Executive Summary
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High-Priced Pain: What to Expect from a Single-Payer Health Care System

Kevin C. Fleming, M.D.

The urge to save humanity is almost always only a false front for the urge to rule it.

—H. L. Mencken

There is renewed interest in "socialized medicine." Some prominent Americans want the United States to adopt national health insurance as a means to cover the uninsured, to establish equality of care, and to control health care costs. Their preferred method is a single-payer health care system in which the government, through taxation, finances and regulates the delivery of health care services.

In fact, the single-payer solution to the problem of the uninsured is a "nirvana approach" to health care. Proponents often highlight the imperfections of the current public–private system of health care financing and delivery and contrast these with an ideological vision of a future egalitarian condition in which these imperfections will disappear and everyone will have access to "free" health care. Although the egalitarian vision holds perennial appeal for some Americans, it would impose a socialist-style command economy and require government control of the production and distribution of goods and services. The striking feature of the command economy, as Professor Alain Enthoven of Stanford University, has observed, is "the contradiction between system and pretensions on the one hand, performance on the other." Policymakers have a duty to examine not only the promises of the single-payer proposal, but also its performance.

Ideology over Experience. Socialism does not work, or at least not very well, based on an ample historical record. Yet supporters of nationalized health care still believe that socialism, through single-payer financing, is uniquely capable of succeeding in the discrete area of health care financing and delivery. Just as nations have learned that political management and control is not the best way to run the coal, steel, farming, banking, airline, or electric power industries, policymakers should conclude that the political process is a poor way to manage health care. Preventing human suffering should, in principle, include rejecting systems that decrease available health resources by depressing general living standards. Any health care intervention, especially any that affects large populations, should scrupulously follow the medical maxim of "first, do no harm."

Adverse Effects. Health care in a single-payer system will be rationed by means other than price. This will have inevitable adverse effects, including:

- **Long waits and reduced quality.** In Britain, over 800,000 patients are waiting for hospital

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care. In Canada, the average wait between a general practitioner referral and a specialty consultation has been over 17 weeks. Beyond queuing for care or services, single-payer systems are often characterized by strict drug formularies, limited treatment options, and discrimination by age in the provision of care. Price controls, a routine feature of such systems, also result in reduced drug, technology, and medical device research.

- **Funding crises.** Because individuals remain insulated from the direct costs of health care, as in many third-party payment systems, health care appears to be "free." As a result, demand expands while government officials devise ways to control costs. The shortest route is by providing fewer products and services through explicit and implicit rationing.
- **New inequalities.** Beyond favoritism in the provision of care for the politically well-connected, single-payer health care systems often restrain costs by limiting surgeries for the elderly, restricting dialysis, withholding care from very premature infants, reducing the number of intensive care beds, limiting MRI availability, and restricting access to specialists.
- **Labor strikes and personnel shortages.** In 2004, a health worker strike in British Columbia, Canada, resulted in the cancellation of 5,300 surgeries and numerous MRI examinations, CT scans, and lab tests. Canada also has a shortage of physicians, and the recruitment and retention of doctors in Britain has become a chronic problem.
- **Outdated facilities and medical equipment.** Advances in medical technology are often seen in terms of their costs rather than their benefits, and investment is slower. For example, an estimated 60 percent of radiological equipment in Canada is technically outdated.
- **Politicization and lost liberty.** Patient autonomy is curtailed in favor of the judgment of an elite few, who dictate what health care needs and desires *ought* to be while imposing social controls over activities deemed undesirable or at odds with an expanding definition of "public health." Government officials would claim a compelling interest in many areas now considered personal.

Conclusion. The very real problems of America's health care system, including the problem of uninsurance, can be addressed through innovative market-based solutions. While critics of the market approach are free to claim that a future health care system based on free and voluntary exchange would have pernicious rather than positive effects, the evidence-based approach to health policy finds little to support the promised superiority of national health insurance. In the end, the socialist vision of medicine will achieve Orwellian results: The promise of health care coverage becomes health rationing, access to universal coverage means delays in access to care, official fairness yields to favoritism by officials, freedom of choice becomes coerced conformity, and democratic deliberation is replaced by bureaucratic decision-making.

