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Backgrounder
Executive Summary

No. 1398 September 26, 2000

A High Price for Patients: An Update on Government Health Care in Britain and Canada

James Frogue

Supporters of government-run health care offer an alluring vision: universal health coverage, free or inexpensive medical services and prescription drugs, unrestricted access to care, doctors with complete clinical freedom, and exemplary quality of care. These advocates of government-subsidized medicine often claim that the U.S. health care system should move in this direction so that it will be more similar to the government-run health care in Canada and Britain. Yet an examination of health care in both Canada and Britain reveals that moving American medicine in this direction would be a terrible mistake.

Though the government-funded health care systems of Canada and Britain are different, they achieve similar results. Both systems are characterized by long lines for treatment, substandard technology, frustrated doctors and patients, and—most important—government rationing of care. Because advocates of government-run health care often praise these systems as a model for the United States, an assessment of how they actually operate is instructive for Americans who contemplate reforming the American health care system.

Fundamental Flaw. There is a problem intrinsic to health care systems run and financed by government fiat: As a result of government subsidies, patients do not see the true cost of medical goods and services. Thus, they naturally demand more than they would otherwise consume. Obviously, the more government subsidizes health care, the more pronounced this trend will be. Increased demand necessarily collides with the limited supply available.

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At this point, the government must begin to ration care, and because the government pays for health care, it has the final say as to who receives treatment. Under universal health care, government rationing is inevitable. Furthermore, the

longer government subsidies are in place, the more acute this problem will become.

To illustrate this point, imagine that the government decided that all restaurant meals should be free, with the government reimbursing the cost of the meal to restaurant owners. Under such a scenario, customers would no longer consider price when deciding where to eat. They would eat out more than they would otherwise, and they would demand the most expensive food. The inevitable result: long lines and shortages of food. As for the restaurant operators, their income to a large extent would be guaranteed, and they would no longer be concerned with providing food efficiently. The government, facing exploding and unsustainable costs, would begin to provide less expensive food or be more selective in choosing which foods to subsidize. Such discrimination would annoy both diners and restaurant owners, harm the delivery of food, and result in lower-quality products.

This problem—the gap between supply and demand when prices are set by the government—is inherent in all government-provided goods or services. Yet when reform-minded critics look at the problems created by socialized markets, they often call for further government involvement.

Both health care systems in Canada and Britain are characterized by:

- **Waiting Lists.** Advocates of government-run health care often claim that universal coverage is a fairer system than private health care because it ensures access to care for all people. Yet these advocates often fail to mention that access to care is *not* guaranteed. Because demand outpaces supply, the government has no choice but to ration care. Absent prices, the only way to "control" demand is to limit supply, which entails waiting lists. In some cases, these waiting lists are so long that some patients literally die while in line.

- **Rationed Prescription Drugs.** Stories appear almost daily in newspapers around America about the cheaper prices Canadian citizens pay for drugs, and American politicians have responded with proposals to subsidize prescription medicine. Yet Canadian drugs are not consistently less expensive than American drugs.

  Some drugs are less expensive in Canada because the government fixes the prices of prescription medicines. Nevertheless, when the government purchases drugs for its citizens, the government necessarily must ration those drugs. With no private-sector alternatives, patients have no choice but to accept what the government—not the doctor—decides is best. In theory, patients could use their own money to purchase prescription drugs outside of the government formulary. In practice, however, this is rare because demand is so low that few drug manufacturers bother to market their products. Reduced availability leads many Canadians to head south to the United States to purchase drugs they cannot purchase at home.

- **Other Problems.** The Canadian and British systems suffer from substandard technology, frustrated doctors, and a vast array of perverse incentives, all of which contribute to low-quality patient care. The problems have progressively worsened in recent years, and their prospects for improvement are not encouraging absent fundamental restructuring—exactly the kind of reform that is too politically difficult to tackle.

Conclusion. Supporters of government-run health care claim that it is better for patients and doctors because it would be fairer, more compassionate, and more inclusive and would deliver higher-quality care than the American system of health care. The reality of government-run medicine belies this argument. In Canada and Britain, access to treatment is far from guaranteed, care is rationed by government bureaucrats, the rich and well-connected receive better care, fed-up doctors flee the system, and patients are left to suffer. In the United States, the health care system, although imperfect, has done a far better job of caring for far more people.

—James Frogue is Health Care Policy Analyst at The Heritage Foundation.

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Supporters of government-run health care offer an alluring vision: universal health coverage, free or inexpensive medical services and prescription drugs, unrestricted access to care, doctors with complete clinical freedom, and exemplary quality of care. These advocates of government-subsidized medicine often claim that the U.S. health care system should move in this direction so that it will be more similar to the government-run health care in Canada and Britain. Yet an examination of health care in both Canada and Britain reveals that moving American medicine in this direction would be a terrible mistake.

Although the government-funded health care systems of Canada and Britain are different, they achieve similar results. Both systems are characterized by long lines for treatment, substandard technology, frustrated doctors and patients, and—most important—government rationing of care. Because advocates of government-run health care often praise these systems as a model for the United States, an assessment of how they actually operate is instructive for Americans who contemplate reforming the American health care system.

Organizing Government Health Care. In the British National Health Service (NHS), there are 115 district health authorities. To a large extent, global budgets are still in use, with the government giving each health authority a lump sum of money. The health authority is then responsible for providing all care to all people within its defined geographic area. Patients face few or no user fees, although various internal market mechanisms are in their infancy. In sum, local health authorities, faced with a fixed budget, decide how and for whom to spend their money.

The Canadian system is more like the U.S. Medicare system; it is administered pricing in fee-for-service. That is, covered medical services are reimbursed at a set price by the government. Canada's 10 provinces and two territories, in coopera-

tion with the federal government in Ottawa, set the prices a doctor can charge for each "covered" medical service. This system is analogous to a health care system consisting of 12 government-run HMOs with no competitors.

Canadian hospitals, like British hospitals, are run on global budgets. The 1984 Canada Health Act effectively eliminated any co-payments for patients by increasing the authority of the federal government to withhold funding for provinces that attempted to charge fees. For all covered services, there is no charge to Canadian citizens in their own province. Private insurance or contracting for covered services is expressly illegal in seven of the 10 provinces and is effectively discouraged in the other three.

Although the federal government contributes less than 25 percent of Canada's health care funding, its ability to influence provincial health policy decisions is profound. The federal government frowns on attempts to innovate or introduce free-market reforms. In 1995, for example, Alberta Premier Ralph Klein implemented reforms that other provinces had contemplated for years. He allowed clinics to charge fees, to be paid by the patient, above the official government-set price. The federal government began docking transfer payments to Alberta, shutting the experiment down within a few months.[1]

THE FUNDAMENTAL FLAW

There is a problem intrinsic to health care systems run and financed by government fiat: As a result of government subsidies, patients do not see the true cost of medical goods and services. Thus, they naturally demand more than they would otherwise consume.[2] Obviously, the more government subsidizes health care, the more pronounced this trend will be. Increased demand necessarily collides with the limited supply available.

