICF, October 26, 1990), prepared for the AFL-CIO; and K. Grumbach et al., "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," *Journal of the American Medical Association*, Vol. 265, No. 19, May 15, 1991, pp. 2549-2554.

- 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 between 1 and 2 percent.
- There is no economic reason why we could not 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.<sup>98</sup>



*"Paying medical expenses with health care debit cards would cut administrative expenses by more than 90 percent."*

**Health Care Debit Cards.** A general system of Medisave accounts would lead naturally to the use of health care debit cards. Patients could, for example, pay for physician visits by using their cards just as people now pay for merchandise at retail stores. Several health care debit card companies already exist, including Pulse Card, headquartered in Kansas City, Kansas, and Security Plus, headquartered in Newport Beach, California.<sup>99</sup>

Health care debit cards could be combined with another technological innovation to reduce other costs and improve the quality of care. Several companies are experimenting with technology that would put a patient's entire medical record on a credit card.<sup>100</sup> This would allow physicians immediate access to each patient's complete medical history. Putting medical records on a credit card could be costly. But it might be less costly than the current system under which physicians treat patients about one-third of the time without access to their records.<sup>101</sup>

**The Benefits of the Canadian System Without the Costs.** Advocates of the Canadian system of national health insurance cite two principal benefits: (1) patients entering the health care system need produce only a national health insurance card in order to receive care, and (2) the administrative costs of the system are lower because the paperwork is reduced and other costs — such as marketing — are eliminated. Fortunately, the United States can enjoy these advantages, without the disadvantages of the Canadian system.

Table IX shows three estimates of how much U.S. administrative costs could be reduced by adopting the Canadian system. The estimates range from a Lewin/ICF estimate of \$34 billion to a General Accounting Office (GAO) estimate of \$67 billion. As noted above, we believe these estimates are too high.<sup>102</sup> But they may serve as an indicator of potential administrative savings — to the degree medical bills are paid with health care debit cards.

Table IX also shows the additional cost in the United States of making health care absolutely free at the point of consumption as it is in Canada. The estimates are based on the GAO's interpretation of a Rand Corporation study, which found that making medical care free greatly increases the amount consumed — even though the additional consumption has little impact on the patients' health. As the table shows, the additional cost of making health care free for everyone more than offsets even the most optimistic estimate of administrative savings.

We used the GAO method to estimate the potential reduction in administrative costs under a system of Medisave accounts and health care debit cards, and the Rand Corporation's method to estimate the likely reduction in

health care spending if people had high-deductible health insurance. Table X shows the probable effects of a generalized system under which everyone (including Medicaid and Medicare patients) has third-party catastrophic insurance and uses health care debit cards to draw on individual Medisave accounts for small medical bills. As the table shows:

- The widespread use of Medisave accounts would reduce administrative costs by as much as \$33 billion.
- Because high deductibles would make patients more prudent purchasers of health care, total spending would go down by as much as \$147 billion.
- Overall, universal catastrophic health insurance combined with Medisave accounts would reduce total spending by \$168 billion — almost one-fourth of what the United States currently spends on health care.

TABLE X

### Economics Effects of Combining Universal Health Insurance with Medisave Accounts and Health Care Debit Cards

(\$ billions)

<u>Adjustment</u>	<u>Change in Costs</u>	
	<u>Low Estimate</u>	<u>High Estimate</u>
<b>Savings in Administrative Costs:<sup>1</sup></b>		
Insurance Overhead	- \$8	- \$17
Physician Administrative Expenses	- 5	- 10
Hospital Administrative Expenses	- 3	- 6
<b>Total</b>	<b>- \$16</b>	<b>- \$33</b>
<b>Coverage for the Currently Uninsured<sup>2</sup></b>	<b>+ 12</b>	<b>+ 12</b>
<b>Behavioral Response<sup>3</sup></b>	<b>- 90</b>	<b>- 147</b>
<b>Total Effect</b>	<b>- \$94</b>	<b>- \$168</b>

<sup>1</sup>Based on GAO estimates of the potential savings in administrative costs with the following adjustments: for high estimate, one-half of savings attained in reduced insurance overhead, two-thirds of savings attained in reduced physician administrative costs and one-third of savings attained in reduced hospital administrative costs; for low estimate, one-half of those amounts. See GAO, *Canadian Health Insurance*, Table 5.1, p. 63.

<sup>2</sup>Based on GAO and Lewin/ICF estimates. See J. Needleman et al., *The Health Care Financing System and the Uninsured* (Washington, DC: Lewin/ICF, April 4, 1990). Prepared for the Health Care Financing Administration.

<sup>3</sup>Based on Rand estimates. For high estimate, 23 percent reduction in total health care costs excluding insurance overhead, research and public health expenditures. For low estimate, spending is reduced by 45 percent for physicians and 10 percent for hospitals.

*"The United States could cut health care costs by one-fourth by using insurance only for large expenses and using health care debit cards to pay for small ones."*

# **MYTH NO. 10: National health insurance would benefit America's 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. Take chronic kidney failure, for example:<sup>103</sup>

- 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, 35 percent of the dialysis centers refused to treat patients over the age of 55, 45 percent refused to treat those over 65 and those over 75 only rarely received treatment.

Table XI, 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. Since our kidneys do not get better with age, these treatment rates undoubtedly reflect rationing decisions rather than medical need.

*"Countries that ration health care almost always discriminate against the elderly."*

TABLE XI

## **Treatment for Kidney Failure**

(New patients per million population, 1978)

	<u>Germany</u>	<u>France</u>	<u>Italy</u>	<u>United Kingdom</u>
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. XVI. Reported in *End Stage Renal Failure* (London: Office of Health Economics, 1980), pp. 3 and 6.

Second, the more limited the resources, the worse the degree of discrimination against the elderly. For example, for the population as a whole 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:<sup>104</sup>

- Per capita, 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.

*"A 75-year-old has four times more opportunity to receive bypass surgery if he lives in the United States rather than in Canada."*

How serious is the problem of the denial of lifesaving medical technology to elderly patients overall? 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. This is 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 hospitals or doctors do. In the United States, for example, some believe that as many as 75 percent of all deaths are directly related to lifestyle.<sup>105</sup>

Despite these caveats, if the life expectancy of any 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 consistent with the proposition that the elderly have the most to lose by nonprice rationing of medical care.

If non-price rationing results in discrimination against the elderly, then they ought to do better in those countries which spend more on health care — and thus have less of a rationing problem. In order to test this proposition, one recent study compared life expectancy at age 80 among OECD countries. The study found that:<sup>106</sup>

- 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 all OECD countries, an 80-year-old male can expect to live a half-year longer in the United States, and an 80-year-old female can expect to live almost a year longer.

- There is very little relationship between health care spending and life expectancy at birth, which tends to correlate with per capita GDP.
- However, 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. 11      National health insurance would benefit racial minorities.**

Critics of the U.S. health care system often point to the disadvantages faced by minorities. On the average, African-Americans and Hispanic-Americans are less likely 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 worse under systems of nonprice rationing than they do in a marketplace where prices allocate resources.<sup>107</sup> What little evidence we have about health care rationing in the United States is consistent with experience in other fields.

Take the rationing of organ transplants, for example. According to the United Network for Organ Sharing, whites received 97.6 percent of the pancreases and high percentages of livers, kidneys and hearts in 1988.<sup>108</sup> 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 and only 8.8 months for whites.<sup>109</sup> 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.<sup>110</sup>

There have been very few studies of how racial minorities fare under national health insurance in other countries. In a recent study of the Inuits and Crees of northern Quebec, both groups had much less access to health care than Caucasians in southern Quebec and in other areas of Canada — despite their much greater health needs. For example:<sup>111</sup>

- The age-adjusted mortality rate for Inuits 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 Inuits.

*"Infant mortality rates are three times greater than for the rest of Quebec among the Crees and four times greater among the Inuits."*



- Life expectancy at birth in 1978 was only 58.9 years for Inuit males (compared to a Canadian average of 72 years) and 61.6 years for Inuit females (compared to a Canadian average of 79 years).<sup>112</sup>

About 45 percent of the aboriginal people of Ontario live in the rural, northern part of the state. And, as in the case of Quebec, the northern counties are underserved.<sup>113</sup>

- In 1986, there were no specialists in allergies and immunology, geriatrics, infectious diseases and pediatric surgery in all of northern Ontario.
- There was only one specialist in dermatology, endocrinology, nephrology, neurology and rheumatology.

When national health insurance was adopted in 1969, Ontario also adopted a program to encourage physicians to move to rural areas — one of the longest running programs of its kind in the world. Yet a recent study 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.”<sup>114</sup>

New Zealand also has both a significant minority population (the Maori) and a comprehensive system of socialized medicine. One study reported that:<sup>115</sup>

- New Zealand’s Maoris have an infant mortality rate 60 percent higher than non-Maoris.
- Life expectancy for Maori males and females is, respectively, 7 and 8 years lower than for other New Zealanders.
- Only 20 percent of these differences can be explained in terms of socioeconomic factors.

There is also evidence that the Maoris get significantly less health care — especially in relationship to the need for it — than other New Zealanders. For example:<sup>116</sup>

- Death from coronary artery diseases is significantly higher among Maoris — 3.5 times as high, for example, among females age 25 to 44.
- Yet Maoris receive only a tiny fraction of the coronary artery bypass operations — well below their percentage of the population.

*"Although they have a higher incidence of heart disease, the Maoris of New Zealand receive many fewer heart operations."*

**MYTH NO. 12: National health insurance would benefit residents of rural areas.**

Little is known about who gets care and who does not under non-price rationing schemes. Britain is one of the few countries that even publishes hospital waiting lists by region and for the country as a whole. Yet in England, as in other countries with national health insurance, rationing decisions are made by doctors and hospital personnel at the local level, and there is no national procedure to guarantee that those in greater 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.<sup>117</sup> What is true of Norway is probably also true of other developed countries. For example:<sup>118</sup>

- The number of British kidney patients receiving dialysis or a transplant in 1989 averaged 305 people per million population in the four metropolitan areas in and around London.
- The number was only 239 in the northern region of Yorkshire and 174 in the western region of West Midlands.