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There is a renewed interest in "socialized medicine." Policy elites generally agree that the establishment of a universal, nationalized health care system would best be achieved through the creation of a single-payer health care system. This is nothing new. Since the Great Depression, political leaders advocating a government-run system have proposed massive large-scale changes, either through a government takeover of the system as in Britain or Canada or through extensive government control and regulation as embodied in the failed Clinton Health Security Act of 1993.[2]

Meanwhile, the pages of American medical and health policy journals are replete with research and discussion of the failures of the current system, including lack of coverage, erosion of benefits, uncontrolled spending, and cost barriers. While the specifics may vary, many Americans, including medical professionals, express serious dissatisfaction with the present U.S. model of health care. Not surprisingly, a single-payer national health insurance program routinely resurfaces as a major proposal for comprehensive change.

Policymakers should ignore imagined outcomes and focus closely on the performance of existing models: the British, Canadian, and other state-run systems. In these systems, health care is subject to bureaucratic and political rationing and driven by

Talking Points

- Single-payer health care systems in Britain, Canada, and other nations experience chronic financial problems, personnel shortages, queues, lower quality, delayed diagnosis and treatment, health worker strikes, political favoritism, and the special provision of care for a privileged class.
- In a single-payer system, political incentives supplant market forces, creating a process that is friendly to special-interest lobbying, bureaucratic redundancy, and the abrogation of personal freedoms. This political process contributes to the misallocation of resources, the expansion of governmental control over health care delivery, and the politicization of medicine.
- Market-based reforms, however, would dramatically expand coverage, promote innovation and economic efficiency, and eliminate existing market distortions in the health care system. Real market competition would allow more efficient and productive providers to thrive, while less productive providers would either become more efficient or go out of business.

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political and budgetary pressures. This leads to inevitable adverse effects, including:

- **Long waits and reduced quality.** In Britain, over 800,000 patients are waiting for hospital care. In Canada, the average wait between a general practitioner referral and a specialty consultation has been over 17 weeks. Beyond queuing for care or services, single-payer systems are often characterized by strict drug formularies, limited treatment options, and discrimination by age in the provision of care. Price controls, a routine feature of such systems, also result in reduced drug, technology, and medical device research.
- **Funding crises.** Because individuals remain insulated from the direct costs of health care, as in many third-party payment systems, health care appears to be "free." As a result, demand expands while government officials devise ways to control costs. The shortest route is by providing fewer products and services through explicit and implicit rationing.
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No government policy can solve all health system problems and cost nothing. Many of these problems could be resolved if policymakers at both the federal and state levels eliminated the existing distortions in the flawed health insurance markets and established a fair and equitable tax credit system that would enable every American family to afford health insurance.[3] Desirable social objectives can be achieved in ways that are compatible with Americans' values of individual and economic freedom and result in a new health care system that is more financially sustainable and produces better economic performance.

Rationale for the Single-Payer Proposal

The single-payer proposal enjoys strong support in certain quarters of America's health policy community. For example, analysts at the Institute of Medicine (IOM) have urged the adoption of universal coverage, rejecting incremental expansions of insurance coverage as inadequate to address the many problems of the current health care system. Among the acceptable approaches to achieve that goal, aside

1. H. L. Mencken, *Minority Report: H. L. Mencken's Notebooks* (Baltimore: Johns Hopkins University Press, 1956, reprinted 1997), p. 247.
2. For a historical discussion of this debate, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), p. 389. See also Jo Ivey Boufford and Phil Lee, "Health Policy Making: The Role of the Federal Government," in Marion Danis, Carolyn Clancy, and Larry Churchill, eds., *Ethical Dimensions of Health Policy* (New York: Oxford University Press, 2002), pp. 158 and 199–200.
3. There are a variety of innovative policy options. For example, see Stuart M. Butler, "Reducing Uninsurance by Reforming Health Insurance in the Small-Business Sector," Heritage Foundation *Backgrounder* No. 1769, June 17, 2004, at *www.heritage.org/research/healthcare/bg1769.cfm*.

from requiring individual or employer-based insurance, is the establishment of a single-payer system administered by the federal government.[4]

