

Routing

Health Care in a Free Society Rebutting the Myths of National Health Insurance

by John C. Goodman

Executive Summary

Almost everyone agrees that the U.S. health care system is in dire need of reform. But there are differing opinions on what kind of reform would be best. Some on the political left would like to see us copy one of the government-run “single-payer” systems that exist in Western Europe, Canada, and New Zealand, among other places. Proponents of socialized medicine point to other countries as examples of health care systems that are superior to our own. They insist that government will make health care available on the basis of need rather than ability to pay. The rich and poor will have equal access to care. And more serious medical needs will be given priority over less serious needs.

Unfortunately, those promises have not been borne out by decades of studies and statistics from nations with single-payer health care. Reports from those governments contradict many of the common misperceptions held by supporters of national health insurance in the United States. Wherever national health insurance has been tried, rationing by waiting is pervasive, putting patients at risk and keeping them in pain. Single-payer systems tend to leave

rationing choices up to local bureaucracies that, for example, fill hospital beds with chronic patients, while acute patients wait for care. Access to health care in single-payer systems is far from equitable; in fact, it often correlates with income—with rich and well-connected citizens jumping the queue for treatment. Democratic political pressures (i.e., the need for votes) dictate the redistribution of health care dollars from the few to the many. In particular, the elderly, racial minorities, and those in rural areas are discriminated against when it comes to expensive treatments. And patients in countries with national health insurance usually have less access to critical medical procedures, modern medical technology, and lifesaving drugs than patients in the United States.

Far from being accidental byproducts of government-run health care systems that could be solved with the right reforms, these are the natural and inevitable consequences of placing the market for health care under the control of politicians. The best remedy for all countries’ health care crises is not increasing government power, but increasing patient power instead.

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Introduction

Despite overwhelming evidence that single-payer health care systems do not provide high-quality care to all citizens regardless of ability to pay, proponents of socialized medicine tout such systems as models for the United States to emulate. Ironically, over the course of the past decade almost every European country with a national health care system has introduced market-oriented reforms and turned to the private sector to reduce health costs and increase the value, availability, and effectiveness of treatments.¹ In making such changes, more often than not those countries looked to the United States for guidance. About seven million people in Britain now have private health insurance, and since the Labor government assumed power, the number of patients paying out of pocket for medical treatment has increased by 40 percent.²

To reduce its waiting lists, the British National Health Service recently announced that it will treat some patients in private hospitals, reversing a long-standing policy of using only public hospitals;³ the NHS has even contracted with HCA International, America's largest health care provider, to treat 10,000 NHS cancer patients at HCA facilities in Britain. Australia has turned to the private sector to reform its public health care system to such an extent that it is now second only to the United States among industrialized nations in the share of health care spending that is private.⁴

Since 1993, the German government has experimented with American-style managed competition by giving Germans the right to choose among the country's competing sickness funds (insurers).⁵ The Netherlands also has American-style managed competition, with an extensive network of private health care providers, and slightly more than one-third of the population is insured privately.⁶ Sweden is introducing reforms that will allow private providers to deliver more than 40 percent of all health care services and about 80 percent of primary care in Stockholm.⁷ Even Canada has changed, using the United States

as a partial safety valve for its overtaxed health care system; provincial governments and patients spend more than \$1 billion a year on U.S. medical care.⁸

In each of these countries, growing frustration with government health programs has led to a reexamination of the fundamental principles of health care delivery. Through bitter experience, many of the countries that once touted the benefits of government control have learned that the surest remedy for their countries' health care crises is not increasing government power, but increasing patient power instead.⁹

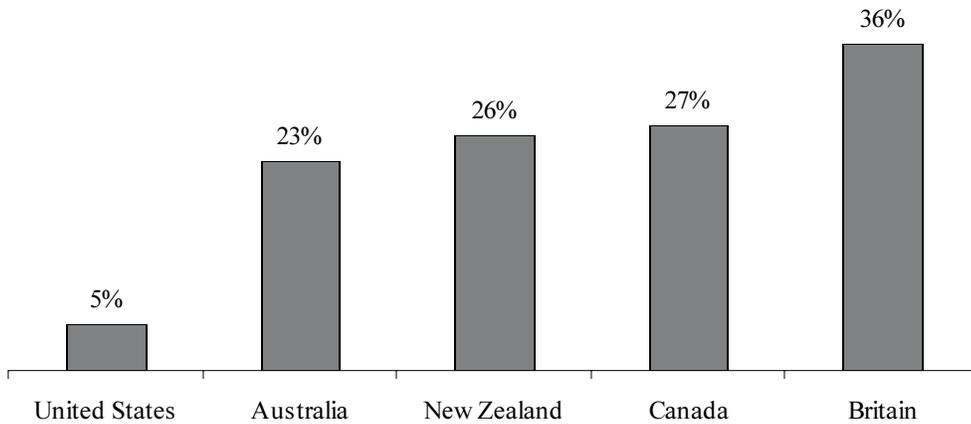
In this paper, we examine 12 popular myths about national health insurance. We have chosen to focus primarily, though not exclusively, on the health care systems of English-speaking countries whose cultures are similar to our own. Britain, Canada, and New Zealand in particular are often pointed to by advocates of national health insurance as models for U.S. health care system reform. In amassing evidence of how these systems actually work, many of our sources are government publications or commentary and analysis by reporters and scholars who fully support the concept of socialized medicine.

Myth No. 1: In Countries with National Health Insurance Systems, People Have a Right to Health Care

In fact, no country with national health insurance has established a right to health care. Citizens of Canada, for example, have no right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue.

One could even argue that Canadians have fewer rights to health services than their pets. While Canadian pet owners can purchase an MRI scan for their cat or dog, purchasing a

Figure 1
Patients Having to Wait More Than Four Months for Surgery (as percentage of all adult surgery patients receiving elective [nonemergency] surgery in last two years)



Source: Cathy Schoen, Robert J. Blendon, Catherine M. DesRoches, and Robin Osborn, “Comparison of Health Care System Views and Experiences in Five Nations, 2001,” Commonwealth Fund, Issue Brief, May 2002.

scan for themselves is illegal (although more and more human patients are finding legal loopholes, as we shall see below).¹⁰

Countries with national health insurance limit health care spending by limiting supply. They do so primarily by imposing global budgets on hospitals and area health authorities and skimping on high-tech equipment. The result is rationing by waiting (see Figure 1).

In Britain, with a population of almost 60 million, government statistics show that more than 1 million are waiting to be admitted to hospitals at any one time.¹¹ In Canada, with a population of more than 31 million, the independent Fraser Institute found that more than 876,584 are waiting for treatment of all types.¹² And in New Zealand, with a population of about 3.6 million, almost 111,000 people are on waiting lists for surgery and other treatments.¹³

Although there may be some waiting in any health care system, in these countries rationing by waiting is government policy. Patients may wait for months or even years for treatment (see Figure 1).¹⁴ For example, Canadian patients waited an average of 8.3 weeks in 2003 from the time they were referred to a specialist until the actual consultation, and another 9.5 weeks before treatment, including surgery.¹⁵ Of the 90,000 peo-

ple waiting for surgery or treatment in New Zealand in 1997, more than 20,000 were waiting for a period of more than two years.¹⁶ The London-based Adam Smith Institute estimates that the people currently on NHS waiting lists will collectively wait about one million years longer to receive treatment than doctors deem acceptable.¹⁷

Among the patients waiting, many are waiting in pain. Others are risking their lives. Delays in Britain for colon cancer treatment are so long that 20 percent of the cases considered curable at time of diagnosis are incurable by the time of treatment.¹⁸ During one 12-month period in Ontario, Canada, 71 patients died waiting for coronary bypass surgery while 121 patients were removed from the list because they had become too sick to undergo surgery with a reasonable chance of survival.¹⁹

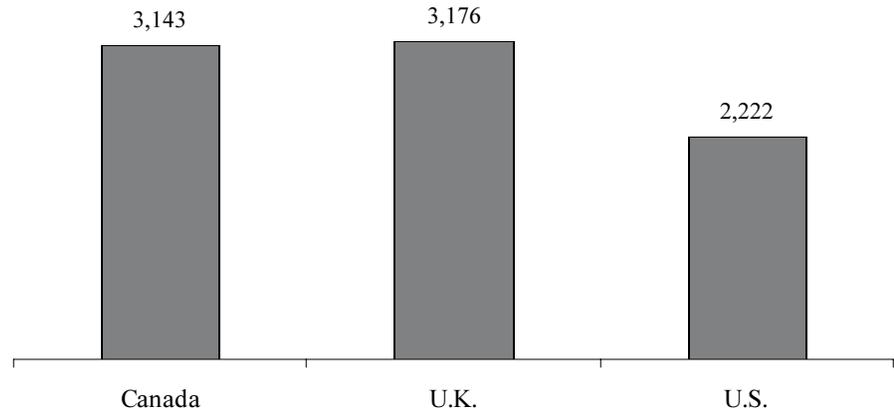
Myth No. 2: Countries with National Health Insurance Systems Deliver High-Quality Health Care

In countries with national health insurance, governments often attempt to limit demand for medical services by having fewer

During one 12-month period in Ontario, Canada, 71 patients died waiting for coronary bypass surgery.