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.<sup>119</sup> The most serious form of rationing is rationing of access to modern medical technology. Often this technology is available only at major hospitals in large cities. This 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.

*"Health care rationing almost always penalizes rural residents."*

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 non-price 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 each year physicians receive tips equal to about 40 percent of their official total income.<sup>120</sup> In Japan an illegal “gift” of \$1,000 to \$3,000 can get a patient admitted sooner and insure treatment by a senior specialist at a Tokyo University hospital.<sup>121</sup> In most countries, rural residents probably know less about the mechanics of currying physicians’ favors.

**Rural Patients in Britain.** The most important philosophical principle advocated by those who established the British National Health Service was equal access to health care. Yet as we noted above, inequalities across England persist 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.<sup>122</sup>

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, the British government tends to spend the most in the metropolitan areas where private sector alternatives are most abundant.

Table XII lists the regions of England by the number of private beds available per person. 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 XI shows:

*"Britain spends the most in those regions where the need is smallest."*

*"British urban regions with the most private hospital beds tend to receive the most government spending."*

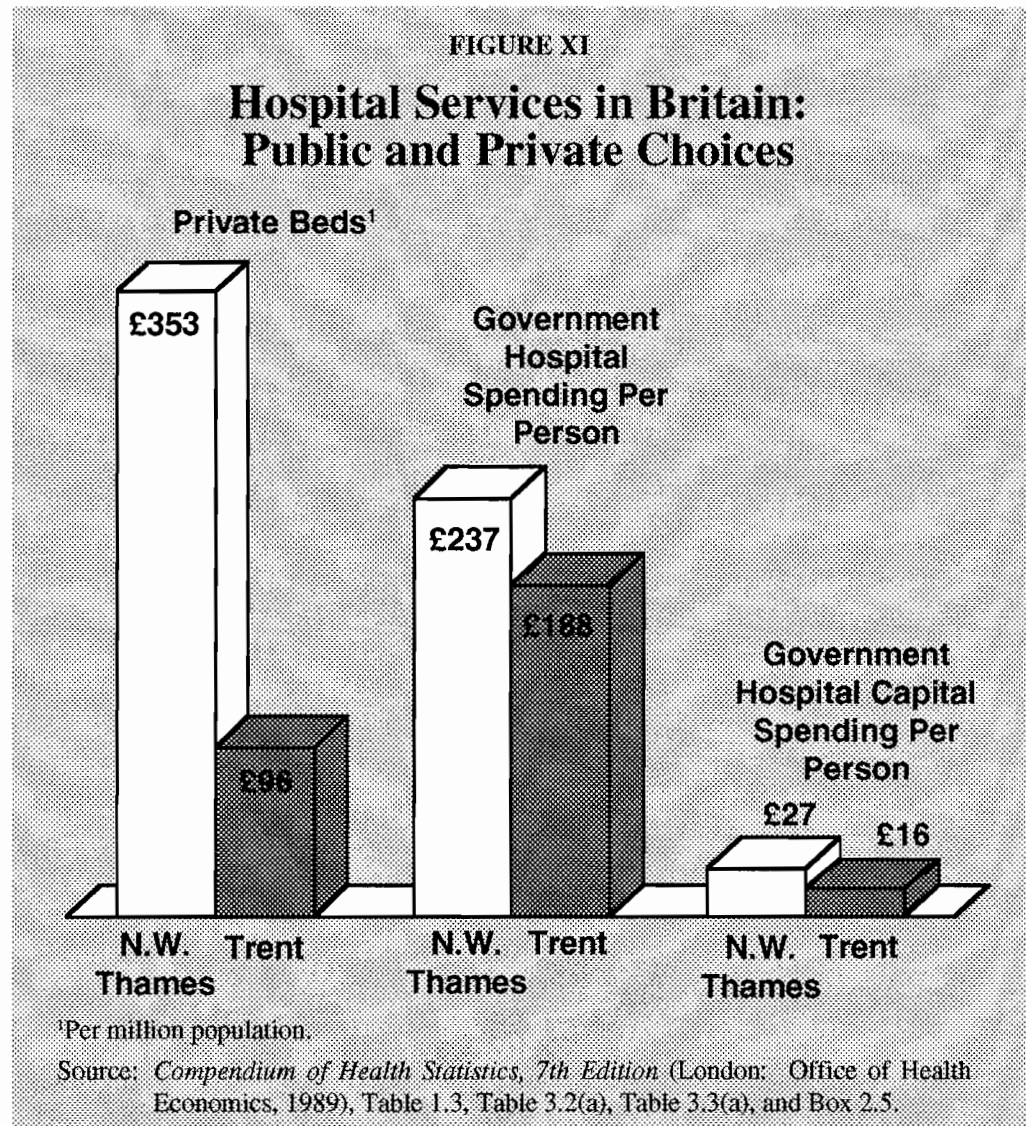
TABLE XII  
**Regional Inequalities in England**

<u>Region</u>	<u>Private Hospital Beds Per Million (1988)</u>	<u>Total Hospital Spending Per Person (1988-89)</u>	<u>Hospital Capital Spending Per Person</u>	
			<u>Amount (1988-89)</u>	<u>Percent Increase (1977-88)</u>
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%
E. 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 Edition* (London: Office of Health Economics, 1989), Table 1.3, Box 2.5, Table 3.2(a) and Table 3.3(a).

- The North East Thames region, which has the largest number of private beds per person, also enjoys 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 has the least private hospital beds per person — has only average NHS hospital spending, the second lowest NHS capital spending and the fourth lowest growth in capital spending.
- The Trent region — which has the second lowest number of private beds per person — has the second lowest NHS hospital spending per person and the very lowest NHS capital spending per person, and is the only region that experienced a decrease in capital spending over the past decade.

"Government spending exacerbates private inequalities between urban N.W. Thames and rural Trent."



**Rural Patients in Canada.** Canada, too, has proclaimed equal access to health care a national goal. Yet there is little evidence of success in achieving it:<sup>123</sup>

- Among Canadian provinces, the number of people per physician varies 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.

As noted above, health care in Canada tends to be hospital-based, with modern technology restricted to teaching hospitals and outpatient surgery discouraged. Moreover, specialists and major hospitals tend to be in major cities. As in other countries, rural residents often travel to the larger cities for medical care. How often does that happen? A major new study produced at the University of British Columbia provides the answer.<sup>124</sup>



TABLE XIII

## Spending on Physician Services Per Person in British Columbia<sup>1</sup>

(1987-1988)

<u>Specialty</u>	<u>Urban<sup>2</sup></u>	<u>Rural<sup>3</sup></u>	<u>Urban/Rural</u>
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%

*"Canadian urban residents are 5 1/2 times more likely to see a thoracic surgeon, 3 1/2 times more likely to see a psychologist and 2 1/2 times more likely see a dermatologist."*

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

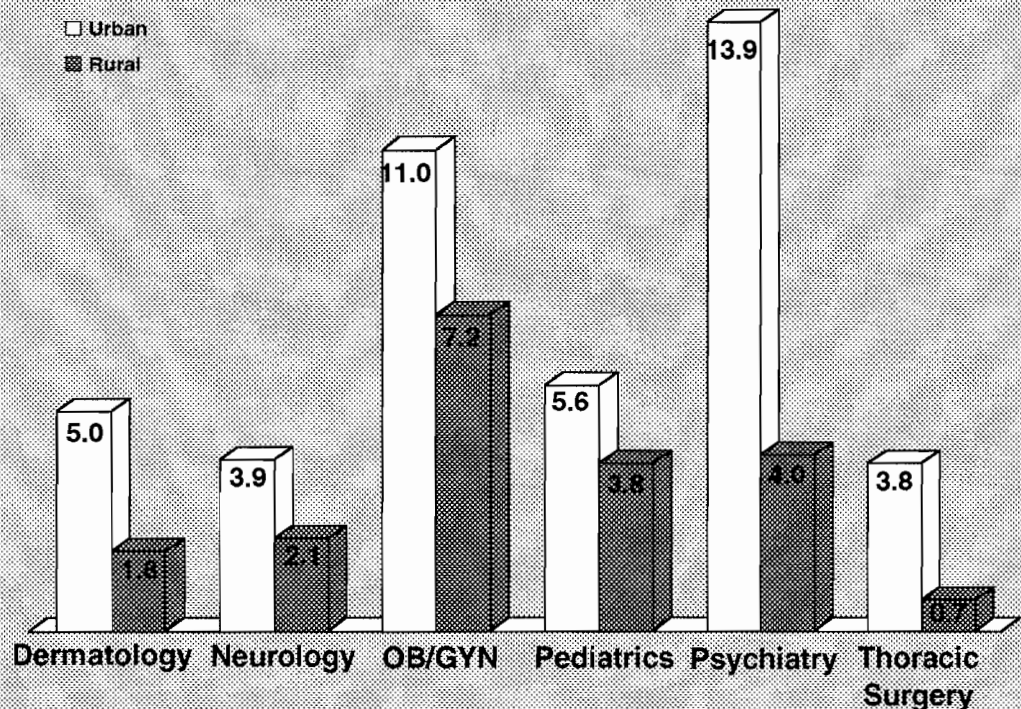
<sup>2</sup>Greater Vancouver and Victoria regional hospital districts.

<sup>3</sup>Twenty-seven non-metropolitan 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. 121-176.

**FIGURE XII**  
**Inequalities in the Use of Physician Services**  
**Among Urban and Rural Patients in**  
**British Columbia**

(Per capita spending, 1987-88)



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. 121-176.