At this point, the government must begin to ration care, and because the government pays for health care, it has the final say on who receives treatment. Under universal health care, government rationing is inevitable. Furthermore, the longer government subsidies are in place, the more acute this problem will become.

To illustrate this point, imagine that the government decided that all restaurant meals should be free, with the government reimbursing the cost of the meal to restaurant owners. Under such a scenario, customers would no longer consider price when deciding where to eat. They would eat out more than they would otherwise, and they would demand the most expensive food. The inevitable result: long lines and shortages of food. As for the restaurant operators, their income, to a large extent, would be guaranteed, and they would no longer be concerned with providing food efficiently. The government, facing exploding and unsustainable costs, would begin to provide less expensive food or be more selective in choosing which foods it would subsidize. Such discrimination would annoy both diners and restaurant owners, harm the delivery of food, and result in lower-quality products.

This problem—the gap between supply and demand when prices are set by the government—is inherent in virtually all government-provided goods or services. Yet when reform-minded critics look at the problems created by socialized markets, they often call for further government spending or regulatory manipulation.

Change in Canada. In Canada, two camps dominate the debate over health care reform: the "magicians" and the "spendthrifts," as Dr. David Gratzer, a Canadian physician, dubs them in his recent book, *Code Blue*. While each camp prescribes a different solution to Canada's health care woes, both believe that increased government involvement in health care will solve Canada's problems. The "magicians" believe that with just the right amount of management and the proper regulations, the system will somehow magically

1. David Gratzer, *Code Blue* (Toronto, Canada: ECW Press, 1999), p. 66.
2. RAND Corporation study. See summary by Joseph P. Newhouse, "Cost Sharing for Medical Care Services," testimony before the Subcommittee on Defense of the Committee on Appropriations, U.S. Senate, June 12, 1984.

work. The "spendthrifts" simply advocate spending more money on a fundamentally flawed system. As Dr. Gratzer points out, both solutions are "like rearranging the deck chairs on the Titanic."[3]

The three major parties in Canada—the leftist New Democrats, the centrist Liberals, and the conservative Reformers—all fall into one or both of Gratzer's categories. Recently, the trend appears to be in favor of the spendthrifts.

As recently as 1994, the Reform Party's leader, Preston Manning, spoke of allowing provincial experimentation with "user fees, deductibles, and private delivery of medical services." The Reform Party abandoned all talk of privatization for the 1997 federal elections. Instead of advocating genuine bottom-up reform, it tried to "out-Liberal the Liberals" by advocating both more funding and higher standards for the Canadian health care system.[4] In other words, the Reformers became both spendthrifts and magicians.

The spendthrift mentality exists in the United States as well. Dr. Marica Angell, the recently retired executive editor of the *New England Journal of Medicine,* told the British Columbia Medical Association in July that the Canadian system is "increasingly making the American system look insane." She continued that long lines in Canada are easily treatable and "the problems are not ones that can't be fixed; you just need more money in [the system]."[5]

Reforms in Britain. The debate in Britain over health care is similar. Earlier this year, Prime Minister Tony Blair's Labor government announced a 35 percent increase in real spending on the NHS over the next five years, to be accompanied by several "reforms."[6] Funding for the NHS increased 70 percent during the Tory years (1979–1997) and even more in the early 1970s, but this combination "spendthrift" and "magician" mentality has not cured and will not cure the growing ills of the NHS.

In December 1999, the government finally admitted that rationing is part of the NHS's agenda when it created the National Institute for Clinical Excellence (NICE). Britain's Health Secretary, Alan Milburn, explained, "there will always be choices to be made about the care to be provided," and "NICE will help make the hard choices, and it will also protect patients from low value or obsolete inventions." In other words, the magicians are hoping that a top-down government solution will cure the problems inherent in the NHS.

Milburn went on to prove his credentials as a spendthrift as well when he concluded, "what our healthcare system needs is consistent growth in funding to meet the challenges it faces."[7] Unfortunately, neither a regulatory body nor increased funding will cure the NHS's problems. The flaw that is fundamental to government-run health care will still exist. Demand will continue to exceed supply, resulting in government rationing of care.

THE RISING COSTS OF GOVERNMENT-RUN MEDICINE

Supporters of government-run health care often claim that subsidized medicine will result in improved health outcomes, exemplary quality of care, unrestricted access to medical services and prescription drugs, and doctors with complete clinical freedom. Yet in Canada and Britain, universal health care has achieved none of these goals. In fact, it is often less successful at attaining these goals than the existing system of largely private health care in the United States, despite its flaws.

3. Gratzer, *Code Blue,* pp. 14–15.
4. *Ibid.,* pp. 72–79.
5. Pamela Fayerman, "Canadian System Easily Fixable, US Doctor Says," *National Post,* July 4, 2000.
6. "In Sickness and in Health," *The Economist,* July 29, 2000, pp. 19–20.
7. Gavin Yamey, "Health Secretary Admits That NHS Rationing Is Government Policy," *British Medical Journal,* January 1, 2000, at *www.bmj.com/cgi/content/full/320/7226/10/a.*

Health Outcomes

Many supporters of government-run health care argue that forcing patients to pay out of pocket for health care services will dissuade them from seeking necessary treatment, causing their health to suffer. However, according to one of the largest social science experiments in history, such user fees do not impair patient health.

Between 1974 and 1982, the RAND Corporation followed the medical spending habits of 2,757 non-elderly families (7,703 persons) in six cities across the United States.[8] The study grouped the participants into four groups. At one extreme, the families had no out-of-pocket medical expenses. This health plan completely covered visits to the doctor, hospital stays, and prescription drugs. At the other end, families faced 95 percent co-insurance payments up to a maximum of $1,000 out of pocket.

The RAND Corporation researchers, led by Harvard professor Dr. Joseph Newhouse, found that:

- Families for whom all medical services were free spent 50 percent more than families on the least generous plan; and
- Hospital admission rates were 30–50 percent higher for those in the free health care plan than for those in the other groups.