Thirty percent of American patients spend more than 20 minutes with their doctor on a visit, compared to 20 percent in Canada and only 5 percent in Britain.

Figure 2
Numbers of Patients Seen Annually (average per physician)



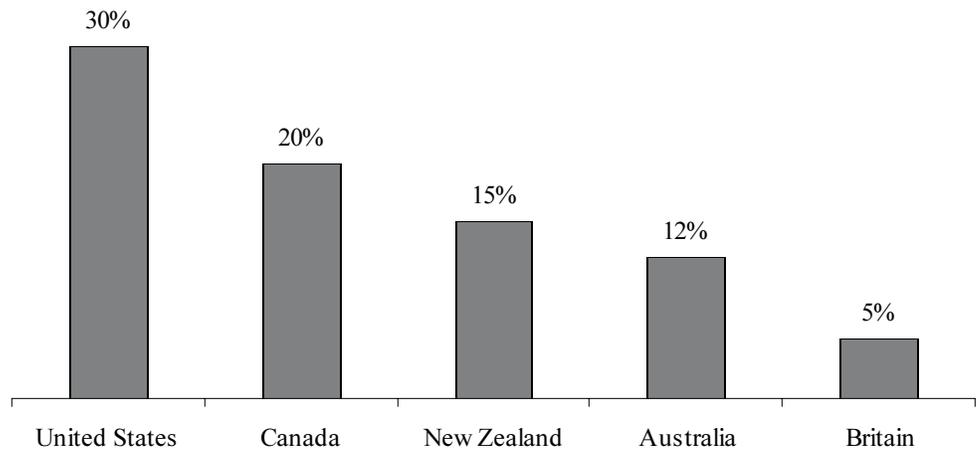
Source: Gerard F. Anderson and Peter S. Hussey, “Comparing Health System Performance in OECD Countries,” *Health Affairs*, May/June 2001.

physicians. Because there are fewer physicians, they must see larger numbers of patients for shorter periods of time. U.S. physicians see an average of 2,222 patients per year, but physicians in Canada and Britain see an average of 3,143 and 3,176, respectively (see Figure 2).²⁰ Family practitioners in Canada bear even higher patient loads—on the average, more than 6,000 per year.²¹ Thus it is not surprising that 30 percent of American patients spend more than

20 minutes with their doctor on a visit, compared to 20 percent in Canada and only 5 percent in Britain (see Figure 3).²²

When Americans see their doctors, they’re more likely to receive treatments with high-tech equipment. As Figure 4 shows, the use of coronary bypass surgery in the United States is slightly more than three times higher per capita than in Canada and almost five times higher than in Britain.²³ The rate of coronary angioplasty in the United States is almost

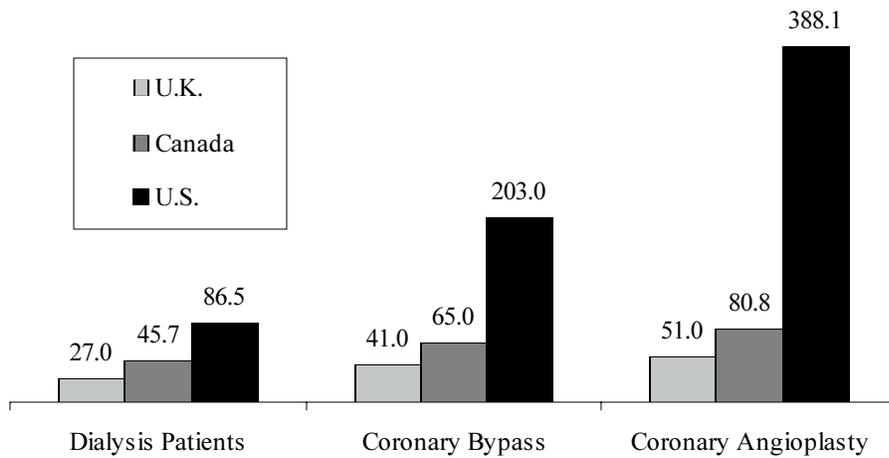
Figure 3
Percentage of Patients Spending More Than 20 Minutes with Their Doctor



Note: Reflects most recent doctor visit.

Source: Karen Donelan et al., “The Cost of Health System Change: Public Discontent in Five Nations,” *Health Affairs*, May/June 1999.

Figure 4
Use of High-Tech Medical Procedures (per 100,000 people per year)



Sources: Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): Exhibit 5.

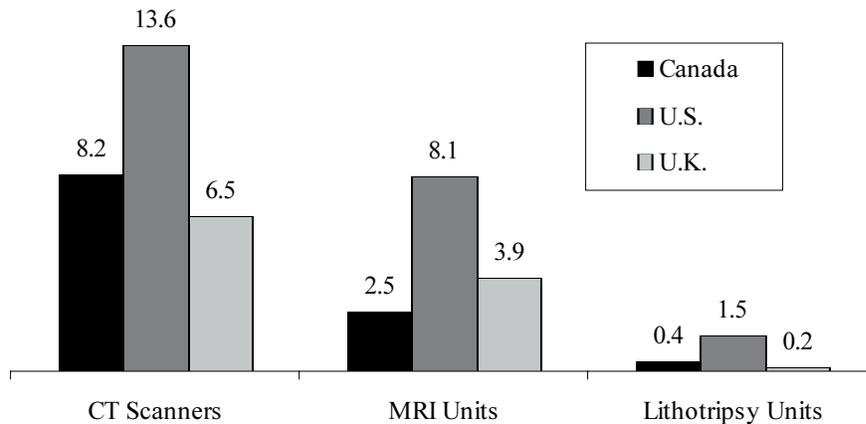
five times higher than in Canada and almost eight times higher than in Britain. The rate of renal dialysis in the United States is almost double that of Canada and almost three times that of Britain. Britain was the codeveloper with the United States of kidney dialysis in the 1960s, yet Britain consistently has had one of the lowest dialysis rates in Europe.

As Figure 5 shows, the United States also compares favorably to Britain and Canada in access to

modern medical technology. Computed Tomography (CT) scanners, which are useful in the diagnosis and treatment of cancer,²⁴ were also invented in Britain. For years Britain manufactured and exported about half the CT scanners used in the world. Yet through the years the British government purchased very few scanners for the NHS, and even discouraged private gifts of the devices to the NHS.²⁵ Today Britain has only half the number of CT scanners per million pop-

Although critics of the U.S. health care system claim we have too much technology, all the evidence suggests that our counterparts have too little.

Figure 5
Access to Modern Medical Technology in the U.S., Britain, and Canada (units per million people)



Source: Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): Exhibit 5, p. 97; and Stephen Pollard, "European Health Care Consensus Group Paper," Centre for the New Europe, January 4, 2001.