Likewise, the World Health Organization (WHO) has called health care a "human right" requiring the provision of "universal and comprehensive primary health care, irrespective of people's ability to pay." According to WHO analysts, equal access "implies equal entitlement to the available services for everyone."[5] Moreover, according to a WHO report, achieving health care "equity" requires national health planning.[6]

Writing in the *JAMA* (*Journal of the American Medical Association*), the Physicians' Working Group for Single-Payer National Health Insurance identified four key principles:

1. Access to comprehensive health care is a human right. It is the responsibility of society, through its government, to ensure this right. Coverage should not be tied to employment.
2. The right to choose and change one's physician is fundamental to patient autonomy. Patients should be free to seek care from any licensed health care professional.
3. Pursuit of corporate profit and personal fortune have no place in caregiving. They create enormous waste and too often warp clinical decision-making.
4. In a democracy, the public should set health policies and budgets. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.[7]

Support for a single-payer system is not pervasive throughout the medical profession. For example, the American Medical Association, the largest professional medical association, favors insurance market reform and the provision of generous health care tax credits and subsidies to low-income Americans to expand health insurance coverage.

Nonetheless, there are prominent medical spokesmen for the single-payer approach. For example, the single-payer position is endorsed by the Society for General Internal Medicine,[8] the American Medical Student Association,[9] and two former editors of the *New England Journal of Medicine*.[10] The current *JAMA* editor in chief has stated, "We are the only developed country in the world that doesn't have a specific health plan for our people. It's a disgrace."[11]

Political support for a single-payer system is confined almost exclusively to liberal Democrats. Repre-

4. Institute of Medicine of the National Academies, Board on Health Care Services, *Insuring America's Health: Principles and Recommendations* (Washington, D.C.: National Academies Press, 2004), at *www.nap.edu/books/0309091055/html* (October 2, 2005).
5. U.N. Commission on Human Rights, "Statement by the World Health Organization," Agenda Item 10: Economic, Social and Cultural Rights, April 1, 2003, at *www.who.int/hhr/information/en/item10_final.pdf* (July 14, 2005), and Russell Mokhiber and Robert Weissman, "Health Care Is a Right: A People's Charter for Health," *The San Francisco Bay Guardian*, December 26, 2000, at *www.sfbg.com/focus/113.html* (July 14, 2005).
6. Margaret Whitehead, "The Concepts and Principles of Equity and Health," World Health Organization, Regional Office for Europe, Copenhagen, 1991, pp. 3–15, at *www.who.dk/Document/PAE/conceptsrpd414.pdf* (March 15, 2005).
7. Physicians' Working Group for Single-Payer National Health Insurance, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," *JAMA*, August 13, 2003, pp. 798–805.
8. Eugene Rich, letter to Bob Doherty, Senior Vice President, Governmental Affairs and Public Policy, ACP-ASIM, 2002, at *www.sgim.org/ACPAccess.doc* (September 27, 2005), and Society of General Internal Medicine, "Support Health Care Reform," *Issue Brief*, at *www.sgim.org/HealthSystemsbrief.cfm* (September 27, 2005).
9. American Medical Student Association, "AMSA's Universal Health Care Leadership Institute 2005: Training Tomorrow's Leaders in the Health Care Justice Movement," 2005, at *www.amsa.org/uhc/uhcli.cfm* (September 28, 2005).
10. Arnold Relman, "The Health of Nations," *The New Republic*, March 1, 2005, at *www.tnr.com/doc.mhtml?i=20050307&s=relman030705* (September 27, 2005; subscription required), and Marcia Angell *et al.*, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Physicians for a National Health Program, at *www.physicianspproposal.org/proposal_group.htm* (September 28, 2005).
11. Liz Kowalczyk, "Universal Health Plan Is Endorsed," *Boston Globe*, August 13, 2003, p. A1.

sentative John Conyers (D–MI) is the sponsor of the United States National Health Insurance Act (H.R. 676), which has 75 cosponsors, including Representative Charles Rangel (D–NY), ranking member of the powerful House Ways and Means Committee.[12] Senator Edward M. Kennedy (D–MA) and Representative John Dingell (D–MI) have also long championed legislation to establish national health insurance. Among Democratic political leaders, former Vice President Al Gore has also come out in favor of a single-payer system as "the best solution" to the nation's health insurance problem.[13] This is a position shared by the Massachusetts Democratic Party[14] and the Green Party platforms.[15] Democratic National Chairman Howard Dean has also called for national health insurance.[16]

Top 10 Expectations from the Single-Payer Experience

In the professional medical literature, the desire to provide health care for all, particularly for the uninsured, is advanced as one of the primary reasons for a single-payer program.[17] However, the potentially adverse effects for the American people of adopting a single-payer system remain largely unexamined in the medical literature.