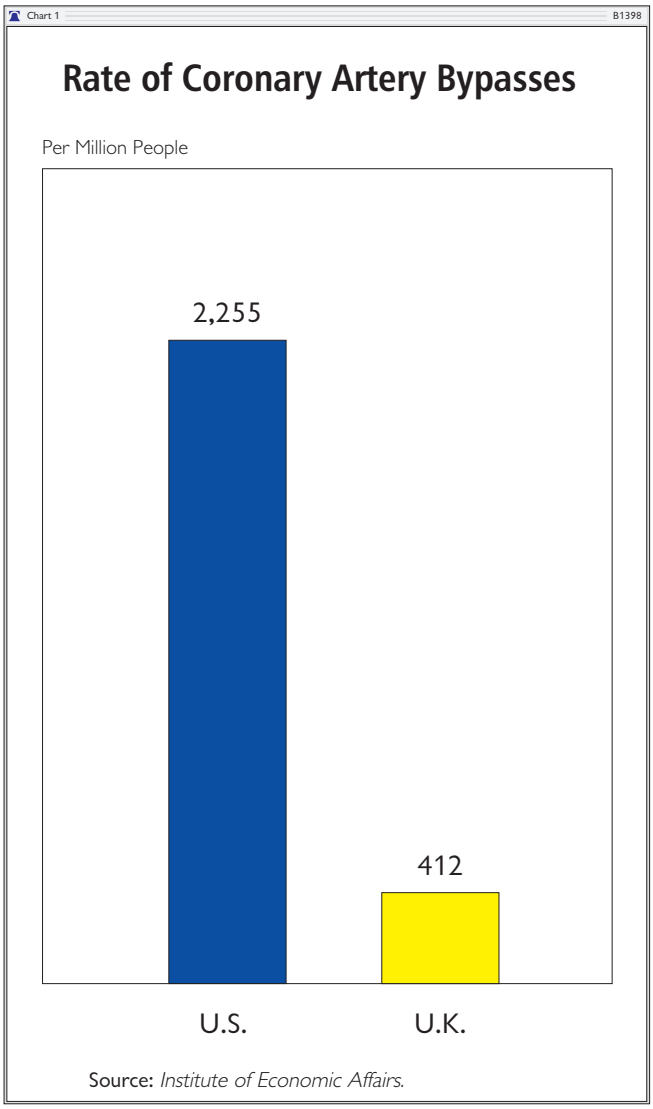
Based on these results, the RAND study reached two conclusions:

- The "use of medical services responds unequivocally to changes in the amount paid out-of-pocket"; and
- "The average person's health changed very little, despite the rather large change in use caused by the insurance plans."

Thus, the study found that user fees were not detrimental; in fact, they produced significantly lower costs without harming patients' health.

Declining Quality of Care

Advocates of government-run health care often claim that universal coverage is a fairer system than private health care because it ensures access to care for all people. Yet these advocates often fail to mention that access to care is *not* guaranteed. Because demand outpaces supply, the government has no choice but to ration care. Absent prices, the only way to "control" demand is to limit supply, which entails waiting lists. In many cases these waiting lists are so long that patients literally die while in line.



Waiting lists for health care in Canada are notorious for being long and slow-moving. For example, in a recent edition of the *Canadian Medical Association Journal,* Dr. Richard F. Davies, a cardiol-

8. Newhouse, "Cost Sharing for Medical Care Services."

ogist at the University of Ottawa, concluded that "Canadian patients are being forced to wait much longer than is really necessary" for coronary artery bypass grafting (CABG). He cited figures collected by the Cardiac Care Network of Ontario for the period April 1, 1996, to March 31, 1997. During this time, 1,514 patients were on the provincial waiting list at any given time. More significantly, 71 patients died while waiting for CABG. In addition, 121 were taken off the list permanently because they had become "medically unfit for surgery" due to their extended waiting time, 211 were removed temporarily, 259 came off for unspecified reasons, and 44 left voluntarily to be treated elsewhere.[9]

Similar revelations are coming out of Britain. According to *The Guardian,* over 1.3 million patients in England alone are on waiting lists for medical care.[10] The new Labor government, elected in 1997, promised to tackle the problem; instead, a year, there were 100,000 more patients on waiting lists. The Independent Health Association of Britain estimates that, in addition to the 1.3 million on waiting lists, there are 465,000 British citizens waiting just to get onto the waiting lists.

Prescription Drugs

Stories appear almost daily in newspapers around America about the cheaper prices Canadian citizens pay for drugs, and American politicians have responded with proposals to subsidize prescription medicine. Yet Canadian drugs are not consistently less expensive than American drugs.

It is true that some dose sizes of some drugs cost less in Canada, but it is also true that some drugs are less expensive in the United States. In the most rigorous academic comparison of international drug prices yet published, University of Pennsylvania economist Patricia Danzon found that it was possible to "prove" that prescription drug prices are 218 percent higher in the United States—or 171 percent higher in Canada—depending on the variables included.[11]

Some drugs are less expensive in Canada because the government fixes the prices of prescription medicines. Nevertheless, when the government purchases drugs for its citizens, the government necessarily must ration those drugs. With no private-sector alternatives, patients have no choice but to accept what the government—not the doctor—decides is best. In theory, patients could use their own money to purchase prescription drugs outside of the government formulary. In practice, however, this is rare because demand is so low that few drug manufacturers bother to market their products. Reduced availability leads many Canadians to head south to the United States to purchase drugs they cannot purchase at home.

In six of the 10 provinces in Canada, the non-elderly and the non-poor have no coverage for prescription drugs. In British Columbia, one of the four provinces with prescription coverage, patients must pay the first $800 for drug purchases on their own. The government picks up 70 percent of costs between $800 and $2,000, and 100 percent of costs above $2,000. This limited coverage extends only to drugs approved by the province.[12]

In addition to price controls, health authorities in Canada control drug spending in two ways: by limiting the number of drugs they approve and by slowing the approval process. Between 1994 and 1998, the Canadian federal government approved only 24 of 400 new drugs. After the federal government approves a drug, the provincial authorities must approve it before it can appear on local formularies and be available for use by patients and doctors. In 1998 and 1999, the federal gov-

9. Richard F. Davies, MD, Ph.D., *Canadian Medical Association Journal,* 1999, 160:146970, at *www.cma.ca/cmaj/vol-160/issue-10/1469.htm.*