The annual rate of cancer deaths is 70 percent higher in the United Kingdom than in the United States.

ulation (6.5) as the United States (13.6).²⁶ Although critics of the U.S. health care system claim that we have too much technology, all the evidence suggests that our counterparts have too little—as a result of the conscious decisions of government officials. Britain’s NHS has also skimped on the newer Magnetic Resonance Imaging (MRI) scanners that can detect disease throughout the body, including aneurysms or tears in the aorta, strokes, and tumors. Britain (at 3.9 MRI scanners per million population) has fewer than half as many as the United States (8.1 per million). There is strong evidence of a general underuse of other valuable therapies as well.²⁷

Canada also compares unfavorably with the United States in access to high-tech equipment. On a per capita basis, the United States has more than three times as many MRI units as Canada, and almost twice as many CT scanners per capita as Canada.²⁸ Per person, the United States has nearly four times as many lithotripsy units—which avoid expensive and invasive surgery by using sound waves to destroy kidney stones and gallstones. As of November 2001, Canada had only three public-sector Positron Emission Tomography (PET) scanners—and one of those only operated one evening a week—compared to 250 in the United States.²⁹

In addition, much of the medical technology that is available in Canada is archaic and ineffective. In Canadian hospitals, for example, 63 percent of all general X-ray equipment is severely outdated, and half of all diagnostic imaging units require replacement.³⁰

Lack of access to technology affects health outcomes. Whereas the Canadian Society of Surgical Oncology recommends that cancer treatment, including surgery, begin within two weeks after preoperative tests, one study found that the median waiting time for surgery varied from almost a month (29.0 days) for colorectal cancer to more than two months (64.0 days) for urologic cancers.³¹ The annual rate of cancer deaths is 70 percent higher in the United Kingdom than in the United States—275 deaths per 100,000 and 194 deaths per 100,000, respectively.³² According to Karol Sikora, former head of the World Health Organization’s cancer pro-

gram, 25,000 people die unnecessarily in Britain each year because they are denied the highest quality cancer care. Much of the reason appears to be rationing of cancer specialists and treatments.³³ For instance, Poland has more radiotherapists per capita than Britain. In fact, Britain has fewer oncologists than any country in Western Europe.³⁴ Forty percent of British cancer patients never see an oncology specialist.³⁵ There are only a few British hospitals that specialize in tumors. In addition, use of chemotherapy in Britain is significantly lower than in neighboring countries. Many health authorities ration cancer drugs, and some are unwilling to fund certain drugs. Such practice leads to similar patients being treated differently depending on where they reside, resulting in a wide variation in clinical outcomes.³⁶

Myth No. 3: Countries with National Health Insurance Make Health Care Available on the Basis of Need Rather Than Ability to Pay

“The United States alone treats health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need,” claims Physicians for Single-Payer National Health Insurance.³⁷ The idea that national health insurance makes health care available on the basis of need rather than ability to pay is an article of faith among supporters of socialized medicine.

But is it really true that national health insurance systems make care available on the basis of need alone? Precisely because of rationing, inefficiencies, and quality problems, patients in countries with national health insurance often spend their own money on health care when they are given an opportunity to do so. In fact, private-sector health care is the fastest-growing part of the health care system in many of these countries. For example, in Britain, 13 percent of the population has private health insurance

to cover services to which they presumably are entitled for free under the NHS, and private-sector spending makes up 15 percent of the country's total health care spending.³⁸

In Canada, the share of privately funded health care spending rose from 24 percent in 1983 to an estimated 30.3 percent in 1998.³⁹ In Australia, private health insurance coverage has risen from around 31 percent of the population in 1998 to almost 45 percent by March 2002.⁴⁰ In New Zealand, 35 percent of the population has private health insurance (again, to cover services theoretically provided for free by the state), and private sector spending is about 10 percent of total health care spending.⁴¹

The almost seven million people in Britain covered by private health insurance account for two-thirds of all patients in private hospitals. Britain's 300 private hospitals account for an increasingly large share of total health care services, including 20 percent of all non-emergency heart surgery and 30 percent of all hip replacements. In 2002 an estimated 100,000 patients elected to pay for private surgery rather than wait for "free" care.⁴²

Despite British claims that health care is a right and is not conditioned on the ability to pay, large numbers of patients waited for care while 10,000 private-pay patients—about half of whom were foreigners—received preferential treatment in top NHS hospitals in 2001.⁴³ Advertisements for one hospital boast that patients come from all over the world, and the rooms are well-furnished, with televisions that have Arabic-language channels. An investigation by the *Observer* found that the NHS earns approximately \$500 million per year in fees from treating private patients.

Since Canada does not allow private health insurance for services covered by its Medicare system, Canadians who see the country's few private physicians or get treatment at a private hospital must pay most of the cost out of pocket. For example, Canadians sometimes choose to undergo cataract surgery on an outpatient basis in private clinics. Although the government will pay the surgeon's fee, private patients often pay \$1,000 to \$1,200 in "facilities fees" to

obtain faster treatment than they can get at a government facility. There is also a budding private market in sophisticated scanning services. Private clinics that apparently skirt the law—on the theory that services are not "necessary" medical care—are booming and now constitute 10 percent of the MRI market. St. Paul's Hospital in Vancouver offers after-hours full-body scans for less than C\$1,000. A Montreal clinic offers a private CT scan for C\$250. Patients wait one or two weeks for these procedures, compared to six-month waits in the public sector. A private company in Vancouver that offers PET scans for C\$2,500 is attracting patients from as far away as Newfoundland.⁴⁴

To reduce waiting lists for cancer treatment, 7 of the 10 Canadian provinces are sending some of their breast and prostate cancer patients to the United States for radiation therapy.⁴⁵ Canadians spend an estimated \$1 billion on care in the United States each year.⁴⁶ Sometimes the patient's home province pays the bill. In other cases, patients spend their own money.

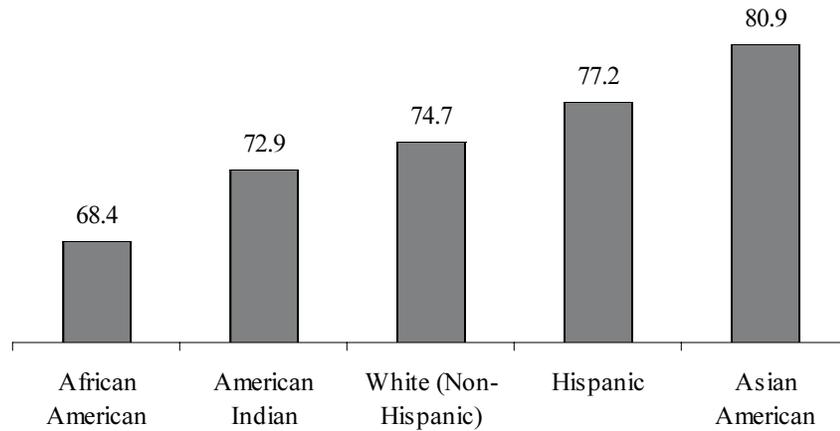
Myth No. 4: Although the United States Spends More per Capita on Health Care Than Countries with National Health Insurance, Americans Do Not Get Better Health Care

This myth is often supported by reference to two facts: (1) that life expectancy is not much different among the developed countries and (2) that the U.S. infant mortality rate is one of the highest among developed countries. If the United States spends more than other countries, why don't we rate higher than the others by these indices of health outcomes? The answer is that neither statistic is a good indicator of the quality of a country's health care system. Other indicators are much more telling.

Average life expectancy tells us almost nothing about the efficacy of health care sys-

Despite British claims that health care is a right and is not conditioned on the ability to pay, large numbers of patients waited for care while 10,000 private-pay patients received preferential treatment in top NHS hospitals in 2001.

Figure 6
U.S. Life Expectancy at Birth, Male (1999)



Source: National Projections Program, Population Division, U.S. Census Bureau, January 13, 2000.

tems because, throughout the developed world, there is very little correlation between health care spending and life expectancy. While a good health care system may, by intervention, extend the life of a small percentage of a population, it has very little to do with the average life span of the whole population. Instead, the number of years a person will live is primarily a result of genetic and social factors, including lifestyle, environment, and education.⁴⁷

As Figure 6 shows, the American population is a mixture of ethnic groups with strikingly different expected life spans. In 1999, male life expectancy at birth ranged from 80.9 years for Asian Americans, 77.2 for Hispanics, 74.7 years for white non-Hispanics, and 72.9 years for American Indians to 68.4 years for African Americans.⁴⁸ Ethnic differences in life spans tend to persist, and, thus, the relative diversity of the U.S. population partly accounts for the lower overall longevity rates in the United States compared with other developed countries.