There is a profound disconnect between what is promised and what is likely to occur based on concrete experience. The anticipated outcome of improved access for individuals, particularly the poor, is the primary outcome imagined. Obviously, the government could provide universal insurance coverage and finance that coverage through taxation. For policymakers in Congress and state legislatures, the more important issue, as the 19th century French economist Frederick Bastiat warned, is "that which is not seen"—the long-term consequences for individuals and families and for their doctors of adopting such a system.[18]

A growing body of empirical evidence shows that nationalized health care systems have undesirable consequences. Based on these national experiences, particularly the experiences of the British National Health Service (NHS)[19] and the Canadian Medicare system, such consequences should be expected.

Expectation #1: Reduced quality of care.

There are many ways to measure quality. One way is to consider key indices of treatment, such as neonatal care. Today, the United States has high neonatal intensive care capacity, with 6.1 neonatologists per 10,000 live births; Australia has 3.7 per 10,000; Canada, 3.3 per 10, 000; and the United Kingdom, 2.7 per 10,000. The United States has 3.3 intensive care beds per 10,000 live births; Australia and Canada have 2.6 per 10,000; and the United Kingdom, 0.67 per 10,000.

12. The bill is comprehensive. It would provide universal coverage under a government health insurance program for all "medically necessary" care, outlaw private health insurance that duplicates benefits provided by the government, and establish a "global budget" for medical services. The bill would finance the program through existing government revenues for health care, an increase of personal income taxes on the top 5 percent of income earners, new taxes on stocks and bonds, and a "modest" (but unspecified) payroll tax increase.
13. Mark Halperin, Elizabeth Wilner, and Marc Ambinder, "Gore Supports Single-Payer," ABC News *The Note*, November 14, 2002, at *www.abcnews.go.com/sections/politics/DailyNews/TheNote_Special2.html* (September 27, 2005).
14. Massachusetts Democratic Party, "The Platform of the Massachusetts Democratic Party," at *www.massdems.org/about/platform.htm* (September 27, 2005).
15. Greens/Green Party USA, "Platform of the Greens/Green Party USA," at *www.greenparty.org/Platform.php* (September 27, 2005).
16. Charles S. Johnson, "Dean Wows Dems with Speech," *The Billings Gazette*, July 17, 2005, at *www.billingsgazette.com/index.php?id=1&display=rednews/2005/07/17/build/state/58-dean.inc* (September 28, 2005).
17. Physicians' Working Group, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance."
18. Frederick Bastiat, "That Which Is Seen, and That Which Is Not Seen," 1850, at *www.jim.com/seen.htm* (September 27, 2005).
19. Alain C. Enthoven, "The NHS Plan: A View from 30,000 Feet," Adam Smith Institute (London), 2001, pp. 1–7, at *www.adamsmith.org/images/uploads/publications/30000feet.pdf* (October 1, 2005).

While American "overinvestment" in lifesaving of premature infants may come at the expense of proportionately less support for preconception and prenatal care, British neonatal intensive care capacity is far below that found in nearly every other Western nation.[20] Although Canada has more generous welfare entitlements, less income disparity, universal health coverage, and more uniform standards of perinatal care than the United States, variations in mortality rates among Canadian neonatal intensive care units appear to be as wide as those reported in the United States and elsewhere.[21]

In cardiovascular care, a comparative study of death rates from stroke and heart disease put Britain's NHS 13th out of 15 European countries studied. In a 17-nation cancer study, the five-year survival rate for lung cancer in Britain was the worst of the 17; for colon cancer, Britain ranked 12th; and for breast cancer, Britain was 11th out of 17 (just above Slovenia, Austria, Estonia, Poland, and Slovakia).[22] In the early 1990s, Britain had fewer radiotherapists per capita than Poland and fewer medical oncologists than any country in Western Europe.