10. David Brindle, "NHS Waiting List Nears Record 1.3m," *The Guardian,* February 20,1998, p. 5.

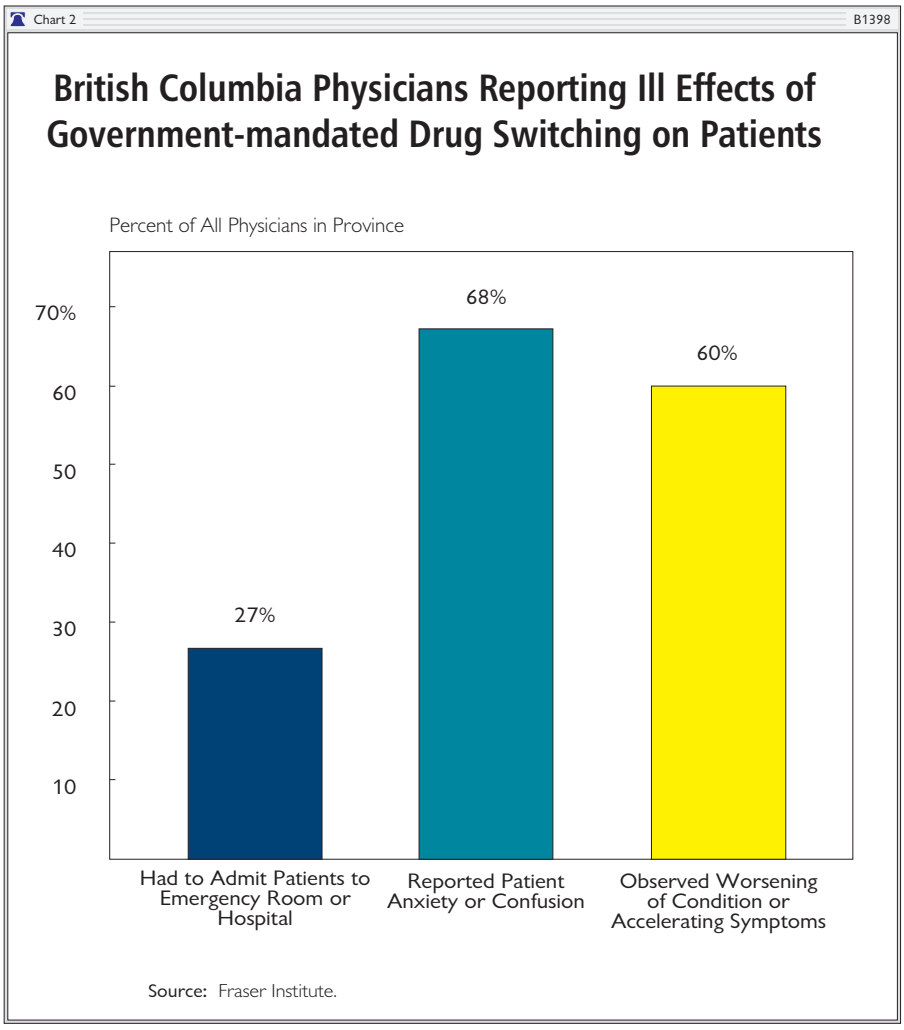
11. As quoted in David Gratzer, "Canada's Prescription to Prevent Drug Research," *National Post,* May 23, 2000.

12. William McArthur, "Prescription Drug Costs: Has Canada Found the Answer?" National Center for Policy Analysis *Brief Analysis* No. 323, May 19, 2000.

ernment approved 99 drugs; of these drugs, the Ontario formulary included only 25.[13]

The lengthy approval process is also used to control spending on prescription drugs. For example, Viagra (a drug to treat impotence) was available in the United States for a year before it was approved for use in Canada. And while the federal approval process is lengthy, the provinces also must approve drugs for use. After approval by the federal authorities, the average wait for approval of a drug in Nova Scotia is 250 days. In Ontario, it is 500 days.[14]

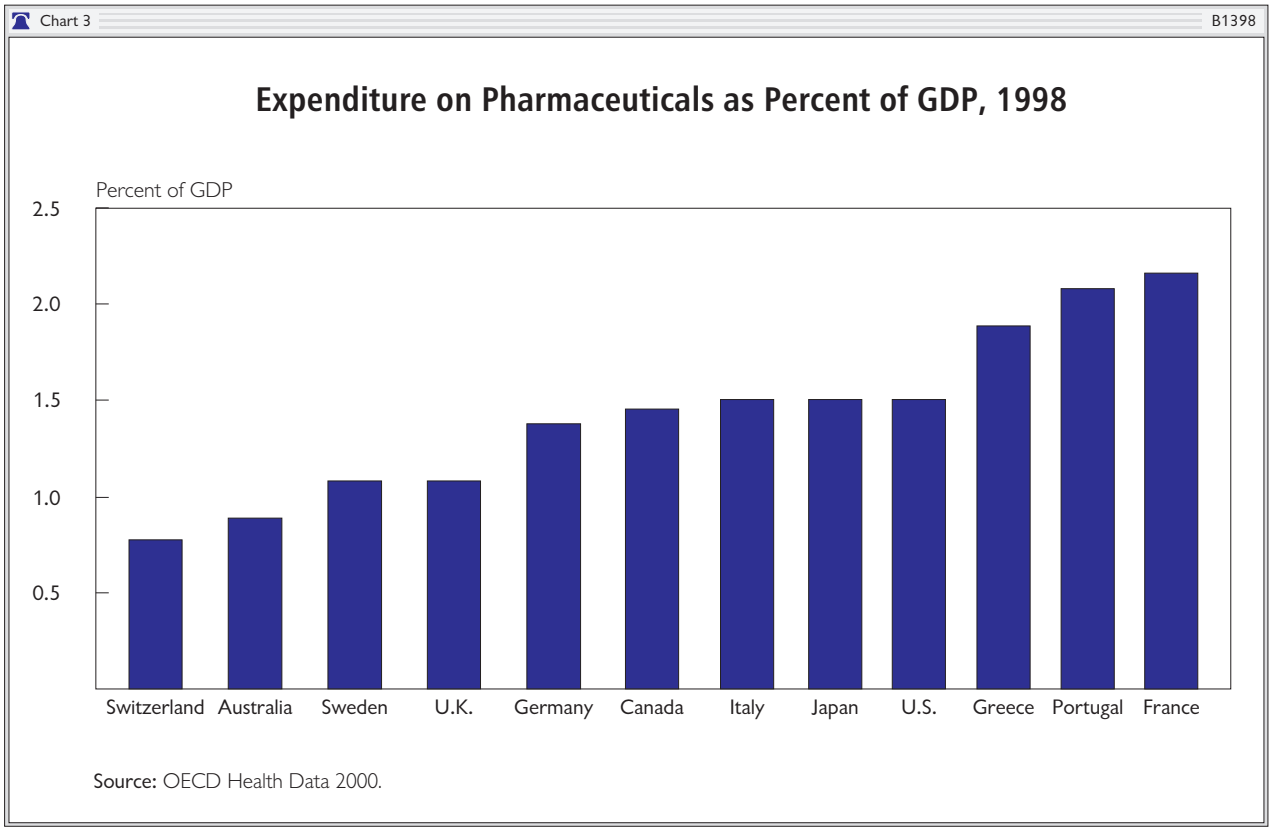
The government's interference in the prescription drug markets also necessitates that bureaucrats control an individual's access to medicine. There are many examples of the inefficiencies produced by such interventions—and of the tragedies they produce. Dr. William McArthur, a Canadian physician, has provided one such story. He tells of a 64-year-old patient he treated who suffered from peptic ulcers. These ulcers were being controlled by a drug called omeprazole, but the government mandated that he be switched to an older, less expensive drug. Three days later, the man required hospitalization and a complete blood transfusion. After 10 more days and several more transfusions, the patient was discharged from the hospital. When discharged, he was taking the same drug—omeprazole—that he had been taking in the first place.[15]



This example is typical of the problems created by government regulation of the prescription drug market. Indeed, in a recent survey, 27 percent of British Columbia physicians reported that they have admitted patients to the emergency room or the hospital as a result of government-mandated substitutions of prescription drugs.[16]

In Britain, each of the 115 local health authorities receives a fixed sum from the central government. With that money, each health authority decides independently which services, technolo-

13. *Ibid.*
14. *Ibid.*
15. William McArthur, "Memo to Al Gore: Canadian Medicine Isn't Cheap *or* Effective," *The Wall Street Journal*, January 21, 2000, p. A19.
16. McArthur, "Prescription Drug Costs."



gies, and prescription drugs to provide. As Dr. David Secher, the director of drug development for the Cancer Research Campaign, explains, this results in "a situation where if you live on one side of the street you may be eligible for expensive anti-cancer treatment, and if you live on the other side, you aren't."[17]

District health authorities in Britain face a dilemma when deciding which drugs to fund. According to Stephen Thornton, chief executive of the NHS Confederation, an advocacy group for health authorities and hospitals, "Every time there is the prospect of a new and effective drug that's going to help people suffering from cancer, my colleagues running local health authorities are going to have to think, 'What are we going to have to stop doing in order to pay for that drug?'" Needless to say, the decision is never easy.