The infant mortality rate in the United States is higher than the average among developed countries, at 7.2 deaths per 1,000 live births in 1998, compared to an average of about 5.0.⁴⁹ Why does the United States have a much higher infant mortality rate than countries with comparable living standards?

Like the life expectancy rate, the U.S. infant mortality rate is a composite average.⁵⁰ Overall, the chances that an infant will die at birth vary widely according to such factors as race, geography, income, and education:

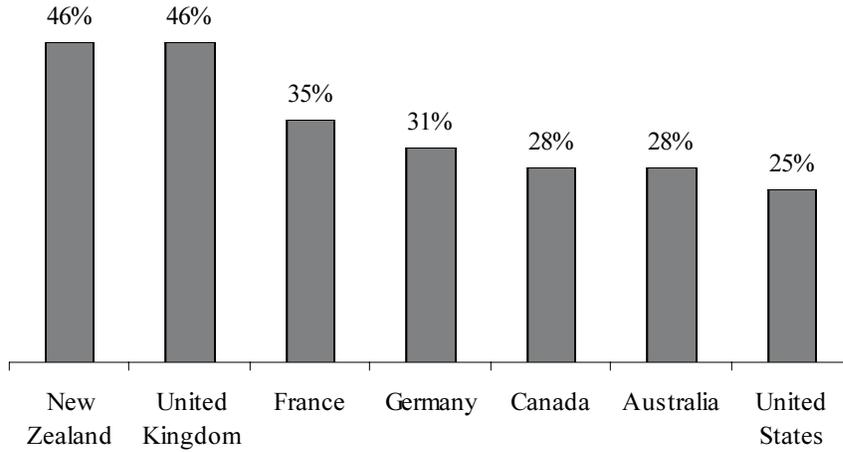
- *Race:* According to the National Center for Health Statistics, in 1997, the mortality rate (per 1,000 live births) for infants born to black mothers was 13.7 compared to 8.7 for American Indian mothers, 7.9 for Puerto Rican mothers, 6.0 for non-Hispanic white mothers, and 5.0 for Asian mothers.⁵¹
- *Geography:* Among the 60 largest U.S. cities, infant mortality ranged from a high of 15.4 (Memphis) to a low of 4.5 (Seattle); among U.S. states, rates varied from a high of 10.2 (Alabama) to a low of 4.4 (New Hampshire).⁵²
- *Income and education:* Infants born to low-income mothers who did not finish high school were about 50 percent more likely to die than infants whose mothers finished college.⁵³

These factors have nothing to do with the quality of (or access to) health care.

A better measure of a country's health care system is mortality rates for those diseases that

In New Zealand and the United Kingdom nearly half of all women diagnosed with breast cancer die of the disease. By contrast, in the United States only one in four dies.

Figure 7
Breast Cancer Mortality Ratio (percentage of those diagnosed with the disease who die of it)



Source: Gerard F. Anderson and Peter S. Hussey, “Multinational Comparisons of Health Systems Data,” Commonwealth Fund, October 2000.

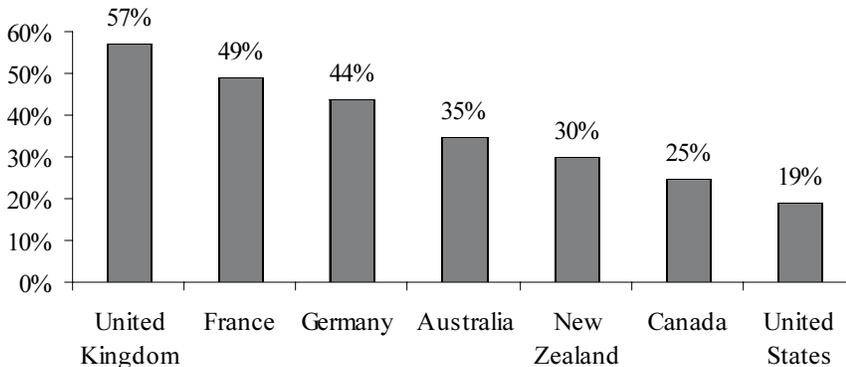
modern medicine can treat effectively. Take cancer, for example. As Figure 7 illustrates, in New Zealand and the United Kingdom nearly half of all women diagnosed with breast cancer die of the disease. In Germany and France, almost one in three dies of the disease. By contrast, in the United States only one in four women diagnosed with breast cancer dies of the disease. This is among the lowest rates of any industrial country.⁵⁴

Similarly, in the United States the mortality rate for prostate cancer is lower than in most

other OECD countries (see Figure 8). Slightly fewer than one in five men in the United States diagnosed with prostate cancer dies of the disease. In the United Kingdom, 57 percent die. France and Germany fare slightly better at 49 percent and 44 percent, respectively. At 30 percent and 25 percent, respectively, death rates from prostate cancer in New Zealand and Canada are still well above that of the United States.

The relatively high incidence of prostate and breast cancer in the United States may be the result of lifestyle and diet as well as genet-

Figure 8
Prostate Cancer Mortality Ratio (percentage of those diagnosed with the disease who die of it)



Source: Gerard F. Anderson and Peter S. Hussey, “Multinational Comparisons of Health Systems Data,” Commonwealth Fund, October 2000.

One of the most surprising features of national health insurance systems is the amount of rhetoric devoted to the notion of equality, especially in relation to the tiny amount of progress that appears to have been made.

**Inequity of access
to resources is
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Canada.**

ics.⁵⁵ This, of course, puts greater demands on the U.S. health care system. Yet patients diagnosed with either of these diseases have a better chance of survival.

**Myth No. 5: Countries with
National Health Insurance
Create Equal Access to
Health Care**

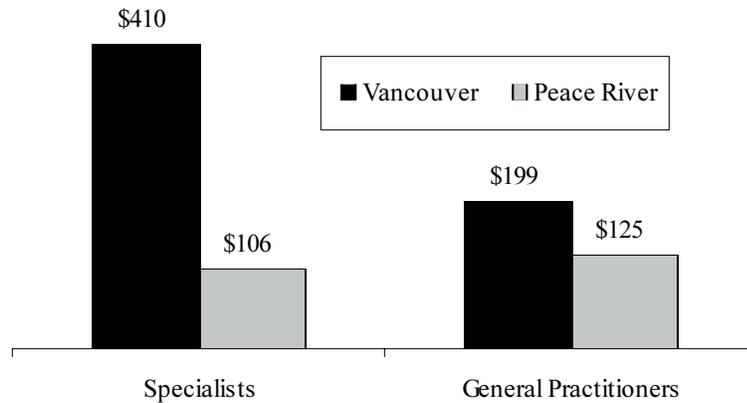
One of the most surprising features of national health insurance systems is the enormous amount of rhetoric devoted to the notion of equality and the importance of achieving it—especially in relation to the tiny amount of progress that appears to have been made. Aneurin Bevan, father of the NHS, declared that “everyone should be treated alike in the matter of medical care.”⁵⁶ But more than 30 years into the program (in the 1980s), an official task force (the Black Report) found little evidence that access to health care was any more equal than when the NHS was started.⁵⁷ Almost 20 years later, a second task force (the Acheson Report) found evidence that access had become *less equal* in the years between the two studies. Across a range of indices, NHS performance figures have consistently shown widening gaps between the best-performing and worst-performing hospitals and health authorities, as well as vastly different sur-

vival rates for different types of illness, depending on where patients live. The problem of unequal access is so well known in Britain that the press refers to the NHS as a “postcode lottery” in which a person’s chances for timely, high-quality treatment depend on the neighborhood or “postcode” in which he or she lives.⁵⁸

Canadian officials also put a high premium on equality of access to medical care. In 1999, for instance, Health Minister Allan Rock stated that “equal access regardless of financial means will continue to be a cornerstone of our system.”⁵⁹ How well have the Canadians done? A series of studies from the University of British Columbia in the 1990s consistently found widespread inequality in the provision of care among British Columbia’s 20 or so health regions. These studies are unique because researchers identified patients by the region in which they lived rather than the region where they received care. This allowed investigators to identify inequities in the amount of care received by residents of each region, including those patients forced to travel hundreds of miles (from one region to another) for treatment.⁶⁰