Organisation for Economic Co-operation and Development (OECD) figures for 1996 show that Britain had 1.7 practicing physicians per 1,000 population; Germany had 3.4 per 1,000; France, 2.9 per 1,000; and Poland, 2.4 per 1,000. The only countries with a lower proportion among the 29 studied by the OECD were South Korea (1.2 per 1,000), Mexico (1.2 per 1,000), and Turkey (1.1 per 1,000).[23] Some of these disparities are attributable to poor clinical practices, but the primary cause of these failures was rationing due to lack of funds. However, to raise expenditure to the levels of other developed countries would require massive tax increases. To improve British health care, alternative sources of funding were advised.[24]

In Britain, total NHS spending on health care is low by international standards. In 1997, total expenditure on health care in the U.K. was 6.9 percent of gross domestic product (GDP). The German figure was 10.7 percent, and the French, 9.6 percent. Of the 29 advanced countries studied by the OECD, only Hungary, Ireland, South Korea, Mexico, Poland, and Turkey spent less. After 1997, British health expenditures increased 81 percent, reaching £96.2 billion in 2004,[25] representing 8.3 percent of GDP, up from 7.6 percent in 2001 but still in the lower half of OECD expenditures with Italy and Hungary.[26]

Yet out of the total increase of £3.6 billion given to hospital and community care in England in 2005–2006, only 13 percent went toward service improvements. "Fifty per cent went on higher pay, according to the King's Fund, and another 37 per cent was absorbed by other 'cost pressures', which included increased drug bills, clinical negligence claims and capital costs."[27] Cost constraints in Britain mean

20. Lindsay Thompson, David Goodman, and George Little, "Is More Neonatal Intensive Care Always Better? Insights from a Cross-National Comparison of Reproductive Care," *Pediatrics*, Vol. 109, No. 6 (June 2002), pp. 1036–1043.
21. Koravangattu Sankaran, Li-Yin Chien, Robin Walker, Mary Seshia, Arne Ohlsson, Shoo K. Lee, and the Canadian Neonatal Network, "Variations in Mortality Rates Among Canadian Neonatal Intensive Care Units," *CMAJ*, Vol. 166, Issue 2 (January 22, 2002), pp. 173–178, at *www.cmaj.ca/cgi/reprint/166/2/173.pdf* (September 1, 2006).
22. David Green and Laura Casper, "Delay, Denial and Dilution: The Impact of NHS Rationing," Institute of Economic Affairs (London), Health and Welfare Unit *Choice in Welfare* No. 55, January 2000, at *www.civitas.org.uk/pdf/cw55.pdf* (October 1, 2005).
23. Organisation for Economic Co-operation and Development, Health Data 99, cited in David G. Green, "They've Had a Good Innings! Does the NHS Discriminate Against the Elderly?" Civitas *Background Briefing* No. 1, p. 3, at *www.civitas.org.uk/pdf/bb1.pdf* (September 1, 2006).
24. Green and Casper, "Delay, Denial and Dilution."
25. United Kingdom Office for National Statistics, "Expenditure on Health in the UK," 2006, at *www.statistics.gov.uk/articles/nojournal/Expenditure_health_UK.pdf* (September 1, 2006).
26. Organisation for Economic Co-operation and Development, "OECD Health Data 2006: How Does the United Kingdom Compare," at *www.oecd.org/dataoecd/29/53/36959993.pdf* (September 1, 2006).

that the NHS does not pay for newer cancer treatments that are widely available in the U.S., including colon and breast cancer chemotherapies.[28]

For Americans, the Canadian model is often cited as a superior system by single-payer advocates. According to 2006 OECD estimates, public health expenditures in Canada are 6.8 percent of GDP, compared to 6.9 percent for the U.S. Yet, according to the OECD, just 10 percent of Canada's GDP is spent on health care, compared to 15.4 percent in the U.S. These raw figures are often cited to prove that the Canadian system is cheaper or more economically efficient than that of the United States.