*"Canadian rural residents are less likely to see any type of specialist than urban residents."*

Since doctors are paid on a fee-for-service basis in Canada, fee-for-service income is a good measure of the value 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 Table XIII and Figure XII show:

- Overall, people living in British Columbia's two largest cities (Vancouver and Victoria) receive about 37 percent more physician services per capita than those living in the 28 rural districts of the province.
- Urban residents receive 55 percent more services from specialists per capita than rural residents, and for specific specialties the discrepancies are even greater.
- On the average, urban residents are 5 1/2 times more likely to receive services from a thoracic surgeon, 3 1/2 times more likely to receive the services of a psychiatrist and about 2 1/2 times more likely to receive services from a dermatologist, an anesthesiologist or a plastic surgeon.



These are the broad averages. The discrepancies are even worse between urban areas and British Columbia's most underserved areas. Table XIV, for example, compares urban spending with spending in 12 other districts for selected services. As the table shows, even if we ignore the smallest districts and focus only on districts with at least 35,000 people, spending 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.

"Spending varies by 4 to 1 for OB/GYN services, 8 to 1 for internists and 35 to 1 for psychiatrists."

TABLE XIV

### Spending on Physician Services By Hospital Districts<sup>1</sup> in British Columbia, 1987-88

<u>Hospital Districts</u>	<u>Total Spending</u>	<u>Specialists</u>	<u>OB/GYN</u>	<u>Psychiatrists</u>	<u>Internists</u>
<b>Urban districts:</b>					
Vancouver	\$345.6	\$214.0	\$11.5	\$14.0	\$26.4
Victoria	348.4	211.8	8.5	13.2	25.6
<b>Selected Rural Districts:</b>					
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	205.7	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
<b>Average for all Rural Districts</b>	<b>253.8</b>	<b>138.1</b>	<b>7.2</b>	<b>4.0</b>	<b>7.0</b>

<sup>1</sup>Based on fees paid to physicians rendering services to patients living in the district indicated, regardless of the area in which the service was performed. All figures are age/sex standardized by regional hospital district and expressed in Canadian dollars.

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. 121-176.

The discrepancies are greater still among people in specific age and sex classifications in the regions, again ignoring the areas with the smallest populations. Roughly speaking:<sup>125</sup>

- An 80-year-old man in Vancouver is 524 times more likely to receive the services of an anesthesiologist than if the same man were living in the Sunshine Coast district (pop. 17,049).
- A small child with a skin rash is 22 times more likely to see a dermatologist if the child is living in Vancouver than in the East Kootenay district (pop. 50,660).
- A baby girl is 10 times more likely to see a pediatrician for any reason if she is living in Vancouver rather than Peace River (pop. 51,252).
- A 40-year-old woman is almost nine times as likely to have plastic surgery if she is living in Vancouver rather than Bulkley-Nechako (pop. 36,952).
- A 40-year-old woman with a mental disorder is 12 times more likely to see a psychiatrist if she is living in Vancouver rather than Fraser-Fort George (pop. 88,250).

**Rural Patients in Latin America.** Although this study 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 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 north/northeast (rural) areas than in the south/central (urban) areas. 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 were designed to create equal access to care, the spending is concentrated in the cities. About one-third of the population lacks regular access to medical care:<sup>126</sup>

- Although more than half of Brazil's population lives in rural areas, residents of urban areas experience nine 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 five times less on inpatient care and 13 times less on outpatient care in rural areas.

*"Under Latin American national health insurance, city dwellers almost always get the best health care."*

*"In the Soviet Union, life expectancy in rural areas has been falling."*

Brazil is not unique. In neighboring Venezuela, government-provided health care is theoretically free to everyone.<sup>127</sup> Yet the vast majority of health care services are provided in the cities.<sup>128</sup> 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.<sup>129</sup> 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.<sup>130</sup>

**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 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 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.<sup>131</sup>

Despite the fact that the Soviet Union was committed to the principle of equal access to health care for over 70 years, there is evidence that inequality in access to medical resources and health outcomes grew.<sup>132</sup>

- In the 1960s, infant mortality rates were virtually the same, on the average, among urban and rural areas.
- In the 1970s and 1980s, 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 1986-87 there was a two year difference in life expectancy between urban and rural areas.*

### **MYTH NO. 13: National health insurance would be good for members of organized labor.**

Many leaders of America's largest labor unions advocate national health insurance, believing that they can turn over employee health care costs to the 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 they would pay 50 percent more.<sup>133</sup>

A national health insurance program similar to Canada's would require at least \$339 billion in new taxes:<sup>134</sup>

- If the program were funded by a payroll tax, the payroll tax rate would rise from its current level of 15 percent to at least 30 percent.
- If it were funded by an income tax, the current income tax rate would increase by 16 percentage points, pushing a middle-income worker from a 28 percent to a 44 percent income tax bracket.
- If it were funded by a consumption tax, the price of everything we buy would increase by almost 10 percent, relative to our income.

*"Financing national health insurance would require a 15 percent payroll tax, a 16 percent income tax, or a 10 percent value-added tax."*

These are the tax rates needed to pay for national health insurance for workers and their families. If new health benefits were created for the elderly or for low-income people now covered by Medicaid, tax rates would be even higher. These estimates also assume health care costs remain at their current level. Any rise in health care spending — which is virtually inevitable — would require even more tax revenue.

Note that under each of the broad-based taxes above, the amount paid rises with income. Thus, under national health insurance, the high-wage industries would pay above-average taxes, even though the workers would receive the average benefit. For example:<sup>135</sup>

- On the average, the auto industry would pay about \$5,641 per employee under a national health insurance payroll tax.
- Add the loss of the current deduction for private health insurance and the total cost rises to \$6,824 per auto worker.
- Since the industry now pays only \$3,055 for private health insurance, the cost of health care for auto workers would more than double.

Those industries with below-average wages would pay below-average national health insurance taxes and would experience a financial gain under national health insurance. (See Table XIV.) Ironically, some of the latter industries are in the distribution chain of direct competitors to the manufacturing industries. Other things equal, for example, foreign auto dealers would gain a substantial cost advantage over domestic auto producers.

TABLE XIV

## Winners and Losers Under National Health Insurance: Selected Industries<sup>1</sup>

<u>Industries That Lose</u>	<u>Initial Change in Cost Per Production Worker</u>	<u>Increase in Total Production Costs:<sup>2</sup></u>	
		<u>Amount</u>	<u>Percent</u>
Motor Vehicles and Car Bodies (Mfg.)*	+ \$3,523	\$951,914,600	4.11%
Tires and Inner Tubes (Mfg.)*	+ \$3,242	\$211,378,400	6.18%
Petroleum and Coal Products (Mfg.)	+ \$3,203	\$350,728,500	0.90%
Tobacco Manufactures	+ \$2,793	\$98,034,300	0.55%
Photographic Equip. and Supplies (Mfg.)	+ \$2,490	\$125,745,000	3.43%
Telecommunications (Non-mfg.)	+ \$2,254	\$1,485,386,000	1.19%
Primary Metal Industries (Mfg.)	+ \$2,007	\$1,215,238,500	2.89%
Chemicals and Allied Products (Mfg.)	+ \$1,939	\$1,206,251,700	1.35%
Mining (Non-mfg.)	+ \$1,901	\$977,114,000	0.99%
Computer and Data Processing Services (Non-mfg.)*	+ \$1,609	\$949,149,100	3.85%
<u>Industries That Win</u>	<u>Initial Change in Cost Per Production Worker</u>	<u>Decrease in Total Production Costs:<sup>2</sup></u>	
		<u>Amount</u>	<u>Percent</u>
Retail Trade (Non-mfg.)	- \$1,488	\$25,989,408,000	5.26%
Hotels and Other Lodging Places	- \$1,387	\$2,007,543,800	4.85%
Amusement and Recreation Services	- \$1,346	\$1,339,539,200	4.83%
Personal Services	- \$1,280	\$896,256,000	2.25%

*"National health insurance taxes would be 50 percent higher than the current cost of private insurance for U.S. manufacturing workers."*

<b>Apparel and Other Textile Products (Mfg.)</b>	<b>- \$1,161</b>	<b>\$1,081,703,700</b>	<b>4.16%</b>
<b>Leather and Leather Products (Mfg.)</b>	<b>- \$738</b>	<b>\$87,969,600</b>	<b>2.30%</b>
<b>Banking</b>	<b>- \$670</b>	<b>\$852,508,000</b>	<b>0.87%</b>
<b>Credit Agencies Other than Banks</b>	<b>- \$486</b>	<b>\$331,014,600</b>	<b>1.68%</b>
<b>Textile Mill Products (Mfg.)</b>	<b>- \$417</b>	<b>\$264,544,800</b>	<b>1.14%</b>
<b>Auto Repair Services and Garages</b>	<b>- \$411</b>	<b>\$305,619,600</b>	<b>0.68%</b>

<sup>1</sup>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 (prior to being passed on to employees) and that national health insurance is funded by a payroll tax.

<sup>2</sup>Based on the contribution to gross national product (GNP) in each industry. Industry GNP for 1987 was taken from the Survey of Current Business, July 1988, Table 6.1, and adjusted to 1989 levels using the growth in overall GNP between 1987 and 1989. The asterisk (\*) indicates an estimated industry GNP using the share of that industry's production workers in that of the larger industry group. For example, motor vehicles and car bodies account for 40 percent of the larger industry group, motor vehicles and equipment.

Source: Aldona Robbins and Gary Robbins, "What a Canadian-style Health Care System Would Cost U.S. Employers and Employees," National Center for Policy Analysis, NCPA Policy Report No. 145, February 1990, Table VII, pp. 12-13.

#### **MYTH NO. 14: National health insurance would improve America's ability to compete in international markets.**

A commonly held view is that U.S. health care costs make U.S. products less competitive in the international marketplace. Those holding this view assert that health care costs add \$700 to the price of every U.S. automobile and that national health insurance would make American auto manufacturers more competitive. Both assertions are wrong.<sup>136</sup>

There is no evidence whatever that private health insurance costs add anything 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 wages.