One of the most insidious effects of price controls on prescription drugs is the devastating effect on a nation's pharmaceutical industry. Canada has always had a highly regulated market, and its drug industry has never been significant. Britain, on the other hand, was once a global powerhouse in drug production. Today, however, its influence is diminishing. In 1988, three of the top 10 best-selling new pharmaceutical products were British. By 1992, only one was. Today, American manufacturers have the top 10 best-selling pharmaceuticals.[18] If the relatively unregulated American market were to succumb to price controls, it would not only hurt the domestic pharmaceutical industry, but also impair other manufacturers around the world who depend on selling their products in the United States.

17. Sarah Lyall, "In Britain's Health Service, Sick Itself, Cancer Care Is Dismal," *The New York Times*, February 10, 2000, at *www.webster.edu/depts/business/mngt/news/faculty/jim/Jim512GBart.html.*

18. Robert Goldberg, "Ten Myths About the Market for Prescription Drugs," National Center for Policy Analysis *Policy Report* No. 230, October 1999, p. 16.

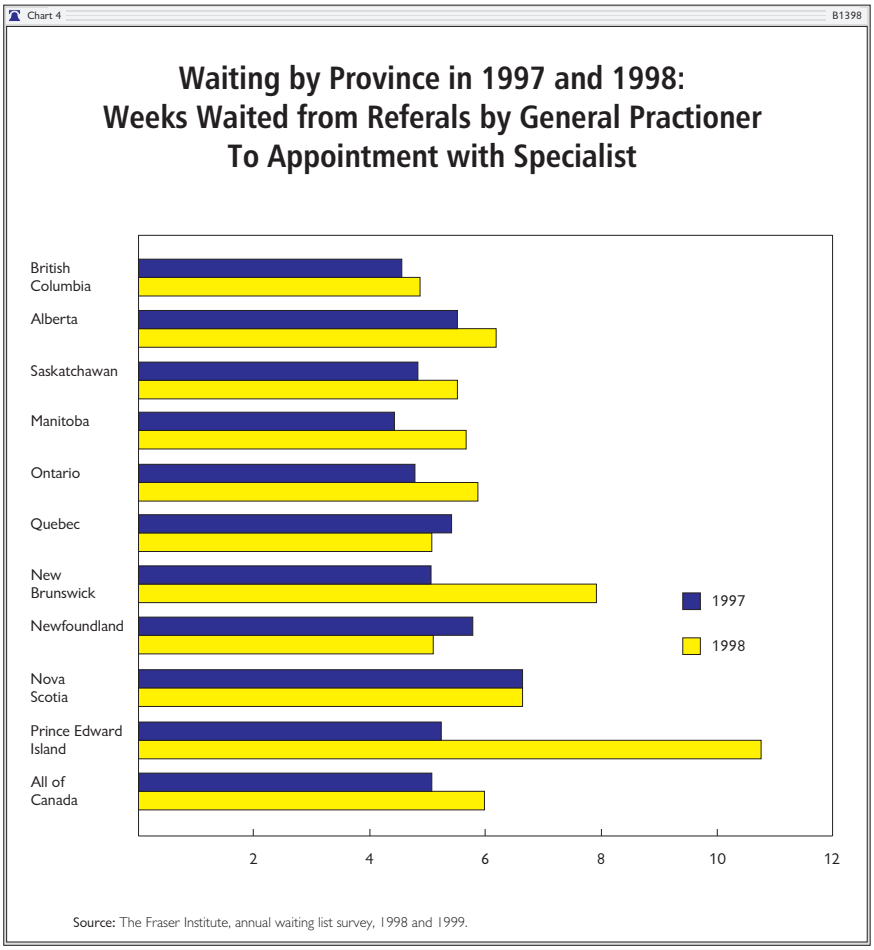


Chart 4
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Waiting by Province in 1997 and 1998:
Weeks Waited from Referals by General Practioner
To Appointment with Specialist
British Columbia
Alberta
Saskatchawan
Manitoba
Ontario
Quebec
New Brunswick
Newfoundland
Nova Scotia
Prince Edward Island
All of Canada
1997
1998
2
4
6
8
10
12
Source: The Fraser Institute, annual waiting list survey, 1998 and 1999.

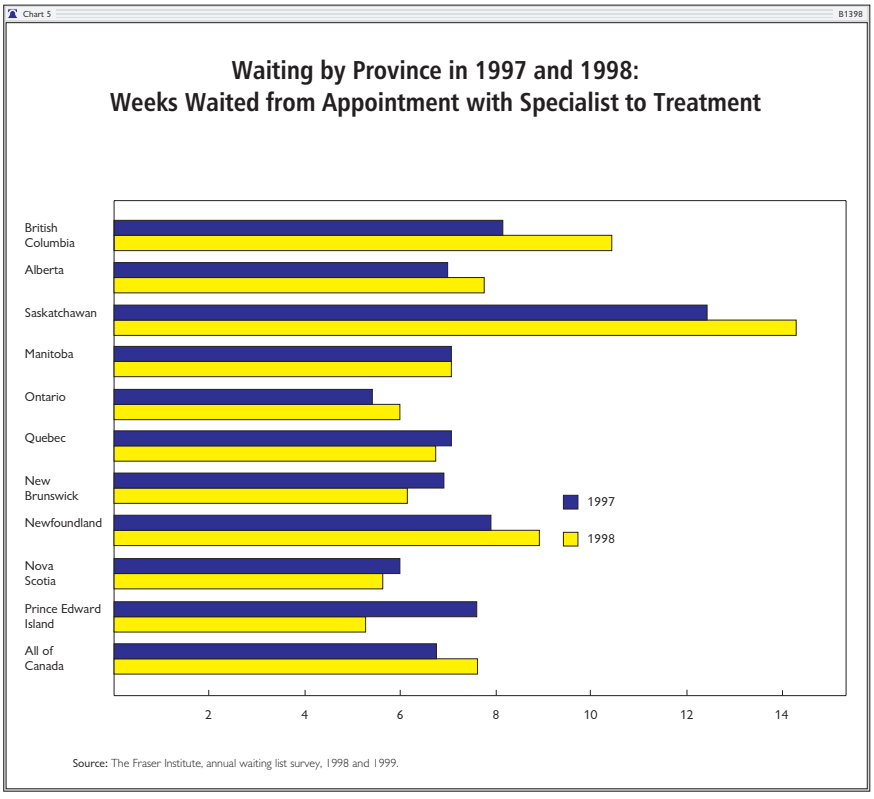
Chart 5
B1398
Waiting by Province in 1997 and 1998:
Weeks Waited from Appointment with Specialist to Treatment
British Columbia
Alberta
Saskatchawan
Manitoba
Ontario
Quebec
New Brunswick
Newfoundland
Nova Scotia
Prince Edward Island
All of Canada
1997
1998
2
4
6
8
10
12
14
Source: The Fraser Institute, annual waiting list survey, 1998 and 1999.