Private health spending is lower in Canada, notes Canadian economist Pierre Lemieux, primarily because most of such outlays "are illegal." The public health monopoly of care in Canada has led to poor quality of service, says Lemieux, including "the frequent rudeness of unionized personnel" and waiting times that "remain high even for critical diseases." The Canadian health care bureaucracy is "oblivious to anguish, discomfort, humiliation and other subjective factors," such as lost time and health risks incurred by waiting.[29]

In spite of its aggressive central planning, a socialist system is not necessarily better equipped to deal with a genuine health care crisis. A recent report on the 2003 Canadian SARS outbreak found Ontario's public health system "unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate." As a result, the report called the structure and capacity of Ontario's public health care "woefully inadequate."[30]

Proponents often tout the Canadian focus on preventive health care, but the truth is that key services such as immunizations for children, routine eye exams, and physiotherapy services are only partially funded. In some regions, like Ontario, they have been completely "delisted" (i.e., are no longer covered). Partial or full de-listing of health care services has occurred regularly across Canadian provinces over the past 15 years. Provincial governments are mandated to fund only a partial list of "medically necessary" services universally, while essential items such as insulin for diabetics or ventolin for asthmatics are often not publicly insured, but instead must be purchased privately.[31]

While emergency care is similar for Canadian and American patients, the Canadian government controls costs by rationing the availability of tests and procedures, limiting access to technology, and restricting the number of specialists. But waiting means a diagnosis delayed or deferred, "and Canadian patients may be more incapacitated before they receive the same high-technology care that they would receive in the United States."[32]

According to Canadian Senators Michael Kirby and Dr. Wilbert Keon, Canadian hospitals "have little incentive to enhance the quality and/or accessibility of their services, to contain or reduce costs, to

27. Nigel Hawkes, "Hospital Salaries Eat Up Half of Health Service's £3.6bn Windfall," *The Times*, February 3, 2006, at *www.timesonline.co.uk/newspaper/0,,174-2022820,00.html* (August 30, 2006).
28. BBC News, "Woman Loses Herceptin Court Bid," February 15, 2006, at *http://news.bbc.co.uk/1/hi/health/4715430.stm* (August 30, 2006), and Karol Sikora, "The Price of Life," *The Daily Telegraph*, August 22, 2006, at *www.telegraph.co.uk/health/main.jhtml?xml=/health/2006/08/22/hcancer22.xml* (August 25, 2006).
29. Pierre Lemieux, "Canada's 'Free' Health Care Has Hidden Costs," *The Wall Street Journal*, April 23, 2004, p. A15, at *www.independent.org/newsroom/article.asp?ID=1292* (October 1, 2005).
30. Darren Yourk, "Ontario Health System 'Woefully Inadequate,'" *The Globe and Mail*, April 20, 2004, at *www.theglobeandmail.com/servlet/story/RTGAM.20040420.wsars0420/BNStory/Front* (October 1, 2005; subscription required).
31. Mark Stabile and Courtney Ward, "The Effects of De-listing Publicly Funded Health Care Services," draft conference paper for "Health Services Restructuring: New Evidence and New Directions," Kingston, Ontario, November 17–18, 2005, at *www.irpp.org/events/archive/nov05JDI/stabile.pdf* (August 27, 2006).
32. Mark J. Eisenberg, "An American Physician in the Canadian Health Care System," *Archives of Internal Medicine*, Vol. 166, No. 3 (February 13, 2006), pp. 281–282.

improve their efficiency or to improve their productivity." The government is able, for a time, to avoid confronting these structural weaknesses only through "repeated injections of large amounts of additional money into the healthcare system."[33]

The British experience is also instructive. While many medical professionals and health policy analysts are critical of the performance of health maintenance organizations (HMOs) in America's employer-based health insurance system, a prominent American HMO has been shown to outperform the British National Health Service. For roughly the same cost, Kaiser Permanente demonstrated better performance than the NHS in primary care services (20 minutes with the doctor at Kaiser, compared to eight minutes in the NHS) and access to specialists (two-week waits at Kaiser, 13 weeks at NHS) with just a third of the NHS's hospital utilization rate. Kaiser also has three times the number of nurses per physician than in Britain.[34]