*"Health care costs do not increase product prices; they reduce workers' take-home pay."*

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 competitive disadvantage relative to other countries.<sup>137</sup> For example:

- The Japanese spend a greater proportion of their income on food, but that doesn't mean that food consumption adds to the price of a Japanese car.
- The Canadians spend a greater proportion of their income on education, but that doesn't mean that education adds to the price of Canadian lumber.

The differences merely reflect consumer preferences and consumer product prices.

However, national health insurance would affect our ability to compete in international markets. That is because such 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 of those taxes to subsidize other industries.
- The industries which would receive subsidies contribute mostly to domestic rather than international markets.
- The industries which would be penalized are the manufacturers which provide most of our exports.

National health insurance would raise the costs of our export goods and lower marketing costs in the U.S. for our foreign competitors. Far from making auto producers more competitive in international markets, it would raise auto production costs relative to foreign rivals and make the industry less competitive.

Despite the fact that one-third of our federal budget goes to defense spending, a burden not equaled by our trading partners, taxes are lower in the U.S. than in most developed countries. As Table XV shows, only Japan currently 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. That additional burden would have a major impact on our ability to compete.

*"National health insurance taxes would hit hardest among the U.S. exporting industries."*



*"National health insurance taxes would make the United States one of the most heavily taxed countries among our trading partners."*

TABLE XV  
**Tax Burdens  
For Major U.S. Trading Partners<sup>1</sup>**

	<u>Taxes as a Percent of GDP</u>
<b>Canada</b>	<b>33%</b>
<b>Japan</b>	<b>29%</b>
<b>United Kingdom</b>	<b>39%</b>
<b>West Germany</b>	<b>38%</b>
<b>United States</b>	<b>29%</b>
<b>United States with National Health Insurance</b>	<b>36%</b>

<sup>1</sup>As of 1986.

Source: Organization for Economic Cooperation and Development.

**MYTH NO. 15: 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 among competing needs. Foreign governments do not merely deny lifesaving medical technology to patients under national insurance schemes. They also take millions of dollars that could be spent to save lives and cure diseases and spend them to provide services to people who are not seriously ill. Often, these services have little if anything to do with health care.

**Spending Priorities in Britain.** Throughout the British National Health Service, there is a tendency to divert funds from expensive care for the small number who are seriously ill toward the large number who seek relatively inexpensive services for minor ills. Take the British ambulance service, for example:<sup>138</sup>

- English "patients" take more than 19.5 million ambulance rides each year — about one ride for every two people in England.
- About 91 percent of these rides are for nonemergency purposes (such as taking an elderly person to a local pharmacy) and amount to what an official task force report described as little more than "free taxi service."



*"While 9,000 kidney patients are denied treatment each year, the British take 19.5 million ambulance rides — about one ride for every two people in England."*

*"The British ambulance service operates as a free taxi service."*

- Yet for genuine emergencies, the typical British ambulance lacks the modern, lifesaving equipment considered standard in American cities.

While as many as 9,000 people die each year from lack of treatment for kidney failure, the NHS provides an array of 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" — about 1.1 million are treated by chiropodists, and "meals on wheels" serves almost 33 million meals.
- Social workers attending to the needs of the elderly and the handicapped help with the installation of more than 17,000 telephones and telephone attachments, help arrange more than 93,000 telephone rentals, help more than 49,000 people with home alterations, assist in arrangements for 63,000 vacations and help an additional 346,000 people with other personal appliances and aids.

While tens of thousands of people classified by their physicians as being in "urgent need" of surgery wait for hospital beds, the NHS spends millions on items that have only marginal effects on health:

- On the average, 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 of these about 2.3 million receive free or subsidized eyeglasses.<sup>139</sup>

If the NHS did nothing more than charge patients the full costs of their sleeping pills and tranquilizers, enough money would be freed to treat 10,000 to 15,000 additional cancer patients each year and save the lives of an additional 3,000 kidney patients. Yet such options are not seriously considered.

A full description of the ways in which "caring" takes priority over "curing" within the British National Health Service would fill a volume the size of a phone book, and readers may wish to consult other references.<sup>140</sup> Suffice it here to say that the tendency pervades British medicine.

**Spending Priorities in Canada.** Although not as pronounced, similar trends can be observed in Canada, where the government has expanded the services of general practitioners while tightly controlling access to modern medical technology. For example:<sup>141</sup>

- In the United States, only 13 percent of all physicians are engaged in general practice or family practice.
- In Canada, over half of all physicians are general practitioners and the percentage of GPs has been rising over the past two decades.
- Ontario even has a policy requiring that 55 percent of its physicians be in general practice.

In general, Canadians have little trouble seeing a GP. But specialist services and sophisticated equipment are increasingly rationed. As noted above, although the United States has seen a major expansion of outpatient surgery, Canada has actively discouraged this trend — presumably to control spending. All over Canada, CAT scanners and other equipment are restricted to hospitals, and Ontario has legislated this restriction.<sup>142</sup> The Canadian system encourages the provision of routine services for the many at the expense of specialized care 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.”<sup>143</sup>

**MYTH NO. 16: When health care is free, total health costs are lower because preventive health services are more widely available.**

A common argument for national health insurance is that “free” health care saves money by encouraging preventive services, which allow doctors to catch conditions in their early stages — before they develop into more costly-to-treat diseases. The argument is wrong for two reasons.

First, careful studies show that, in general, preventive medicine raises rather than lowers overall health care costs. Preventive medicine is “economical” only when special at-risk groups are targeted. Giving preventive services to the entire population usually costs more than any savings from early detection of disease.<sup>144</sup> This does not mean that preventive care is undesirable. Diagnostic tests which show that no disease is present benefit patients by relieving anxiety and creating reassurance of health. Preventive care is like a *consumer good* which creates benefits in return for a cost. It is not like an *investment good* which promises a positive economic rate of return.

*“Although preventive care is valuable, it rarely pays for itself.”*

Second, under national health insurance preventive care may actually become less available, precisely because care is free. A comparison of American and British GPs in the 1970s found that the British saw a GP four times as often. Yet when Americans did see a doctor, they spent two-and-one-half times as long with the physician and received far more preventive services.<sup>145</sup>

Because the services of GPs are “free” to Britons, an inordinate number of their visits are for trivial complaints. In order to handle the case load, British doctors have responded by spending less time with each patient. Moreover, because of the British government’s desire to control costs, British physicians have much less access to diagnostic equipment, and most send their patients to a hospital even for chest x-rays and simple blood tests. As a result, preventive medical care is slighted in the NHS system. According to the 1970s comparison:

“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. 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.”<sup>146</sup>

One consequence of the lack of preventive care in Britain is that many illnesses are never diagnosed. For example, a series of screenings conducted by the British government several decades ago implied that for every case of diabetes, rheumatism or epilepsy known to a general practitioner, another was undiagnosed. For every case of psychiatric illness, bronchitis, blood pressure, glaucoma and urinary infection, another five were undiagnosed. For every known case of anemia, eight were undiagnosed.<sup>147</sup> The evidence suggests that things may not have improved:<sup>148</sup>

- A fairly recent study (1989) concluded that for every diabetic being treated under the National Health Service, another case of diabetes is undiagnosed.
- Another study (1988) suggests that one in 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 general practitioner.

*"American patients get more preventive services than British patients, even though they must pay for it out of pocket."*

At one-half the age of the British system, Canadian national health insurance does a better job — but 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 other condition warrants it.<sup>149</sup> And we have already seen how limits on technology have caused extensive waits for other diagnostic services, including Pap smears, mammograms and CAT scans.

Note that the United States does not necessarily do a better job at delivering preventive medicine. As in the case of 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.<sup>150</sup> However, as the discussion above shows, socializing the health care system by no means guarantees that these problems will be solved.

**MYTH NO. 17: The defects of national health insurance schemes in other countries could be remedied by a few reforms.**

The characteristics described above are not accidental by-products of government-run health care systems. They are the natural and inevitable consequences of politicizing medical practice.

Why are low-income and elderly patients so frequently discriminated against under national health insurance? Because such 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 respond to the political demands of the middle-class working population, and they serve the interests of this population.

Why do national health insurance schemes skimp on expensive services to the seriously ill while providing so many inexpensive services to those who are only marginally ill? Because the latter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small 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 hospital bureaucracies? Because the alternative is politically impossible. As a practical matter, no government can make it a national

*"The defects of national health insurance are the inherent outcome of the politics of medicine."*

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 the elderly can use hospitals as nursing homes, or that elderly patients must be moved so that surgery can proceed.

These decisions are so emotionally loaded that no elected official can afford to claim responsibility for them. Important decisions on who will and will not receive care and on how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.

**MYTH NO. 18: People in all developed countries, including the United States, prefer national health insurance.**

As far back as the presidency of Richard Nixon, polls showed as much as 61 percent of the people favored national health insurance.<sup>151</sup> And only 3 percent of Canadians and 12 percent of the British say they would trade their own system for the U.S. health care system.<sup>152</sup> But on closer examination, all those polls tell us is that most people prefer a free lunch.

Polls also tell us that most Britons believe the cost to them of national health insurance is about 1/20th of what it actually costs. At 1/20th of its real costs, the British health care system might look attractive to most people. Since health care taxes are also disguised in Canada, it seems likely that Canadians are unaware of their individual contribution to national health insurance as well. Thus, most of these people think they get a lot more than they pay for. And given the international publicity about the American health care costs, it's not surprising that people prefer something-for-nothing rather than something better but very expensive.

When individuals are asked to compare benefits with costs, their responses to polls are much more revealing. 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."
- When the United States was spending 8.2 percent of GNP on health care, most respondents thought we were spending 13 to 15 percent and identified 16 to 20 percent as the appropriate amount.<sup>153</sup>

*"Most Britons believe their share of the cost of national insurance is only 1/20th of the real cost."*



- A majority favor covering the uninsured through employer mandates or through an expansion of Medicare.<sup>154</sup>
- But when asked about paying, people were unwilling to pay higher income taxes and supported the proposal only if it were financed by “sin taxes” or taxes on employers.<sup>155</sup>

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. For example:<sup>156</sup>

- The public overwhelmingly disapproves of any cost-containment measure that translates into a lower quality of care.
- By a margin of 81 to 18 percent, the public is unwilling to accept longer waits for doctors’ appointments or elective surgery.