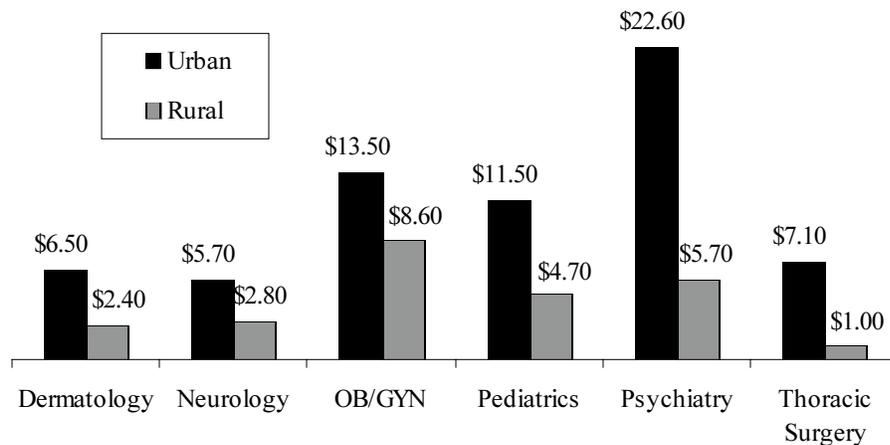
For example, the rural Peace River region of British Columbia spends much less per patient on specialists than Vancouver health authorities. One might suppose the higher level of GP services would offset the lower level of specialist services in Peace River. As

Figure 9
Per Capita Spending on Physician Services in British Columbia



Note: 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, 1993–94,” University of British Columbia, 1995.

Figure 10
Inequalities in the Use of Physician Services among Urban and Rural Patients in British Columbia (per capita spending 1993–94)



Note: 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. Source: Arminée Kazanjian et al., “Fee Practice Medical Expenditures Per Capita and Full-Time-Equivalent Physicians in British Columbia, 1993–94,” University of British Columbia, 1995.

Figure 9 shows, that was not the case. Vancouver residents also enjoy about 60 per cent more GP services.

These examples are not isolated. Inequity of access to resources is pervasive. Spending on specialist services in Vancouver was almost four times as high as spending on specialists in rural Cariboo. Per capita spending on all services was almost three times as high in Vancouver (\$609) as in Peace River (\$231). Differences between the rural and urban regions in British Columbia were especially striking in certain specialties—a seven-fold difference in spending on thoracic surgery, a four-fold difference in spending on psychiatric services and a three-fold difference in spending on dermatology (see Figure 10).

Myth No. 6: Countries with National Health Insurance Hold Down Costs by Operating More Efficient Health Care Systems

A widely used measure of hospital efficiency is average length of stay (LOS). By this standard,

U.S. hospitals are ahead of their international counterparts (see Figure 11).⁶¹ The average length of a hospital stay in the United States is 5.4 days compared to 6.2 days in Australia, 9.0 in the Netherlands, and 9.6 in Germany. Whereas patients from other countries routinely convalesce in a hospital, American patients are more likely to recover at home.

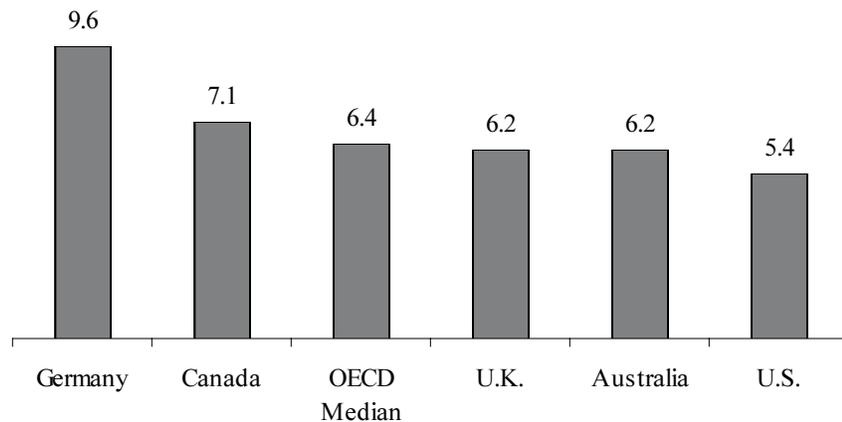
It is an inefficient use of resources to fill an acute care hospital bed with a patient waiting for nonemergency care, a geriatric patient waiting to transfer to a nonacute facility, or simply because the hospital has not gotten around to discharging that patient. This is especially true when there are lengthy waiting lists for hospital admission. Generally, the more efficient the hospital, the more quickly it will admit and discharge patients.⁶²

Long-term care patients who should be in nursing homes, in geriatric wards, or at home are often found occupying acute care beds in Britain—a practice known as “bed blocking.” As a result, many patients must wait for admission and treatment because patients treated earlier are waiting for discharge to an appropriate facility and thus “blocking” access to a bed. Officials estimate that about 3.3 per cent of beds are blocked at any given time.⁶³

A comparison of the British NHS and Kaiser Permanente concluded that the per capita costs of the two systems were similar. However, Kaiser provided its members with more comprehensive and convenient primary care services and much more rapid access to specialists and hospital admissions.

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Figure 11
Average Length of Hospital Stay



Source: Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): 97, Exhibit 5.

Many public health officials think the actual number may be far higher. Liam Fox, admittedly the British Conservative Party's shadow health secretary and thus a Labor government critic, has estimated that the true number of blocked beds is closer to 15 percent.⁶⁴

The statistics on bed utilization indicate bed management in Britain is highly inefficient. More than one million people are waiting for medical treatment in British hospitals at any one time, and an estimated 500,000 surgeries were cancelled in the past five years because of the shortage of NHS hospital beds.⁶⁵ Yet close to 30,000 beds (16 percent of the total) are empty on any given day.⁶⁶ These estimates imply that as many as one out of three NHS hospital beds is unavailable for acute care patients.

A *British Medical Journal* comparison of the British NHS and Kaiser Permanente, a large U.S. health maintenance organization (HMO), concluded that the per capita costs of the two systems were similar. However, the analysis found that Kaiser provided its members with more comprehensive and convenient primary care services and much more rapid access to specialists and hospital admissions. After adjustments for differences between countries, the NHS cost was calculated at \$1,764 per capita compared to a Kaiser cost of \$1,951.⁶⁷ However, as Figure 12 shows, Kaiser had two

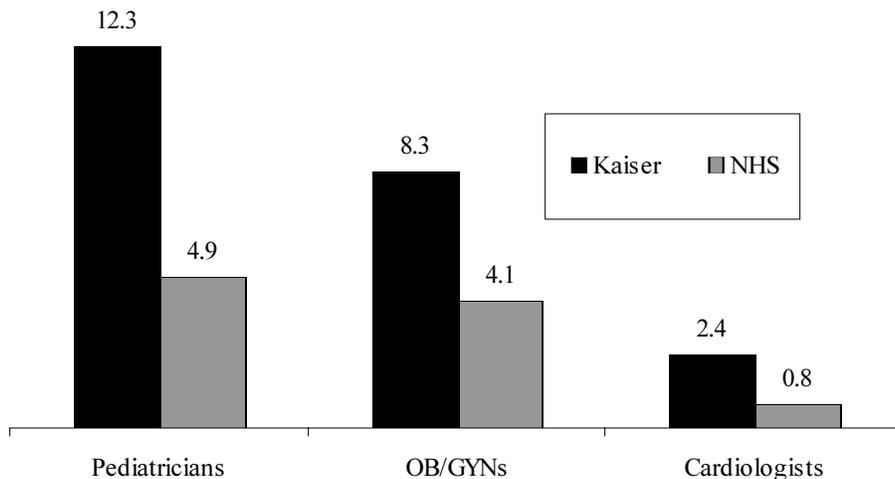
and one half times as many pediatricians, twice as many obstetricians-gynecologists, and three times as many cardiologists per enrollee as the NHS. After referral, waiting times to see a specialist were more than six times as long in the NHS. For nonemergency hospital admission, 90 percent of Kaiser patients waited less than three months; one-third of NHS patients waited more than five months.