By design, the NHS limits access to medical specialists. "In the UK," according to a report in *The Guardian*, "general practice is a bottomless pit where everyone sees fit to throw their effluent."[35] According to Geoffrey Rivett, "Twenty years of cost cutting, contracting out cleaning and catering to the lowest cost tender, and the removal of management from the shop floor had their inevitable effects."[36] The culture of public service has diminished, and the NHS has fostered a culture of staff "indifference, rudeness and a lack of respect for individuals or for privacy," slovenliness, and "even a lack of simple compassion."[37]

Based on the published reports, British hospitals are often dirty, and the institutional food is "often unpalatable," while overworked British doctors are seeing patients in visits that are so short that the quality of diagnosis is often threatened. Meanwhile, British patients often have no choice of appointment date or time and endure a low level of service in the government health care system that they would find intolerable in other areas of British life. Not surprisingly, there are now "more bureaucrats in the NHS than hospital beds."[38]

Regrettably, says Rivett, the recent belief that modernization and elimination of "the internal market would remedy many problems proved as spurious as earlier magic solutions," as large infusions of money "seemed to make little difference."[39] As Richard Smith, editor of *BMJ* (*British Medical Journal*), remarked in 2002, "It seems to be universally agreed that the NHS is sick. It is plagued by delay, low quality care, and poor outcomes."[40]

The United States is more productive in the treatment of breast cancer, lung cancer, and cholelithiasis than Germany and Britain. The reasons can be traced directly to their respective health care systems. For example, "the United Kingdom has not invested as quickly in technologies that have dramatically improved the diagnostic capabil-

33. "Competition Only Way of Rescuing Healthcare, Say Kirby and Keon," *Canadian Healthcare Technology*, October 2004, at *www.canhealth.com/oct04.html#anchor34729* (August 27, 2006).

34. Richard Feachem, Neelam Sekhri, and Karen White, "Getting More for Their Dollar: A Comparison of the NHS with California's Kaiser Permanente," *BMJ*, Vol. 324, Issue 7330 (January 19, 2002), pp. 135–143, at *http://bmj.bmjjournals.com/cgi/reprint/324/7330/135* (October 1, 2005).

35. Mark Gould, "Lesson from America," *The Guardian*, November 5, 2003, at *http://society.guardian.co.uk/nhsplan/story/0,7991,1077525,00.html* (February 24, 2005).

36. Geoffrey Rivett, "The Next Chapter of *From Cradle to Grave: Fifty Years of the NHS*," *Health Service Journal*, at *www.nhshistory.hsj.co.uk/index.htm* (September 28, 2005).

37. Minnette Marrin, "The Health Service Is Sick from the Neck Up," *The Daily Telegraph*, January 21, 2000, p. 28, at *www.minettemarrin.com/minettemarrin/2000/01/the_health_serv.html* (October 2, 2005).

38. Anthony Browne and Matthew Young, "NHS Reform: Towards Consensus," Adam Smith Institute (London), 2002, pp. 8, 10, and 15, at *www.adamsmith.org/pdf/browne-paper-1.pdf* (February 24, 2005).

39. Rivett, "The Next Chapter."

40. Richard Smith, editorial, "Oh NHS, Thou Art Sick," *BMJ*, Vol. 324, Issue 7330 (January 19, 2002), pp. 127–128, at *http://bmj.bmjjournals.com/cgi/content/full/324/7330/127* (October 1, 2005).

ities of medicine and significantly reduced recovery time." On the other hand:

> [Germany] has a system more like the United States had 20 years ago. In Germany, medical expenses are paid for on a task-by-task basis for services of doctors and hospitals. As a result, hospitals in Germany have no financial incentive to reduce length of stay.[41]

Expectation #2: Periodic funding crises.

The rationing of health care, whether by price or by some other means, is inevitable. Under the British NHS, the extensive implicit rationing is "severe and intentionally conceals life and death decisions from patients."[42] This is accomplished by design, through fewer resources and lower spending than one finds in OECD nations. Doctors carry this out via queues, by withholding specialist referrals and by telling patients that nothing can be done for them, rather than disclosing that treatments do exist but are not covered.[43]

Although surveys frequently demonstrate public satisfaction with single-payer systems such as the NHS, there are chronic complaints over insufficient funding.[44] Similar concerns are raised in America, where government programs such as Medicaid are blamed for being Scrooge-like because of attempts at cost cutting.[45] However, the problem of insufficient funds is intractable, as there is always more desire for services than money. In Canada, this has translated into a system where "everything is free, but nothing is readily available."[46] That is, when governments restrict public spending in order to reduce costs, patient demand far outstrips health care supply.