**MYTH NO. 19: Since national health insurance is popular in other countries, it would also be popular in the United States.**

*"National health insurance survives in other countries because those with the power to change it know how to get to the front of the rationing lines."*

National health insurance works in other countries for three reasons. First, the wealthy, powerful and sophisticated — those most skilled at articulating their complaints — find ways to maneuver to the front of the rationing lines. Second, those pushed to the end of the lines are generally unaware of medical technologies they are being denied. Third, there are no (or severely limited) contingency fees, no generally recognized right of due process and no cadre of lawyers willing to represent those who are discriminated against.

National health insurance “works” in other countries because those who could change the system are best served by it. If a member of the British Parliament, the CEO of a large British company or the head of a major British trade union had no greater access to renal dialysis than any other British citizen, the British NHS would not last a week.

“Don’t push me around” is a distinctively American phrase. 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 basic rights of 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.**

Chrysler Chairman Lee Iacocca, the United Auto Workers and many others have looked longingly at the health care systems of other countries and called for a U.S. government solution. 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 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. The government then leaves decisions about how to ration the funds to the health care bureaucracy.<sup>157</sup>

There is nothing mysterious about this process, and 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 with 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, even this obstacle could be overcome.

In short, Chrysler employees could realize “benefits” of national health insurance through private action, without government intervention, provided 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, federal government coercion would be required.

*"Chrysler doesn't need government; it can adopt its own system of national health insurance."*

## THE POLITICS OF MEDICINE

“Public choice” is the name of a relatively new discipline which attempts to integrate economics and political science.<sup>158</sup> Its chief goal is to explain political phenomena by reference to 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. Take the concept of competition. Just as producers of goods and services compete for consumer dollars, so politicians in a democracy compete for votes. Moreover, the process of competition leads to certain well-defined results.

In the economic marketplace, competition inevitably forces producers to choose the most efficient method of production. Those who fail to do so either go out of business or mend their ways. The 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 to endorse the winning platform. If he does not, he becomes vulnerable; for if his opponent adopts the winning platform, the opponent will win.

Of course in the real world, things are rarely so simple. Many factors influence voters other than substantive political issues — a candidate’s religion, general appearance, speaking ability, party affiliation, etc. 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 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 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 their top priority is to win elections and hold office.

*"In health policy, as in other areas, politicians often have little choice about what they can do."*

"Virtually all the defects of national health insurance can be explained by the pressures of the politics of medicine."

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 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 those factors which determine the nature of the winning platform.

This corollary is crucial 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 has defects. But these 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 which govern national health insurance programs are *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 ran the British National Health Service, seems to have appreciated this fact. Powell wrote that "whatever is entrusted to politicians becomes political even if it is not political anyhow"<sup>159</sup> and goes 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."<sup>160</sup>

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.<sup>161</sup> That is, far from being the consequence of preferences

of politicians (who could be replaced by different politicians with different preferences in the next election), the major features of 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. This was a major reason why many middle- and upper-middle-class British citizens supported national health insurance for the working class. It was also a major reason why they supported formation of the NHS in 1948.<sup>162</sup> 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. This is the contention of Dennis Lees, Professor of Economics at the University of Nottingham, who wrote that “the British people, left free to do so, would almost certainly have chosen to spend more on health services themselves than governments have chosen to spend on their behalf.”<sup>163</sup> The same may be true in other countries with national health insurance programs.

To see why this is true, let us first imagine a situation in which a politician is trying to win over a single voter. To keep the example simple, let us suppose 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 \$5 in medical care, \$3 in a retirement pension and \$2 in 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 this way, he risks losing this voter to a clever opponent.

Now it might seem that if the voter wants \$5 spent on medical care, we can conclude that he would have spent the \$5 on medical care himself if he were spending \$10 of his own money. But this is not quite true. State-provided medical care has one feature that is generally missing from private medical markets and from other government spending programs as well — non-price rationing. Non-price rationing, as we have seen, imposes heavy costs on patients (the cost of waiting and other inconveniences), leads to deterioration in the quality of services rendered and creates various forms of waste and inefficiency.

*"Countries with national health insurance tend to spend less, because rationing makes health care dollars worth less."*



Thus, other things 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. It also means that, under socialized medicine, spending for health care will be less attractive to voters relative to spending programs which do not involve non-price 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 non-market devices. Moreover, the greater the rationing problems, the less attractive health care spending will be. So we would expect even less spending on health care in a completely “free” service like the NHS than in a health service that charged 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 every one in the surrounding community. No matter what level of spending is chosen, some voters will have preferred 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 in levels of provision. Yet, as we have seen, those inequalities continue and many argue that levels of provision among geographical areas of Britain, Canada and New Zealand today are just as unequal as they would have been in the absence of national health insurance.

In theory, creating regional equality is a relatively simple task. All governments have to do is spend more in areas that are relatively deprived and less in areas that are relatively well-endowed. But most governments have not done this. Why? Public choice theory supplies a possible answer.

Policymakers must make two choices about spending in a particular area or region. First, they must decide how many total dollars are to be spent there. Second, they must decide how to allocate those dollars. In a democracy, there is no particular reason why per capita spending will be the same in all areas.

Per capita spending may differ across voting districts for numerous reasons. Voter turnout may be higher in some districts than in others, which 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.

*"Inequalities arise because people make unequal demands on government."*

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 the previous section, suppose that, say, \$10 is going to be spent in the city of Merseyside, England. 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 areas chose to spend a larger fraction of their income on medical care. There is no reason to suppose that their preferences were radically altered by national health insurance, and thus no reason to suppose that in allocating public spending, vote-maximizing politicians are doing anything other than responding to voter preferences.

**Spending Priorities: “Caring” vs. “Curing.”** We have mentioned the British National Health Service’s emphasis on “caring” rather than “curing.” This feature of the NHS marks a radical difference between British and American health care.

There can be no doubt that Britain's choices are the result of conscious political decisions. And the current trend is toward even more caring and less curing. American economist Mary-Ann Rozbicki recently asked a number of British health planners the following question: “If you suddenly enjoyed a sharp increase in available resources, how would you allocate it?” The response was invariably the same. They would put the additional resources into services for the aged, the chronically ill and the mentally handicapped.<sup>164</sup> Commenting on this response, Rozbicki writes:

“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.”<sup>165</sup>

*"The temptation is to spend on trivial services for the many rather than provide expensive care for the few who really need it."*

*"Under national health insurance, voters remain 'rationally ignorant' about medical care."*

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

"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.*"<sup>166</sup>

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

Like the citizens of other countries, most Britons know little about medical technology. This ignorance, moreover, is quite "rational." Information is costly. The rational person has an incentive to expand his knowledge about any subject *only* to the point at which the cost of an additional bit of information is equal to its benefit. This is the economic explanation for the commonly observed fact that the average person does not become an expert in medical science.

In Britain, however, the average citizen has much less incentive to become knowledgeable about medicine than his counterpart in the United States. Precisely because the medical market in the U.S. 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. This knowledge is of almost no value unless the citizen can inform millions of other voters, persuade them to "throw the rascals out" and achieve a change of policy. Such a campaign would be enormously expensive, undoubtedly costing the citizen far more than he could expect to recover 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. Such information increases the demand for new services and, thus, promises to enhance the income of those who supply them. In the NHS, however, the suppliers of medical care have no such incentives. Doctors, nurses and hospital administrators increase their income chiefly by persuading the government to pay them more. They increase their comfort, leisure time, and other forms of satisfaction by encouraging patients to demand not more but *less*.

*"The use of modern medical technology invariably gives way to political pressure to spend the money elsewhere."*

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, writes that "the British populace appears much less sophisticated in its medical demands than the American populace."<sup>167</sup>

The general ignorance about medical science which prevails among British voters has a profound impact on NHS policies. Other things equal, people will always place a higher value on those services with which they are familiar and on benefits about which they are certain. The known is preferred to the unknown and certainty to uncertainty. The average British voter is familiar with, and fairly certain about, the personal value of the non-acute services provided by the NHS. He 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 non-price rationing. All of the services of the NHS require rationing. But in some sectors, the rationing problems are far greater than in others because quality can sometimes be sacrificed to quantity. We have seen that, in comparison with American doctors, British GPs 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.

*"Half the hospital beds in England are in 19th-century buildings."*

Such adjustments cannot be made with most acute services. It is not feasible to sacrifice quality for quantity in, for example, CAT scans, organ transplants and renal dialysis. Patients either receive full treatment or no treatment, and very few patient-pleasing adjustments can be made.

These characteristics of health care rationing have an important effect on the preferences of potential patients — even those who are knowledgeable about medicine. The existence of non-price rationing tends to make all health care services less valuable than those services would be in the free market. But because non-acute 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 non-acute treatment is perfectly rational.

**Spending Priorities: Current Expenditure vs. 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, over 50 percent of the hospital beds are in 19th-century buildings. Moreover, despite 800,000 people on the hospital waiting lists, there are fewer hospital beds today than there were when the NHS was founded.

Capital expenditure, as we have seen, creates a flow of long-term benefits. 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 us explain this preference? Indeed it can. To see how, we first need to 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 decision making



is replaced by public decision making, 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. Since 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. In order 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.

*"Politicians seldom realize the full costs or the full benefits of their decisions."*

Yet since 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, since a politician is not likely to be in office for very many years, long-term penalties and rewards are largely irrelevant. Finally, since politicians have no property rights in their decisions, the worst that can happen is that they fail to be reelected. And this may be an acceptable price to pay for the opportunity to hold office today.

For all of these reasons, democratic governments have a natural tendency to skimp on capital spending. It is probably no accident that Britain, one of the most socialistic of the major industrialized countries, has one of the lowest rates of capital formation in the world.