One of the most striking differences between the two health systems was the length of stay. Kaiser had 270 acute care bed days per 1,000 population, whereas NHS patients stayed in the hospital more than three times as long—an average of 1,000 acute care bed days per 1,000 population.⁶⁸ In summary, the study found that

The widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment are not supported by this analysis. Kaiser achieved better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition and greater investment in information technology.⁶⁹

The Congressional Research Service has

Figure 12
Kaiser Permanente (California) vs. NHS; Specialists per 100,000 Enrollees



Source: Richard G.A. Feachem, Neelam K. Sekhri, and Karen L. White, “Getting More for Their Dollar: A Comparison of the NHS with California’s Kaiser Permanente,” *British Medical Journal* (January 19, 2002): 135–43.

estimated administrative costs for Medicare at 2 percent of total program costs, compared to 9.5 percent for private insurance and 11.9 percent for HMOs.⁷⁰ Many single-payer advocates have used this estimate as an argument for forcing all Americans to join Medicare. Steffie Woolhandler, a prominent member of the Physicians’ Working Group for Single-Payer National Health Insurance, and her colleagues estimate that administrative costs account for close to one-third of U.S. health care expenditures (31.0 percent), nearly twice as much as in Canada (16.7 percent).⁷¹

These estimates are misleading, however. Determining the administrative costs of any government program is difficult, if not impossible. And comparisons with the private sector are problematic. Part of the reason is that government regulators can shift administrative costs to physicians or patients, just as tax collectors shift the cost of recordkeeping and data collection onto taxpayers. For example, a study by the American Medical Association estimated that a physician spends an average of six minutes on every Medicare claim (compared, say, to 20 minutes spent with the patient) and the physician’s staff spends an average of one hour.⁷²

Actuary Mark Litow (Milliman & Robert-

son) estimated the hidden costs (inclusive of taxes) in public programs. He found that Medicare and Medicaid spend 26.9 cents for every dollar of benefits, compared to 16.2 cents spent by private insurance.⁷³

Myth No. 7: National Health Insurance Would Benefit the Elderly and Racial Minorities

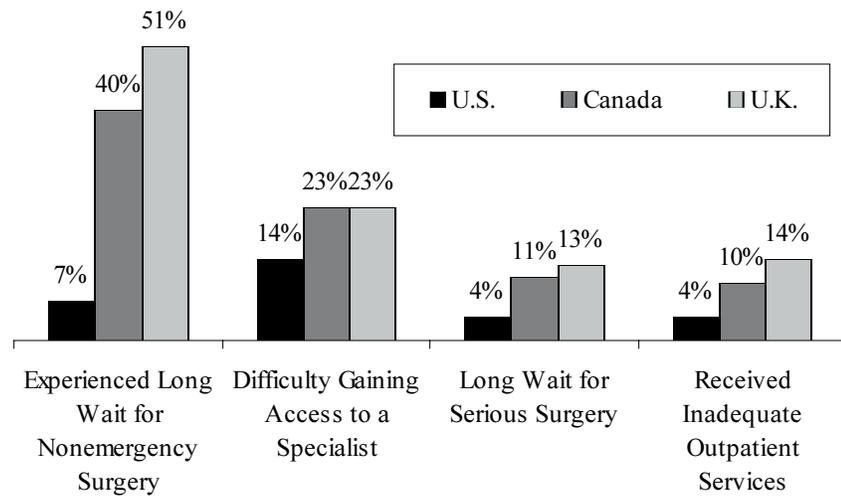
It is frequently argued that national health insurance would benefit the elderly and reduce racial health disparities that exist in the United States. Empirical studies show this not to be the case. Minorities are often discriminated against under national health insurance (see Figure 13).⁷⁴ In a market where prices are used to allocate resources, goods and services are rationed by price. Willingness to pay determines which individuals utilize resources. In a nonmarket system, things are very different. Unable to discriminate on the basis of price, suppliers of services must discriminate among potential customers on the basis of other factors. Race and ethnic background are invariably among those factors.⁷⁵

In a recent study of Canadian Indian groups, researchers found that all of the

New Zealand’s guidelines for end state renal failure programs say that “in usual circumstances, people over 75 should not be accepted.” Since New Zealand has no private dialysis facilities, this amounts to a death sentence for elderly patients with kidney failure.

During the 1990s, health care spending in all but 3 of 15 OECD countries studied grew at about the same rate as in the United States—or higher.

Figure 13
How the Elderly Evaluate Their Health Care



Source: Cathy Schoen et al., “The Elderly’s Experiences with Health Care in Five Nations,” Commonwealth Fund, May 2000.

groups sampled had much less access to health care than Caucasians—despite their greater health needs.⁷⁶ Further, health disparities persisted between Canadian Indians and Caucasians. The infant death rate during the study period was 13.8 per 1,000 live births for Indian infants and 16.3 per 1,000 for Inuit infants, approximately twice the rate (7.3 per 1,000) of that for all Canadian infants during the same period. Overall, Canadian aboriginal people “die earlier than their fellow Canadians and sustain a disproportionate share of the burden of physical disease and mental illness.”⁷⁷

In New Zealand, the same disparities persist. The average life expectancy for Maori men (68 years) is 5.5 years less than for non-Maori men. The average for Maori women (73 years) is six years less than for non-Maori women.⁷⁸ Furthermore, those Maori who live in the least deprived areas live seven years longer than those in the most deprived areas. The corresponding figure for women is eight years. Australia also has a significant minority population (the Aborigines). Various studies have reported that death rates are higher for Aborigines in all age groups.⁷⁹ In infancy, Aborigines are 3.1 to 3.5 times more likely to die than other Australians. In the 35 to 54 age group, they are six to seven times more likely to

die than other Australians. Despite the greater overall health needs of these populations, minorities in countries with national health insurance systems are routinely marginalized by systems that direct resources and services toward the more affluent, white, urban majority.

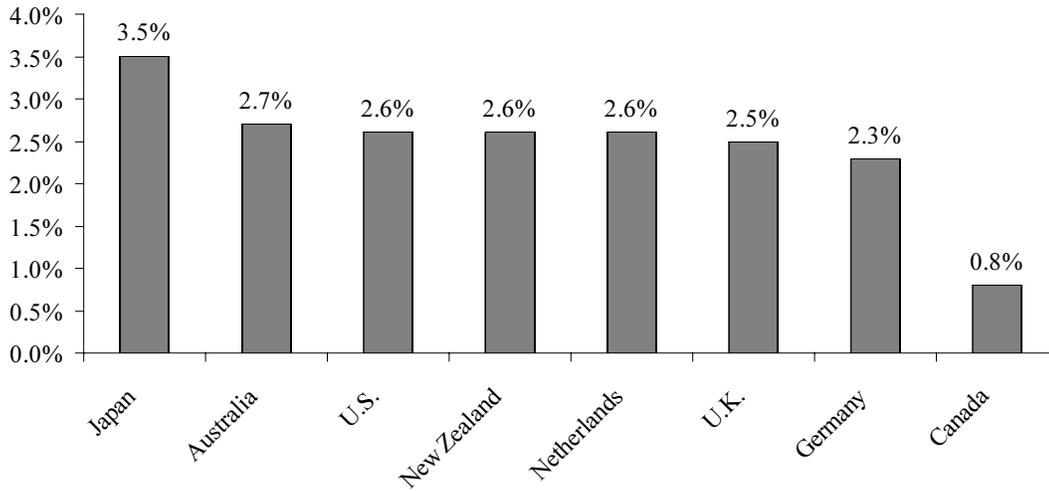
If the experience of other countries is any guide, the elderly have the most to lose under a national health insurance system. In general, when health care is rationed, the young get preferential treatment, while older patients get pushed to the rear of the waiting lines.