Table 1 B1398

Total Expected Waiting Time from Referral by General Practitioner, by Specialty, 1998 (In Weeks)

	British Columbia	Alberta	Saskatchawan	Manitoba	Ontario	Quebec	New Brunswick	Newfoundland	Nova Scotia	Prince Edward Island	All of Canada
Plastic Surgery	27.9	25.8	22.1	30.2	13.1	10.7	16.5	26.7	37.3	--	17.5
Gynaecology	13.0	14.7	28.4	14.6	12.6	13.3	16.4	9.4	13.1	9.4	14.5
Ophthalmology	17.9	11.2	24.5	21.1	22.9	23.9	13.9	14.9	23.3	64.0	22.0
Otolaryngology	16.8	23.4	33.9	6.4	13.1	11.3	15.4	34.9	21.8	--	15.7
General Surgery	11.1	7.6	14.3	9.3	6.4	8.6	7.2	6.7	6.6	4.0	8.4
Neurosurgery	12.6	34.9	26.7	14.1	17.3	13.4	29.4	11.5	10.3	--	18.6
Orthopaedic Surgery	30.0	30.4	37.0	24.2	21.9	23.6	11.3	18.2	20.4	41.3	25.4
Cardiovascular Surgery (Elective)	24.4	14.1	21.8	9.5	19.8	13.2	--	60.0	--	--	20.2
Urology	13.7	9.2	21.4	10.8	8.9	7.5	11.4	11.1	8.8	10.8	10.4
Internal Medicine	10.1	9.5	9.0	10.0	7.5	7.9	11.9	6.3	9.7	18.0	8.7
Radiation Oncology	11.5	7.3	3.6	9.1	6.6	7.2	5.2	4.2	4.0	--	7.4
Medical Oncology	2.9	3.9	6.8	--	3.5	3.1	--	9.7	3.0	3.0	3.6
Weighted Median	15.2	14.0	20.2	12.4	11.9	11.9	14.1	14.5	11.9	16.0	13.3

Source: The Fraser Institute, *www/fraserinstitute.ca/media/media_releases/1999/wyt/table1.html*

ONE BRITON'S EXPERIENCE

Reporter James Hughes-Onslow of Britain's *Daily Telegraph* recently chronicled his own experience with the National Health Service.

January 21: Mr. Hughes-Onslow experiences stomach pains and "violent rumblings and strange noises."

February 14: He manages to see his general practitioner (GP), who recommends an "immediate" colonoscopy, particularly because his mother died of bowel cancer.

March 2: He is experiencing "pain and bleeding" but still has received no word from the specialist. The following day, his GP phones to say it is "quite normal" not to have heard from the hospital yet.

March 29: A letter finally arrives from the hospital. A consultation—but not the colonoscopy itself—is scheduled for April 7.

April 7: The specialist agrees that an immediate colonoscopy is necessary, especially considering the patient's family history. He suggests that Hughes-Onslow walk himself over to the secretary in charge of appointments to see that it is scheduled. Hughes-Onslow explains his situation to the secretary, who replies, "without even looking up from her paperwork," that "soon means six weeks or two months. Urgent means at least one month."

April 22: Mr. Hughes-Onslow writes a letter to the *Evening Standard* protesting his treatment. The next day, Professor Gordon McVie, director general of the Cancer Research Campaign, calls Hughes-Onslow. McVie offers to help speed the process and suggests, "you have to pull every string available to you."

May 10: Hughes-Onslow arrives at the hospital only to find that his colonoscopy has been cancelled. After he complains, the appointment is reinstated. The test is unsuccessful because the colon is blocked.

May 19: Following a barium enema and a CT scan the previous week, it is determined that there is clearly an obstruction. Despite the doctor's "full diary" for May and June, he squeezes Mr. Hughes-Onslow in for June 2.

June 2: The operation removes two and a half feet of colon.

June 14: Professor McVie reviews the pathology reports and finds that Hughes-Onslow indeed has cancer, which has spread though several layers of the colon. The colon could have perforated at any moment, which would have been disastrous for Hughes-Onslow. The long wait for treatment, although short by British standards thanks to Hughes-Onslow's connections and perseverance, could have easily been fatal.[1]

1. James Hughes-Onslow, "I Had to Pull Strings to Survive Cancer," *The Sunday Telegraph,* June 25, 2000.

PERVERSE INCENTIVES

Under government-run health care, the incentives for patients, doctors, politicians, and hospitals discourage innovation and efficiency.

Patients have the incentive to:

- **Use** emergency rooms as their 24-hour family doctor for every minor ailment including the common cold. *Result: Overcrowded emergency rooms, overflowing waiting lists, and higher overall costs to the system.*
- **Obtain** every diagnostic test, even for the most minor complaints, because tests are free for the patient. *Result: Inefficient use of diagnostic tests and lengthy waiting lists.*
- **Recover** from surgeries in hospitals for long periods of time rather than recovering at home or getting outpatient procedures. *Result: Fewer hospital beds available for real emergencies.*
- **See** numerous doctors about the same problem; many cost-free opinions are better than one. *Result: Doctors who are overworked and patients who consequently face greater difficulty in trying to make appointments.*

Doctors have the incentive to:

- **Order** as many tests as possible to maximize fees; more tests result in higher pay. Patients never object because they do not pay. *Result: Overcrowded testing labs and machines, making it more difficult for patients to get access.*
- **Refuse** complicated cases; complex cases often require new and experimental treatments that are not necessarily "covered" by government-run fee-for-service payments. *Result: Doctors who offer only "covered" services.*
- **Leave** the country for better paying careers with more freedom to treat patients and do research. *Result: Fewer experienced doctors.*
- **Avoid** discussing treatment options and prices with patients or promoting healthy lifestyles because there is no compensation for conversation and no reason to develop relationships. *Result: Uninformed patients who make poor choices.*

Politicians have the incentive to:

- **Maintain** redundant hospitals no matter how much money might be saved by closing them, because closures are politically unpopular. *Result: Inefficient, wasteful hospitals that drain resources away from other priorities.*
- **Refuse** to make major changes in the system because voters view change with suspicion and always assume that reforms will cost them something. *Result: Failure to make appropriate policy changes.*
- **Allow** waiting lists to develop because limiting supply is the only realistic way, in a world of fixed budgets, to stem demand. *Result: Delayed access to care or refusal to provide care altogether.*
- **Suppress** information about waiting lists. Politicians are not forthcoming about them, and they often refuse even to collect data on waiting lists. *Result: Inability to determine the extent of the health care system's problems.*
- **Limit** the clinical freedom of doctors and hospitals because new and improved services and techniques are expensive. *Result: Stifled innovation.*

- **Allocate** resources to better service the government's voter base. Politicized medicine has political results. *Result: Inefficient, inappropriate, and inequitable allocation of resources.*

Hospitals under global budgets have the incentive to:

- **Fill** beds with low-cost patients to keep out high-cost patients; "bed blockers" reduce demand on global budgets. *Result: Seriously ill patients denied access to hospital beds.*
- **Delay** or defer the purchase of the latest, most modern equipment. This often-expensive equipment is too much for already strained global budgets. *Result: Inferior care for patients.*
- **Oppose** any restructuring of the health care system as it would inevitably threaten bureaucratic and administrative jobs. *Result: Blocking of necessary systemic change.*
- **Make** inefficient budgetary decisions. By spending all monies allocated to it, a hospital makes a better case that it needs more government funding the following year. *Result: Hospitals that, with no incentive for efficiency, continue to pull in taxpayers' money while providing patients with the same second-rate service.*[1]

1. David Gratzer, *Code Blue* (Toronto, Canada: ECW Press, 1999), pp. 143–145.

Substandard Technology

In the spring of 1999, a banner on Toronto's Gardiner Expressway read, "Magnetic Resonance Imaging [MRI], Coming Summer 1999." St. Joseph's, a hospital in Canada's largest city, was finally acquiring technology that has been used in the United States since the mid-1980s. In America, the latest technology—Positron Emission Topography (PET)—is already superseding MRIs.[19] When St. Joseph's might acquire PET, if ever, is anybody's guess.

The use of the most modern medical technologies and innovations is stifled in government-run health care. The newest and latest services and products are inevitably expensive. Budget-conscious government bureaucrats are loath to approve coverage of pricey new technologies as their budgets are always stretched to the maximum. Thus, providing coverage for a brand-new item means budget overruns or the elimination of a service currently on budget. Doctors, scientists, and other innovators recognize that it will take years for their innovations to be adopted; therefore, they are less likely to attempt new techniques and procedures or to invent new technologies.

A survey of teaching hospitals in Washington State, Oregon, and British Columbia found that 18 surgical and diagnostic procedures commonly available in the United States are not available to Canadian patients.[20] Furthermore, according to the Organisation for Economic Co-operation and Development (OECD),[21] Canada ranks consistently ahead of only Mexico, Poland, and Turkey in available medical technology. The OECD ranks Canada 21 out of 29 in availability of CAT scanners, and 19 in MRI availability. In one particularly telling incident, an Ontario man frustrated at the long waits for an MRI attempted to book himself into a private veterinary clinic by listing his name as "Fido."[22]

19. Sally Pipes, "Canada's Health Care Goes South," *Investor's Business Daily,* August 16, 1999, p. A28.
20. McArthur, "Memo to Al Gore: Canadian Medicine Isn't Cheap *or* Effective."
21. A Paris-based institution with 29 member nations from the industrialized world.
22. Steven Pearlstein, "Canada's Public System Is Overwhelmed, and Under Attack," *The Washington Post,* December 18, 1999, p. A20.

In the British NHS, lack of access to modern technologies and medicines often results in low survival rates for patients, especially in cases involving cancer and cardiovascular disease. The World Health Organization (WHO) estimates that every year, cancer kills 25,000 Britons because of substandard care. As Dr. Tim Maughan, a clinical oncologist specializing in gastrointestinal cancer and lymphoma in Cardiff, Wales, has said, "The health service has been chronically under funded for the last 10 to 15 years and is desperately short of money, and I'm not aware of where things are worse than in cancer."[23]

Survival rates for cancer-stricken British patients are markedly lower than for American patients. Consider the five-year survival rates for:

- Lung cancer (in men): 6 percent in Britain, 13 percent in the United States;
- Colon cancer (in men): 41 percent in Britain, 64 percent in the United States; and
- Breast cancer (in women): 67 percent in Britain, 84 percent in the United States.[24]

Frustrated Doctors

The effect of government-run health care on medical practice is pronounced and harmful. Despite claims to the contrary, many Canadian doctors are frustrated and angry; many leave Canada every year. Young doctors are particularly likely to leave, and many worry that Canada will face a shortage of doctors in years to come.

Because Canada has regulated and subsidized many industries, the "brain drain" is a problem for many trades there. Prime Minister Jean Chrétien's Advisory Council on Science and Technology has warned that the flight of the highly educated is causing serious problems for universities and the high-technology sector.

This problem is particularly acute in the health care field. According to a recently released report from the Canadian Institute for Health Information, many doctors—especially younger ones—are leaving Canada for the United States. Over 70 percent of the physicians who are leaving graduated from medical school in the past 10 years. Young physicians "are leaving for better working conditions and more research opportunities," says Dr. Hugh Scully, president of the Canadian Medical Association.[25] "It would be fair to say we saw a significant problem," said Chummer Farina, executive director of the study.[26]

This trend is especially alarming because budget constraints have led to the enrollment of fewer students in medical school. Furthermore, while some doctors immigrate to Canada to work there on temporary visas, few stay permanently. And older doctors are retiring at an accelerated rate.[27] The net loss of doctors is a "very real, continuous worry," says Dr. Scully.

UNEQUAL AND UNFAIR

Advocates of government-run health care often claim that such systems are "equal" and "fair" because they put all citizens on one tier. Yet it is preposterous to claim that a one-tier system really exists in a nationalized system of health care delivery. There never has been and never will be a health care system in which all people, regardless of class or condition, are treated equally. While the rich and well-connected *always* get better access and treatment regardless of how the health care system is organized, a government-run system can add new levels of inequality based on social standing or political position.