John and Sylvia Jewkes, two British economists who were longtime students of the NHS, argued on numerous occasions that its lack of capital spending was solely the result of the political pressures just described. Successive chancellors of the exchequer, according to the Jewkes, skimmed on “those items where the consequences in the short period would be least noticeable and least likely to arouse protest.”<sup>168</sup> They went on to write that

“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 . . .

*"Governments follow the line of least resistance."*

"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."<sup>169</sup>

**Administrative Controls.** One of the most remarkable features of national health insurance is the enormous amount of decision-making power left in the hands of doctors. By and large, the medical communities in Britain, Canada and New Zealand have escaped the disciplines of both the free market and government regulation. In the view of Michael Cooper,<sup>170</sup> Anthony Culyer<sup>171</sup> and many others, this discretion is the principal reason for many of the gross inefficiencies found in the British National Health Service.

In addition to the power of GPs and consultants, other producer interest groups also have obtained power and influence. Within the NHS, these include hospital administrators, junior doctors and nonmedical hospital staff. The complaint made again and again is that the NHS is primarily organized and administered to benefit such special interest groups rather than patients. As Dennis Lees puts it,

"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."<sup>172</sup>

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 welfare of consumers.<sup>173</sup> 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. Since consumers outnumber producers, it might seem that, with democratic voting, consumers would always have the upper hand. If sheer voting power were the only power, this 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 as we have seen, information is costly. Organizing a political coalition is also costly. And the incentives for any single individual to bear these costs are extremely weak.

Producers are in a different position. Since they are working in the industry, they already possess a great deal of information about which policies are consistent with their self-interest and which are not. Their costs of political organizing also are much lower because they are relatively few in number and share common interests. In addition, because the personal stake of each producer in regulatory issues is far greater than that of a representative consumer, each producer has a much greater *personal incentive* to contribute to political efforts that protect the interests of producers as a group.

Producer interest groups, then, ordinarily have enormous advantages over consumer groups in issues involving government regulation of their industry. These advantages appear to be more than sufficient to overcome their relative vulnerability in terms of sheer voting power. This insight was provided by Professor Milton Friedman almost thirty 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 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

*"The health care bureaucracy is given enormous power to ration care."*

*"The system naturally serves the interests of those who work in it, rather than the interest of patients."*

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."<sup>174</sup>

Public choice theory, then, predicts that administrative inefficiencies caused by producer interest groups within health care bureaucracies will continue to be a permanent feature of socialized medicine. There is no reason to believe that this defect can be "reformed" away.

**Why the NHS Continues to Exist.** Not long ago, an article appeared in *Medical Economics* with the heading, "If Britain's Health Care Is So Bad, Why Do Patients Like It?"<sup>175</sup> That British patients *do* like the NHS had been confirmed repeatedly by public opinion polls. The same can be said of Canadians. The most recent surveys show that only 3 percent of Canadians and only 12 percent of the British public would trade the U.S. system for their own.<sup>176</sup>

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."

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."<sup>177</sup> 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."<sup>178</sup> 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."<sup>179</sup>

*"Far from complaining, British patients tend to be grateful for whatever is done."*

The expectations and the level of knowledge of British patients, however, is only part of the explanation for the system's popularity. 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 public believes that the entire cost of the NHS is met, not from general taxes, but from the weekly payroll tax (called the "insurance stamp").<sup>180</sup> 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 — 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 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 Congressman Bob Bauman on a trip to England in 1975. Traveling with a group of congressmen to examine the NHS first hand, 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 the Congressman asked her what she thought of the NHS, her reply was, "Oh, it's a wonderful system we have in Britain. You know, our medical care is all free."<sup>181</sup>

It might seem that an enterprising politician or political party could win a British election by offering the British public a better deal. Why not tell voters what the NHS really costs them, then offer to return their tax dollars so they could purchase private health insurance and health services?

The average British voter would undoubtedly be better off as a result, but that doesn't mean that most would approve of the plan. For one thing, even if voters knew what the NHS really costs, they might not be convinced



*"Special interests resist mightily any proposal for fundamental change."*

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.<sup>182</sup>

For another thing, defenders of the NHS — including trade unions, thousands of NHS employees and many British doctors — would play on existing fears and suspicions. Surprising as it may seem, the sagging morale and continual frustrations of NHS doctors have not produced enormous numbers of converts to free enterprise medicine. Perhaps many prefer the "protection" of a government bureaucracy to the rigors of free market competition. Whatever the reason, most of Britain's medical profession *supports* the idea of socialized medicine.<sup>183</sup> 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.<sup>184</sup> Even Sweden is searching for ways to introduce the disciplines of the competitive marketplace into its public system.

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

## CONCLUSION

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 America would not be well-served by an expansion of government bureaucracy or by greater governmental 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 our health care problems.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

## Footnotes

<sup>1</sup> See Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs*, Fall 1991, pp. 39-59; and Alain C. Enthoven, "Internal Market Reform of the British Health Service," *Health Affairs*, Fall 1991, pp. 60-70.

<sup>2</sup> Jeremy W. Hurst, "Reforming Health Care in Seven European Nations," *Health Affairs*, Fall 1991, pp. 18-19.

<sup>3</sup> *Ibid.*, p. 18.

<sup>4</sup> A blueprint for the reforms may be found in Patricia Danzon and Susan Begg, *Options For Health Care in New Zealand* (Wellington: New Zealand Business Roundtable, 1991).

<sup>5</sup> For general changes in Europe, see the discussion in Bengt Jönsson, "What Can Americans Learn From Europeans?," Symposium: International Comparisons of Health Care Systems, *Health Care Financing Review*, Annual Supplement, 1989, pp. 79-93.

<sup>6</sup> See Clyde H. Farnsworth, "Economic Woes Force Canada to Reexamine Medical System," *New York Times*, November 24, 1991; and Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989), p. 52.

<sup>7</sup> See Diane Rowland and Alexandre V. Telyrikov, "Soviet Health Care From Two Perspectives," *Health Affairs*, Fall 1991, pp. 71-86.

<sup>8</sup> For a description of Chile's health care reforms, see John C. Goodman and Peter A. Ferrara, "Private Alternatives to Social Security in Other Countries," National Center for Policy Analysis, NCPA Policy Report No. 132, April 1987; and Tarsicio Castañeda, "The Chilean Health System: Organization, Operation and Financing," in *Health Economics: Latin American Perspectives* (Washington, DC: Pan American Health Organization, 1989), pp. 3-25.

<sup>9</sup> The 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?," p. 83.

<sup>10</sup> The analysis that follows is based on Neuschler, *Canadian Health Care*, 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. 229-236.

<sup>11</sup> *Ibid.*

<sup>12</sup> *Ibid.*

<sup>13</sup> Jacques 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. 152-158. 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. 159-164.

<sup>14</sup> 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.

<sup>15</sup> See the discussion in Neuschler, *Canadian Health Care*, p. 50.

<sup>16</sup> This section is based on Dale A. Rublee and Markus Schneider, "International Health Spending: Comparisons With the OECD," *Health Affairs*, Fall 1991, pp. 187-198. 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.

<sup>17</sup> Finn Diderichsen, "Health and Social Inequities in Sweden," *Social Science and Medicine*, 1990, Vol. 31, No. 3, Table IV, p. 363.

<sup>18</sup> Per Maseide, "Health and Social Inequities in Norway," *Social Science and Medicine*, Vol. 31, No. 3, 1990, pp. 331-342.

<sup>19</sup> Maseide, "Health and Social Inequities in Norway," Table 1, p. 333.

<sup>20</sup> Michael Walker (Fraser Institute), "Why Canada's Health Care System Is No Cure for America's Ills," Heritage Foundation Backgrounder, November 13, 1989, pp. 7-8.

- <sup>21</sup> The treatment for patients with chronic renal failure and the use of CAT scanners continued its rise in virtually every country throughout the 1980s — an acknowledgment of the medical value of these innovations. Some have argued that the U.S. went too far in its use of pacemaker implants, however.
- <sup>22</sup> See John C. Goodman, *National Health Care in Great Britain* (Dallas: Fisher Institute, 1980), pp. 96-104.
- <sup>23</sup> Jönsson, "What Can Americans Learn From Europeans?", Table 8, p. 88.
- <sup>24</sup> *Ibid.*, pp. 88-89.
- <sup>25</sup> *Ibid.*, Table 10, p. 89.
- <sup>26</sup> See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, forthcoming).
- <sup>27</sup> Day and Klein, "Britain's Health Care Experiment," p. 43. For discussion of British hospital rationing, see Goodman, *National Health Care in Great Britain*, ch. 6. Enoch Powell, former Minister of Health, has argued that waiting lines 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).
- <sup>28</sup> For 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.
- <sup>29</sup> Estimate of the Fraser Institute (Vancouver) based on sampling in five Canadian provinces.
- <sup>30</sup> Hospital admissions as a percent of the total population average 16.1 percent for all OECD countries. The figures are 15.9 percent for the United Kingdom, 13 percent for New Zealand and 14.5 percent for Canada. See Schieber et al., "Health Systems in Twenty-four Countries," Exhibit 4, p. 27.
- <sup>31</sup> Health 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: BC/BS, 1991), p. 6.
- <sup>32</sup> For example, in Ontario in 1989 the number of people waiting for open-heart surgery 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. 115-116.
- <sup>33</sup> Danzon and Begg, *Options for Health Care in New Zealand*, Table 2-3, p. 26.
- <sup>34</sup> General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, June 1991, Table 4.1, p. 55.
- <sup>35</sup> See, for example, Joan Breckenridge, "Grief, Frustration Left in Wake Of Man Who Died on Waiting List," *Globe and Mail* (Ontario), January 25, 1989.
- <sup>36</sup> For Britain, see the discussion in Enthoven, "Internal Market Reform of the British Health Service." 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, "A Different View of Queues in Ontario," p. 112.
- <sup>37</sup> Enthoven, "Internal Market Reform of the British Health Service," p. 62.
- <sup>38</sup> For New Zealand, estimate of the New Zealand Department of Health. OECD statistics show an occupancy rate of 74.8 percent for New Zealand in 1983 and 83.3 percent for Canada. See Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris: OECD, 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., "Health Care Systems in Twenty-four Countries," Exhibits 4 and 5, pp. 27, 29.
- <sup>39</sup> Hospital 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*, 1989 (London: OHE, 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 et al., "Health Care Systems in Twenty-four Countries," Exhibits 4 and 5, pp. 27, 29.
- <sup>40</sup> In Canada, the latest estimate is 23 percent. See Neuschler, *Canadian Health Care*, p. 18.
- <sup>41</sup> See Rosie DiManno, "Hard Choices Facing Health Care System," *Toronto Star*, January 28, 1989; "Ceiling System Needs Radical Surgery," (Sunday) *Toronto Star*, March 27, 1988; and Robert G. Evans et al., "Controlling Health Expenditures: The Canadian Reality," *New England Journal of Medicine*, Vol. 320, No. 9, March 2, 1989, p. 574.
- <sup>42</sup> For an analysis of international length of stay statistics, see Rita Ricardo-Campbell, *The Economics and Politics of Health* (Chapel Hill, NC: 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.