In Britain, many elderly do not receive the treatment and specialized care they need. Although more than one-third of all diagnosed cancers occur in patients 75 years of age or older, most cancer-screening programs in the NHS do not include people over age 65.⁸⁰ Only one in 50 lung cancer patients over age 75 receives surgery.⁸¹

New Zealand’s guidelines for end state renal failure programs say that age should not be the sole factor in determining eligibility, but that “in usual circumstances, people over 75 should not be accepted.” Since New Zealand has no private dialysis facilities, this amounts to a death sentence for elderly patients with kidney failure.⁸²

Although there is very little relationship

Figure 14
Average Annual Real Growth in per Capita Health Spending (1960–1998)



Source: Gerard F. Anderson et al., “Health Spending and Outcomes: Trends in OECD Countries, 1960–1998,” *Health Affairs*, May/June 2000.

between health care spending and life expectancy at birth in OECD countries, at age 80 there is a significant correlation. An 80-year-old U.S. female can expect to live almost a year longer than her British counterpart. An 80-year-old U.S. male can expect to live a half-year longer than his British counterpart.⁸³

Myth No. 8: Countries with National Health Insurance Systems Have Been More Successful Than the United States 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 percentage of GDP. Does that mean that our predominantly private health care system is less able to control spending than developed countries with national health insurance? Not necessarily.

Almost without exception, international comparisons show that wealthier countries spend a larger proportion of their GDP on health care.⁸⁴ In his classic 1977 and 1981

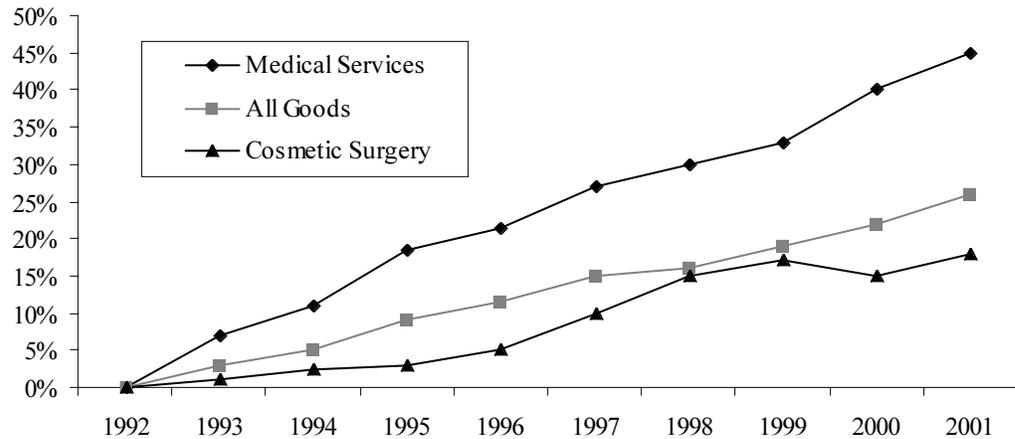
studies, health economist Joseph Newhouse found that 90 percent of the variation in health care spending among developed countries is based on income alone.⁸⁵

Most international statistics on health care spending are produced by the Organization for Economic Cooperation and Development. However, OECD statistics are not always useful because different countries use different methods to report costs.⁸⁶ No effective international guidelines exist, and some countries include services that others do not.⁸⁷ For instance, the OECD definition of health care expenditures includes nursing home care. But while Germany includes nursing home care as part of total health expenditures, Britain does not.⁸⁸ Some countries count hospital beds simply by counting metal frames with mattresses, whether or not they are in use. In others, a “bed” is counted only if it is staffed and operational.⁸⁹

Figure 14 shows the result of an attempt by scholars at Johns Hopkins University and OECD to develop more accurate health care spending measurements among OECD countries. The study calculated the average annual increase in the percentage of per capita spending on health care by OECD countries for the period 1960 to 1998.

Fewer than one-third of British patients who suffer a heart attack have access to beta-blockers, despite the fact that post-heart attack use of the drug reduces the risk of sudden death from a subsequent heart attack by 20 percent.

Figure 15
Comparative Rates of Inflation (compared to base year 1992)



Source: Author's calculation using data from the Consumer Price Index and the American Society of Plastic Surgeons. See Devon Herrick, "Why Are Health Costs Rising?" National Center for Policy Analysis, Brief Analysis no. 437, May 7, 2003.

As the figure shows, the countries of the OECD have been no more successful than the United States in controlling costs and many have been far less successful. During the 1990s, health care spending in all but 3 of 15 OECD countries studied grew at about the same rate as in the United States—or higher. The notable exception to the spending trend among OECD countries is Canada. The Canadian federal government limited spending increases by cutting funding. It reduced block grants to provinces for health care as a percentage of GDP in 1986 and again in 1989; funding to the provinces was frozen at 1989-90 levels through 1995, and further cuts were made in the second half of the 1990s.⁹⁰

Not all health care prices are rising. Although health care inflation is robust for those services paid by third-party insurance, prices are rising only moderately for services patients buy directly. As Figure 15 shows, the real (inflation-adjusted) price of cosmetic surgery fell over the past decade—despite a huge increase in demand and considerable innovation. Cosmetic surgery is one of the few types of medical care for which consumers pay almost exclusively out of pocket. Even so, the demand for cosmetic surgery exploded in recent years. Despite the quadru-

pling of the number of surgeries, cosmetic surgeons' fees remained relatively stable.

Myth No. 9: Single-Payer National Health Insurance Would Reduce the Cost of Prescription Drugs for Americans

Advocates of single-payer insurance maintain that it would provide all Americans with full coverage for necessary drugs and control drug costs by establishing a national formulary—a list of drugs available to patients under the national health plan—and negotiating drug prices with manufacturers "based on their costs (excluding marketing and lobbying)."⁹¹ However, access to new, more effective (and more expensive) prescription drugs is often restricted in countries with national health insurance.

Drug development is costly. Only one in five drugs tested ever reaches the public, and the cost of bringing a new drug to market now averages \$900 million.⁹² A government facing rising health care costs is tempted to negotiate prices just above the costs of production, ignoring the

The cost of bringing a new drug to market now averages \$900 million.

research and development (R&D) costs. Countries with single-payer systems thus reap the benefits of new drugs without sharing the burden of their development. As a result, many pharmaceutical firms based in single-payer countries have gone abroad to recoup their costs, and drug innovation is limited.

One way that single-payer countries control their drug spending is by delaying the introduction of the newest, most expensive drugs or by restricting access to them. In Britain, many drugs that are available to private pay patients are not available to NHS patients.⁹³ Each local health board decides which drugs will be covered, and expensive drugs are often left off the lists because of budget constraints. For example, Dr. Edward Newlands, the British doctor who codeveloped the brain cancer drug Temodal, cannot prescribe it to his patients. Fewer than one-third of British patients who suffer a heart attack have access to beta-blockers used by 75 percent of patients in the United States, despite the fact that post-heart attack use of the drug reduces the risk of sudden death from a subsequent heart attack by 20 percent.⁹⁴

The American news media often feature stories about buses of elderly Americans who travel to Canada to buy cheaper prescription drugs. Less publicized, however, is the fact that some Canadians travel to the United States to buy drugs not available at any price in Canada. One of the newest drugs to treat noninsulin dependent diabetes—Glucophage XR—is not available in Canada.⁹⁵ Some drugs are approved for use in one province, but not another. Furthermore, Canada’s federal Patented Medicines Price Review Board only allows manufacturers to charge higher prices for new drugs if they are judged to be “a substantial improvement” over existing drugs. From 1994 to 1998 the board approved only 24 of the 400 drugs considered.⁹⁶

A Fraser Institute study found that the main effect of Canadian price controls has been to limit patients’ choices, causing them to rely more on hospitals and surgery.⁹⁷ The consequences of restricted access to drugs have been particularly profound in British Columbia. British Columbia can require that

a patient receiving subsidized drugs under the provincial health plan be treated with the least costly drug, even if it is a completely different compound, as long as it is deemed to have the same therapeutic effect. Twenty-seven percent of physicians in British Columbia report that they have had to admit patients to the emergency room or hospital as a result of the mandated switching of medicines, and 60 percent have seen patients’ conditions worsen or their symptoms accelerate due to mandated switching.⁹⁸

Despite the fact that countries with single-payer systems go to great lengths to limit both price and availability of prescription drugs, they don’t appear to be all that successful at holding down drug spending. OECD data from 1992 showed that when per capita spending on medications was adjusted for purchasing power parity, the United States spent less than France, Germany, and Japan. It spent a few dollars more than Canada and substantially more than Britain. During the 1990s, drug spending in the United States inched up relative to other countries, but since much of that spending represents the substitution of drug therapies for more expensive doctor and hospital services, the United States is getting a significant return on its investment in drugs.⁹⁹ Research by Columbia University professor Frank Lichtenberg, for example, indicates that each dollar spent on drugs correlates with roughly a four-dollar decline in spending on hospitals.¹⁰⁰

In short, it may be a good thing that the United States spends more on prescription drugs than other countries. Effective prescription drugs can prevent or shorten expensive hospital stays and doctor visits, and investment in pharmaceutical R&D yields more cutting-edge medications.