The evidence on this is overwhelming. Consider, for example, a recent survey of cardiovascular caregivers in Ontario, Canada.[28] The report

23. Lyall, "In Britain's Health Service, Sick Itself, Cancer Care Is Dismal."

24. *Ibid.*

25. Veronique Mandal, "More Young Doctors Leaving Canada: Study," *National Post,* August 10, 2000, p. A4.

26. David Stonehouse, "PM Ignored Brain Drain Warning," *National Post,* August 10, 2000, p. A1.

27. Mandal, "More Young Doctors Leaving Canada."

concluded that the politically powerful, the rich, and the potentially litigious received preferential treatment. Over 80 percent of doctors and 53 percent of hospital administrators had been involved personally in a case involving preferential treatment. When asked what factors contributed to that preferential treatment:

- Nearly 90 percent cited a patient's personal connections to the doctor;
- Nearly 80 percent cited the patient's standing in the community, where poor care would embarrass the hospital if the patient were unhappy;
- Over 70 percent cited a patient whose prominence could be helpful to the hospital;
- Nearly two-thirds cited a patient who was potentially litigious; and
- Over 25 percent cited legitimate medical reasons, without external pressures.[29]

Other studies have reached the same conclusion: Those at the top of the socioeconomic ladder in Canada receive preference and priority.[30] Anecdotally, many stories exist that confirm the existence of preferential treatment for the prominent or well-to-do:

- In August of 1990, Quebec Premier Robert Bourassa learned that he needed an operation for melanoma. Instead of waiting his turn in the vaunted Canadian system, he chartered a plane at his own expense and flew to Washington, D.C., for a consultation at the National Cancer Institute in Bethesda, Maryland. In November, Bourassa returned for the surgery. It was a success.[31]
- Last year, Vancouver Grizzlies basketball star Shareef Abdur-Rahim was able to skip over a 984-person queue—over a year's wait in Canada—to obtain an MRI scan of an injured knee.[32]
- Earlier this year, singer Celine Dion was successfully treated for infertility at a Manhattan clinic—not in her native Canada.
- In August of this year, singer Madonna flew from her London home to Los Angeles for delivery of her baby. When asked about this by a reporter, she explained, "Come on, have you ever been to the hospitals in England? They are old and Victorian."[33]
- Earlier this year, Health Minister Allan Rock received intense criticism when it was revealed that a wealthy member of the Moroccan royal family paid $60,000 for heart surgery in a Montreal hospital. This payment allowed the patient to skip a waiting list of over 1,000 Quebecers. Sylvie Dore, a hospital official, said there is nothing illegal or unusual about this example of preferential treatment. "It is totally legal and happens all the time," she explained.[34]

28. The survey was sent out to Ontario's 268 cardiologists, 68 cardiovascular surgeons, 300 general internists, 300 general practitioners, and the CEOs of 218 acute care hospitals. There was a 72.4 percent response rate.
29. David A. Alter *et al.*, "A Survey of Provider Experience and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada," *Annals of Internal Medicine,* Vol. 129, No. 7 (October 1998), pp. 567–572.
30. N. E. Adler *et al.*, "Socioeconomic Inequalities in Health. No Easy Solution," *Journal of the American Medical Association* (JAMA), Vol. 269, No. 24 (June 23–30, 1993), pp. 3140–3145; S. J. Katz *et al.*, "British Columbia Sends Patient to Seattle for Coronary Artery Surgery, Bypassing the Queue in Canada," *JAMA,* Vol. 266, No. 8 (August 28, 1991), pp. 1108–1111; S. J. Katz and T. P. Hofer, "Socioeconomic Disparities in Preventive Care Persist Despite Universal Coverage. Breast and Cervical Screening in Ontario and the United States," *JAMA,* Vol. 272, No. 7 (August 17, 1994), pp. 530–534; N. P. Roos and C. A. Mustard, "Variation in Health Care Use by Socioeconomic Status in Winnipeg, Canada: Does the System Work Well? Yes and No," *Millbank Quarterly,* Vol. 75, No. 1 (1997), pp. 89–111; J. Siemiatycki *et al.*, "Equality in Medical Care Under Health Insurance in Montreal," *New England Journal of Medicine,* Vol. 303, No. 1 (July 3, 1980), pp. 10–15.
31. Nancy Wood, "Missing But Not Forgotten," *McLean's*, December 10, 1990, p. 14.
32. Mark Kennedy, "Critical Condition," *Montreal Gazette,* February 13, 1999, p. B1.
33. Dominic Mohan, "Madonna Calls Her New Son Rocco Ritchie," *The Sun,* August 12, 2000.

Canadians with the financial resources routinely travel south to the United States to obtain treatment. At one clinic in Grafton, North Dakota, 80 percent of the clientele is Canadian because there is no wait for MRI scans there.[35]

Olympic Medical Hospital in Port Angeles, Washington, is beginning a new program this fall in which its doctors will travel to Victoria, Canada, to consult with Canadian physicians before their patients travel to the United States for treatment. This program was established after a spring 2000 survey in which a large number of Canadian doctors responded that they would send their patients to the United States for treatments that would otherwise be delayed or denied in Canada. "There is a *huge* amount of frustration with the Canadian system," according to Eric Lewis, chief financial officer of Olympic Medical.[36]

Many American hospitals and clinics along the Canadian border report booming business from Canadian patients.[37] It is not accurate to claim that Canada is a one-tiered system in which everyone, regardless of wealth or community stature, is treated equally.

Unlike Canada, where private treatment for "covered" services is illegal, Britain has a booming private sector in health care. It operates outside of the NHS and does so without any tax subsidies or tax preferences. The private health care industry is completely unregulated by the British government, and business is booming. According to the Independent Health Care Association (IHA), 7 million of Britain's 55 million citizens are now covered by private insurance.

In Britain, those who are not covered by private insurance can still purchase private-sector services à la carte. In 1996, 100,000 Britons paid out of pocket for operations rather than waiting in NHS lines for treatment. By 1999, that number was 160,000. In 1993, 12 percent of all private-sector heart bypass operations, hip replacements, and other forms of acute care were paid for by individuals, not insurance. Today, 20 percent of these operations are paid for by individuals.

CONCLUSION

Taxpayers are justly frustrated with the unresolved problems of America's health care system, which subsidizes employment-based health insurance through tax incentives. Yet Americans should be wary of politicians who promise that they can provide better health care services than the private sector can provide.

Supporters of government-run health care claim that such a system is better for patients and doctors. They say it would be fairer, more compassionate, and more inclusive and would deliver higher-quality care than America's existing system of health care. The reality of government-run medicine, however, belies this argument. In Canada and Britain, access to treatment is far from guaranteed, care is rationed by government bureaucrats, the rich and well-connected receive better care, fed-up doctors flee the system, and patients are left to suffer.

In the United States, the health care system, although imperfect, has done a far better job of caring for far more people at a much higher level of quality. Policymakers should address the weaknesses of the current system—by eliminating the health insurance market's inequities and market distortions created by federal law and state regulations—and expand access to private plans for the uninsured. In other words, they should refrain from making current problems worse.

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34. David Gamble, "Moroccan Royal Jumps Heart Surgery Queue in Montreal," *Montreal Gazette,* May 2, 2000, at *www.nationalpost.com/search/story.html?f=/stories/000502/277218.html.*

35. Gratzer, *Code Blue,* p. 68.

36. Author's conversation with Chief Financial Officer Eric Lewis on September 12, 2000.

37. Ruth Walker, "Snags in Canada's Health Care," *Christian Science Monitor,* March 23, 2000, at *www.csmonitor.com/durable/2000/03/23/p1s3.htm.*