<sup>43</sup> See the discussion in Schieber et al., "Health Care Systems in Twenty-four Countries," pp. 28-30.

<sup>44</sup> Quoted in Economic Models, Ltd., *The British Health Care System* (Chicago: American Medical Association, 1976), p. 33.

<sup>45</sup> Quoted in Harry Swartz, "The Infirmary 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.

<sup>46</sup> *British Medical Journal*, December 12, 1942, p. 700.

<sup>47</sup> Aneurin Bevan, *In Place of Fear* (London: Heinemann, 1952), p. 76.

<sup>48</sup> *Inequalities in Health* (Black report), (London: Department of Health and Social Security, 1980).

<sup>49</sup> See Julian LeGrand, "The Distribution of Public Expenditure: The Case of Health Care," *Economica*, Vol. 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. Snaith 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*, ch. 9. For a recent update on government failures to make any progress in achieving equality of access to health care, see "Dying of Inequality," *The Economist*, April 4, 1987, p. 52.

<sup>50</sup> Noyce, Snaith and Trickey, "Regional Variations in the Allocation of Financial Resources to the Community Health Service," Table III, p. 556.

<sup>51</sup> Julian LeGrand, "The Distribution of Public Expenditure: The Case of Health Care," *Economica*, Vol. 45, No. 178, May 1978.

<sup>52</sup> See 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, DC: American Enterprise Institute, 1981), pp. 187-190.

<sup>53</sup> Cotton M. Lindsay, *Canadian National Health Insurance: Lessons for the United States* (Nutley, NJ: Hoffmann-LaRoche, 1979).

<sup>54</sup> *Choices for Health Care*, pp. 19-22.

<sup>55</sup> General Office of Accounting, *Canadian Health Insurance*, pp. 53 ff.

<sup>56</sup> A review of the hospital records of open-heart surgery patients in Toronto found that while physicians generally assign 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, "A Different View of Queues in Ontario," p. 121.

<sup>57</sup> "Public Health in the Provinces," p. 14.

<sup>58</sup> Walker, "Why Canada's Health Care System Is No Cure for America's Ills," p. 9.

<sup>59</sup> Robert J. Blendon and Humphrey Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs*, Spring 1989, p. 156.

<sup>60</sup> *Ibid.*

<sup>61</sup> Day and Klein, "Britain's Health Care Experiment," pp. 43-44.

<sup>62</sup> *Choices for Health Care*, p. 75.

<sup>63</sup> Neuschler, *Canadian Health Care*, pp. 17-18 and p. 20.

<sup>64</sup> *Ibid.*

<sup>65</sup> DiManno, "Hard Choices Facing Health Care System."

<sup>66</sup> Tracey Tyler, "Frustrated Heart Patients Head to Ohio For Surgery," *Toronto Star*, January 22, 1989.

<sup>67</sup> Neuschler, *Canadian Health Care*, p. 50.

<sup>68</sup> *Ibid.*

<sup>69</sup> John K. Iglehart, "Canada's Health Care System Faces Its Problems," *New England Journal of Medicine*, Vol. 322, No. 8, p. 566.

<sup>70</sup> Milan Korcak, "US Cash Registers Humming as Canadian Patients Flock South," *Canadian Medical Association Journal*, Vol. 144, No. 6, February 1991, pp. 745-747.



- <sup>71</sup> David Caplan, letter to the editor of *New England Journal of Medicine* (July 13, 1989), p. 115. Reprinted in the House Wednesday Group, "Public Health in the Provinces," September 22, 1989, p. 12.
- <sup>72</sup> "Public Health in the Provinces," p. 14.
- <sup>73</sup> "The Crisis in Health Care: Sick to Death," *Macleans*, February 13, 1989, p. 32.
- <sup>74</sup> Walker, "Why Canada's Health Care System is No Cure for America's Ills," p. 9.
- <sup>75</sup> "Canadians Cross Border to Save Their Lives," *Wall Street Journal*, December 12, 1990. Cited in Michael Tanner, "Canadian Health Care in America: Prescription for Disaster," American Legislative Exchange Council, *State Factor*, Vol. 17, No. 8, June 1991, p. 1.
- <sup>76</sup> *Ottawa Citizen*, February 4, 1989. Cited in "Public Health in the Provinces," p. 15.
- <sup>77</sup> "The Crisis in Health Care," p. 32.
- <sup>78</sup> *Ibid.*
- <sup>79</sup> *Ibid.*
- <sup>80</sup> *Ibid.*, p. 33.
- <sup>81</sup> *Globe and Mail* (Ontario), May 28, 1988. Cited in Neuschler, *Canadian Health Care*, p. 48.
- <sup>82</sup> *Toronto Sun*, September 14, 1989. Cited in Neuschler, *Canadian Health Care*, p. 93.
- <sup>83</sup> *Edmonton Journal*, January 6, 1990. Cited in Neuschler, *Canadian Health Care*, p. 96.
- <sup>84</sup> *Winnipeg Free Press*, July 5, 1989. Cited in Neuschler, *Canadian Health Care*, p. 94.
- <sup>85</sup> *St. John's Evening Telegram*, June 28, 1989. Cited in Neuschler, *Canadian Health Care*, p. 94.
- <sup>86</sup> Canadian Broadcasting Company radio show, "As It Appears," January 25, 1989. Cited in Neuschler, *Canadian Health Care*, p. 95.
- <sup>87</sup> Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?," *Journal of the American Medical Association*, Vol. 262, No. 21, December 1, 1989, p. 3028.
- <sup>88</sup> A summary of Rand research may be found in Mark R. Chassin, ed., *The Appropriateness of Selected Medical and Surgical Procedures* (Ann Arbor: Health Administration Press, 1989).
- <sup>89</sup> George Telling Smith, *Patterns of Prescribing* (London: Office of Health Economics, 1991).
- <sup>90</sup> Office of Health Economics, "Variations Between General Practitioners," OHE Briefing, No. 26, July 1990.
- <sup>91</sup> Brook, "Practicing Guidelines and Practicing Medicine: Are They Incompatible?," p. 3021.
- <sup>92</sup> See, for example, Adam L. Linton, "Guidelines for Medical Practice: The Reasons Why," *Canadian Medical Association Journal*, Vol. 143, No. 6, pp. 485-490.
- <sup>93</sup> For 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*, Vol. 324, No. 18, May 2, 1991, pp. 1253-1258. See also a critique of the study's methodology by the Health Insurance Association of America in *Medical Benefits*, Vol. 8, No. 10, May 30, 1991, p. 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 results of other studies are reviewed below.
- <sup>94</sup> E.S. Savas, "How Much Do Government Services Really Cost?" *Urban Affairs Quarterly*, September 1979, p. 24.
- <sup>95</sup> See John C. Goodman, Gary Robbins and Aldona Robbins, "Employee Benefits Law: The Case for Radical Reform," National Center for Policy Analysis, NCPA Policy Report No. 147, March 1990.
- <sup>96</sup> American Medical Association Center for Health Policy Research, "The Administrative Burden of Health Insurance on Physicians," *SMS Report*, Vol. 3, No. 2, 1989.
- <sup>97</sup> See the description in Goodman and Ferrara, "Private Alternatives to Social Security in Other Countries."
- <sup>98</sup> See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, forthcoming.
- <sup>99</sup> See Burt Sims, "Cutting Health Care Costs: A Major Breakthrough," *US Business to Business*, Winter 1991.

<sup>100</sup> Currently, there are three competing technologies: magnetic striped cards, smart cards (with integrated circuits) and optical memory (laser) cards. See C. Peter Waegemann, "Patient Cards — The Promise of the Future?," *Medical Practice Management*, Spring 1990, pp. 264-268.

<sup>101</sup> Ibid., p. 264.

<sup>102</sup> For critiques of these estimates, see "GAO Report on Canadian Health Care Tainted by Charges of Partisanship," *Health Benefits Letter*, Vol. 1, No. 16, September 18, 1991; and the letters to the editor in the *New England Journal of Medicine*, Vol. 325, No. 18, pp. 1316-1319.

<sup>103</sup> *End-Stage Renal Failure* (London: Office of Health Economics, 1980), pp. 3 and 6.

<sup>104</sup> See 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*, Vol. 321, 1989, pp. 1443-1448; and the discussion in Naylor, "A Different View of Queues in Ontario," pp. 117-118.

<sup>105</sup> Jack A. Meyer and Marion E. Lewin, "Introduction," in Meyer and Lewin, eds., *Charting The Future of Health Care* (Washington, DC: American Enterprise Institute, 1987), p. 5.

<sup>106</sup> Schieber et al., "Health Care Systems in Twenty-four Countries," pp. 36-37.

<sup>107</sup> See Walter Williams, "Legislating Black Unemployment," National Center for Policy Analysis, NCPA Policy Report No. 112, July 1984.