Myth No. 10: Under National Health Insurance, Funds Are Allocated So That They Have the Greatest Impact on Health

The one characteristic of foreign health care systems that strikes American observers

Twenty-seven percent of physicians in British Columbia report that they have had to admit patients to the emergency room or hospital as a result of the mandated switching of medicines.

While thousands of people die each year from lack of kidney dialysis, the NHS provides an array of comforts for chronically ill people with less serious health problems.

**Table 1
Selected Features of British NHS, Part One**

	Annual Number
Nonemergency ambulance rides	15,000,000
Missed physician appointments	10,000,000
Patients receiving nonmedical services	1,500,000

Source: “Community Care Statistics 2000/2001, Referrals, Assessments and Package of Care for Adults,” U.K. Department of Health, 2001.

**Table 2
Selected Features of British NHS, Part Two**

	Annual Number
Home alterations	375,000
Occupational therapy	456,000
Day care services	260,000
Home care/home help services	578,000

Source: “Community Care Statistics 2000/2001, Referrals, Assessments and Package of Care for Adults,” U.K. Department of Health, 2001.

as the most bizarre is the way in which limited resources are allocated. Foreign governments do not merely deny lifesaving medical technology to patients under national insurance schemes. They also take money that could be spent saving lives and curing disease and spend it serving people who are not seriously ill. Often, the spending has little if anything to do with health care.

The British National Health Service’s emphasis on “caring” rather than “curing” marks a radical difference between British and American health care. The tendency throughout the NHS is 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 British ambulance service, for example. British “patients” take between 18 million and 19 million ambulance rides each

year—about one ride for every three people in Britain.¹⁰¹ Almost 80 percent of these rides are for such nonemergency purposes as taking an outpatient to a hospital or a senior to a pharmacy and amount to little more than free taxi service (see Table 1). While thousands of people die each year from lack of kidney dialysis, the NHS provides an array of comforts for chronically ill people with less serious health problems. For example, the NHS provides nonmedical services to about 1.5 million people a year. These include day care services to more than 260,000, home care or home help services to 578,000, home alterations for 375,000, and occupational therapy for 300,000 (See Table 2).¹⁰²

More than one million people are waiting to be admitted to NHS hospitals,¹⁰³ but the equivalent of 1,692 full-time doctors are tied up waiting for patients who do not appear for

appointments or call to cancel.¹⁰⁴ If the NHS did nothing more than charge patients the full costs of missed appointments, it would free up enough money to treat thousands of additional cancer patients each year. Yet such options are not seriously considered.¹⁰⁵

Myth No. 11: A Single-Payer National Health Care System Would Lower Health Care Costs because Preventive Health Services Would Be More Widely Available

Proponents of national health insurance often argue that because care is “free” at the point of service, people will be more likely to seek preventive services. Thus, money will be saved when doctors catch conditions in their early stages before they develop into expensive-to-treat diseases. Yet the evidence shows that patients in government-run health care systems do not get more preventive care than Americans do, and even if they did, such care would not save the government money.

Preventive care may even be less available under a single-payer system *because* care is free. A comparison of American and British physicians in the 1990s found that the British saw a physician almost as often as Americans (roughly six times a year).¹⁰⁶ Yet when Americans did see a doctor, the consultation was six times as likely to last more than 20 minutes.¹⁰⁷ A recent survey of 200 British GPs and more than 2,000 consumers found that 87 percent of smokers want more advice and help in quitting from their GPs, but 93 percent of GPs say they lack the time to give such advice.¹⁰⁸ Moreover, British physicians have much less access to diagnostic equipment and must send their patients to hospitals for chest X-rays and simple blood tests.¹⁰⁹ In Canada, fee structures are designed to discourage physicians from providing office-based procedures. Doctors can only bill for the time they spend examining and evaluating patients, not for diagnostic

tests. Access to preventive care—which is often costly in itself—is tacitly discouraged by cash-strapped health care bureaucracies.

If anything, the amount of preventive care people get under single-payer systems seems to be based more on socioeconomic status and education than on whether medical care is “free” or not. Studies comparing women in Ontario and in two areas of the United States found that their chances of receiving a Pap smear or clinical breast cancer screening increased with education and income regardless of whether a woman had health insurance.¹¹⁰

Myth No. 12: The Defects of National Health Insurance Schemes in Other Countries Could Be Remedied by a Few Reforms

The characteristics described above are not accidental byproducts of government-run health care systems. They are the natural and inevitable consequences of placing the market for health care under the control of politicians.¹¹¹ Health care delivery in countries with national health insurance does not just happen to be as it is. In many respects, it could not be otherwise.

Why are low-income patients so frequently discriminated against under national health insurance? Because such insurance is almost always a middle-class phenomenon. Prior to its introduction, every country had some government-funded program to meet the health care needs of the poor. The middle-class working population not only paid for its own health care but also paid taxes to fund health care for the poor. 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 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 lat-

The amount of preventive care people get under single-payer systems seems to be based more on socioeconomic status and education than on whether medical care is “free” or not.

The failures of socialized medicine are evident in every country that implements it, and there is no reason to believe that a single-payer system in the United States would be any different.

ter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small numbers of voters). Democratic political pressures 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—to have those decisions made by politicians—is politically impossible. As a practical matter, no government can make it a national policy to let 25,000 of its citizens die from lack of the best cancer treatment every year.¹¹² Nor can any government announce that some people must wait for surgery so that the elderly can use hospitals as nursing homes, or that elderly patients must be moved so that surgery can proceed. These decisions are so emotionally loaded that no elected official could afford to claim responsibility for them. Important decisions on who will receive care and how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.

Why do the rich and the powerful manage to jump the queues and obtain care that is denied to others? Because they are the people with the power to change the system. If they had to wait in line for their care like ordinary people, the system would not last for a minute. For example, the president of the Canadian Medical Association, Dr. Victor Dirnfeld, suggested in 1998 that the Canadian system is in fact a two-tiered system, and said that he knew of seven prominent political figures in British Columbia and Ontario who received special treatment. “Instead of waiting three months for an MRI,” he said, “they will have it done in three or four days.”¹¹³ More recently, Canada’s Health Minister, Allan Rock, underwent a successful surgery after he was diagnosed with prostate cancer in January 2001. Rock was sharply criticized by other Canadian prostate cancer patients who waited much longer for treatment—often more than a year between diagnosis and surgery.¹¹⁴

Conclusion

The realities of national health insurance documented in this paper—waiting lines, rationing, lack of cutting-edge medical technology, restricted access to the latest prescription drugs, inequitable distribution of care—are not accidental. Such problems flow inexorably from the fact that politicians and bureaucrats—not patients and doctors—are given the authority to allocate limited health care resources.

Yet proponents of socialized medicine insist that a single-payer health care system is the only way to solve the structural problems of the U.S. health care system. They conveniently ignore or explain away the flaws of single-payer systems, arguing that we could design a better system and spend more money than Britain and Canada, thus getting better results. But the failures of socialized medicine are evident in every country that implements it, and there is no reason to believe that a single-payer system in the United States would be any different. Advocates of national health insurance would do well to look at how countries like Germany, Sweden, and Australia are choosing free-market reforms to alleviate the problems of their national health systems. Through painful experience, many of the countries that once heralded the benefits of government control have learned that the best remedy for their countries’ health care crises is not increasing government power, but increasing patient power instead.¹¹⁵

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