<sup>108</sup> Associated Press, May 20, 1989.

<sup>109</sup> Reported in the *Dallas Morning News*, August 19, 1990.

<sup>110</sup> Phillip J. Held, Ph.D. et al., "Access to Kidney Transplantation: Has the United States Eliminated Income and Racial Differences?," *Archives of Internal Medicine*, Vol. 148, December 1988, pp. 2594-2600. A possible reason for the discrepancy is Medicare reimbursement policies, which place greater burdens on lower-income patients. Prior to 1987 (the period covered by the study), Medicare did not pay for outpatient drugs such as cyclosporine — which can cost transplant patients up to \$5,000 per year. It would be irrational to spend \$50,000 on a transplant and have it rejected because the patient could not afford \$5,000 in medication. Currently, Medicare pays for 80 percent of immunosuppressive drugs for one year.

<sup>111</sup> Jean-Pierre Thorrez, Peter Foggin and Andre Rannou, "Correlates of Health Care Use: Inuit and Cree of Northern Quebec," *Social Science and Medicine*, Vol. 30, No. 1, pp. 25-34.

<sup>112</sup> Canadian average life expectancy is for 1982.

<sup>113</sup> Malcolm Anderson and Mark W. Rosenberg, "Ontario's Underserved Area Program Revisited: An Indirect Analysis," *Social Science and Medicine*, Vol. 30, No. 1, pp. 35-44.

<sup>114</sup> Ibid., p. 43.

<sup>115</sup> E.W. Pomare, "Groups with Special Health Care Needs," *New Zealand Medical Journal*, October 26, 1988, pp. 711-713.

<sup>116</sup> Ibid.

<sup>117</sup> Maseide, "Health and Social Inequities in Norway," p. 331.

<sup>118</sup> Office of Health Economics, *Compendium of Health Statistics, 7th Edition*, 1989, Table 3.36(a), p. 49.

<sup>119</sup> See John C. Goodman and Gerald L. Musgrave, "National Health Insurance and Rural Health Care," National Center for Policy Analysis, NCPA Policy Report No. 107, October 1991.

<sup>120</sup> Lajos Csaszsi, "Interpreting Inequalities in the Hungarian Health System," *Social Science and Medicine*, Vol. 31, No. 3, p. 280.

<sup>121</sup> Naoki Ikegami, "Japanese Health Care: Low Cost Through Regulated Fees," *Health Affairs*, Fall 1991, p. 104.

<sup>122</sup> "Dying of Inequality," *The Economist*, April 4, 1987, p. 52.

<sup>123</sup> Anderson and Rosenberg, "Ontario's Underserved Area Program Revisited," Table 1, p. 37 and Table 4, p. 39. Statistics are for 1985-86.

<sup>124</sup> 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. 121-176.

<sup>125</sup> Ibid.

<sup>126</sup> Kwiko and Rodriguez Neto, "Brazil," *The International Handbook of Health Care Systems*.

- <sup>127</sup> In 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.
- <sup>128</sup> Jesus E. Rodriguez and Carlos Sabino, *Social Security in Venezuela* (Caracas: Cedice), forthcoming.
- <sup>129</sup> Joseph Bastien, "Community Health Workers in Bolivia: Adapting to Traditional Roles in the Andean Community," *Social Science and Medicine*, Vol. 30, No. 3, 1990, pp. 281-287.
- <sup>130</sup> Kenyon 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*, Vol. 23, No. 2, 1986, pp. 139-148.
- <sup>131</sup> See Edmund Wnuk-Lipinski and Raymond Illsley, "International Comparative Analysis: Main Findings and Conclusions," *Social Science and Medicine*, Vol. 31, No. 8, pp. 879-889.
- <sup>132</sup> Ibid., p. 884. See also Elena Mezentsseva 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*, Vol. 31, No. 8, pp. 867-877.
- <sup>133</sup> Aldona Robbins and Gary Robbins, "What a Canadian-style Health Care System Would Cost U.S. Employers and Employees," National Center for Policy Analysis, NCPA Policy Report No. 145, February 1990.
- <sup>134</sup> Ibid.
- <sup>135</sup> Ibid.
- <sup>136</sup> See Robbins and Robbins, "What a Canadian-style Health Care System Would Cost U.S. Employers and Employees," pp. 20-22.
- <sup>137</sup> See Uwe Reinhardt, "Health Care Spending and American Competitiveness," *Health Affairs*, Winter 1989, pp. 5-21.
- <sup>138</sup> These and other statistics in this section are taken from Department of Health and Social Security, *Health and Personal Social Services for England*, 1985 and 1991 editions (London: Her Majesty's Stationery Office, 1985 and 1991).
- <sup>139</sup> New charges for these services were introduced in the spring of 1989, however.
- <sup>140</sup> See 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. 125-132; and Goodman, *National Health Care in Great Britain*, pp. 192-196.
- <sup>141</sup> General Accounting Office, *Canadian Health Insurance*, p. 38.
- <sup>142</sup> Neuschler, *Canadian Health Care*, p. 18.
- <sup>143</sup> Michael Walker, "Neighborly Advice on Health Care," *Wall Street Journal*, June 8, 1988. Cited in Neuschler, *Canadian Health Care*, p. 51.
- <sup>144</sup> See Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, DC: Brookings Institution, 1986).
- <sup>145</sup> Goodman, *National Health Care in Great Britain*, pp. 55-87.
- <sup>146</sup> Ibid., p. 70.
- <sup>147</sup> Cooper, *Rationing Health Care*, p. 13.
- <sup>148</sup> See *Patterns of Prescribing*, pp. 21-22.
- <sup>149</sup> Elizabeth Rosenthal, "In Canada, A Government System That Provides Health Care to All," *New York Times*, April 30, 1991.
- <sup>150</sup> *International Journal of Epidemiology*, November/December, 1990.
- <sup>151</sup> Jon Gabel, Howard Cohen and Steven Fink, "Americans' Views on Health Care: Foolish Inconsistencies?," *Health Affairs*, Spring 1989, p. 111.
- <sup>152</sup> Blendon and Taylor, "Views on Health Care: Public Opinion in Three Nations," p. 153.
- <sup>153</sup> Gabel et al., "Americans' Views on Health Care: Foolish Inconsistencies?," p. 110.
- <sup>154</sup> Ibid., pp. 109-110.
- <sup>155</sup> Ibid., p. 112.
- <sup>156</sup> Ibid., p. 114.
- <sup>157</sup> See the discussion in Jönsson, "What Can Americans Learn from Europeans?," pp. 84-86.

- <sup>158</sup> The two seminal works on public choice theory are Anthony Downs, *An Economic Theory of Democracy* (New York: Harper Row, 1957); and James Buchanan and Gordon Tullock, *The Calculus of Consent* (Ann Arbor: 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*, Vol. 59, pp. 51-66, 1988; and Gary S. Becker, "A Theory of Competition Among Pressure Groups for Political Influence," *The Quarterly Journal of Economics*, Vol. 48, pp. 371-400.
- <sup>159</sup> Powell, *Medicine and Politics, 1975 and After*, p. 5.
- <sup>160</sup> *Ibid.*, p. 67.
- <sup>161</sup> John C. Goodman, "National Health Care in Great Britain: Lessons for the U.S. A.," (Dallas: Fisher Institute, 1980), ch. 10.
- <sup>162</sup> Dennis Lees, "An Economist Considers Other Alternatives," in Helmut Schoeck, ed., *Financing Medical Care: An Appraisal of Foreign Programs* (Caldwell, Idaho: Caxton Printers, Ltd., 1963), p. 80.
- <sup>163</sup> Dennis Lees, "Economics and Non-economics of Health Services," *Three Banks Review*, No. 110, June 1976, p. 9.
- <sup>164</sup> 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. 17.
- <sup>165</sup> *Ibid.*
- <sup>166</sup> *Ibid.*, p. 18. (Emphasis added.)
- <sup>167</sup> *Ibid.*, p. 17.
- <sup>168</sup> John and Sylvia Jewkes, *Value for Money in Medicine* (Oxford: Basil Blackwell, 1963), p. 55.
- <sup>169</sup> *Ibid.*, pp. 59-60.
- <sup>170</sup> Michael Cooper, *Rationing Health Care* (London: Croom Helm, Ltd., 1975), p. 73.
- <sup>171</sup> Anthony Culyer, "Health: the Social Cost of Doctors' Discretion," *New Society*, February 27, 1975.
- <sup>172</sup> Lees, "Economics and Non-economics of Health Services," p. 12.
- <sup>173</sup> A representative sample of such studies is contained in Paul W. MacAvoy, ed., *Crisis of the Regulatory Commissions* (New York: Norton, 1970).
- <sup>174</sup> Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), p. 143.
- <sup>175</sup> John J. Fisher, "If Britain's Health Care Is So Bad, Why Do Patients Like It?" *Medical Economics*, August 21, 1978.
- <sup>176</sup> See Blendon and Taylor, "Views on Health Care: Public Opinion in Three Nations," pp. 149-157.
- <sup>177</sup> Derek Robinson, "Primary Medical Practice in the United Kingdom and the United States," *New England Journal of Medicine*, Vol. 297, No. 4, July 28, 1977, p. 189.
- <sup>178</sup> Rozbicki, *Rationing British Health Care*, p. 18.
- <sup>179</sup> Quoted in Harry Swartz, "The Infirmary of British Medicine," p. 31.
- <sup>180</sup> Cooper, *Rationing Health Care*, p. 87.
- <sup>181</sup> Quoted by Lew Rockwell in *World Research INC*, March 1979, p. 5.
- <sup>182</sup> *Ibid.*, p. 6.
- <sup>183</sup> John Walsh, "Britain's National Health Service: the Doctors' Dilemmas," *Science*, Vol. 201, July 28, 1979, p. 329.
- <sup>184</sup> Neuschler, *Canadian Health Care*, p. 52.

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The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
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