Indeed, the "NHS has long-run excessive rationing built into it," say British analysts at the Adam Smith Institute of London, because there are constant pressures to contain spending and only indirect and infrequent pressures to increase it.[47] For example, to contain costs, access to health care in the NHS is rationed by age. Indeed, British elderly are frequently denied access to beneficial technologies such as renal dialysis and medicines for Alzheimer's disease.[48] A recent decision by the National Institute for Clinical Excellence (NICE) not to pay for two expensive colon cancer drugs for NHS patients is an example of explicit rationing. According to Professor Karol Sikora, former chief of the World Health Organization Cancer Unit, "if you look at those it has sanctioned and read between the lines, it seems that you and I are worth only about £30,000 a year to the NHS."[49]

Similarly, access to dentistry in the NHS is rationed by prices that are set well below the Euro-

41. William W. Lewis, *The Power of Productivity: Wealth, Poverty and the Threat to Global Stability* (Chicago: University of Chicago Press, 2004), pp. 9–14, 75, and 97.
42. Joanna Coast, Jenny Donovan, Andrea Litva, John Eyles, Kieran Morgan, Michael Shepherd, and Jo Tacchi, "'If There Were a War Tomorrow, We'd Find the Money': Contrasting Perspectives on the Rationing of Health Care," *Social Science & Medicine*, Vol. 54, Issue 12 (June 2002), pp. 1839–1851.
43. *Ibid.*
44. Andrew Bindman, "Whose Health Care Is More Efficient?" *BMJ*, Vol. 327, No. 7418 (August 28, 2002), pp. E96–E98, at *http://bmj.bmjjournals.com/cgi/content/full/327/7418/E96* (October 1, 2005).
45. Editorial, "The Perils of Cutting Medicaid," *The New York Times*, April 17, 2004, p. A14.
46. James Frogue, David Gratzer, Timothy Evans, and Richard Teske, "Buyer Beware: The Failure of Single-Payer Health Care," Heritage Foundation *Lecture* No. 702, May 4, 2001, at *www.heritage.org/Research/HealthCare/HL702.cfm*.
47. Browne and Young, "NHS Reform," pp. 8–15.
48. John Goodman, Gerald Musgrave, and Devon Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World*, (Lanham, Md.: Rowman & Littlefield Publishers, 2004), pp. 147–150; Angus Deaton and Christina Paxson, "Mortality, Income, and Income Inequality over Time in Britain and the United States," National Bureau of Economic Research *Working Paper* No. 8534, October 2001, pp. 3–48; Ananova.com, "Health Chiefs Accused of Rationing Alzheimer's Drugs," November 1, 2002, at *www.ananova.com/news/story/sm_706687.html* (February 25, 2005; unavailable January 10, 2006), and National Center for Policy Analysis, "British Hospitals Ration Alzheimer's Drugs," *Daily Policy Digest*, November 25, 2002, at *www.ncpa.org/iss/hea/2002/pd112502f.html* (October 1, 2005).

pean market. As a result of insufficient fees, many dentists are unable to recoup practice investments and decide to "escape the treadmill and piece-work of the NHS" by opting for private practice or moving overseas.[50] The cumulative NHS underinvestment in health care during the past 30 years, compared to the European average, has reached a reported $399 billion.[51] To address historically long wait lists, the NHS has increased its staff by 45,000 a year since 1999, to a peak of 1.33 million. However, this has created a deficit of £700 million–£750 million, resulting in more recent plans to reduce outlays for drugs, hospitals, and services and to cut staff levels by 100,000.[52]

Remarking on the current financial crisis afflicting the NHS, Conservative Party leader David Cameron said:

> There is a huge mystery at the heart of British politics, which is how can they have spent quite so much money on the health service and yet today we have got thousands of people facing the sack and we have got hospitals facing closure and vast deficits.[53]

Like their market counterparts, not-for-profit hospitals and single-payer systems must achieve a sufficient positive margin (i.e., a profit) to ensure financial viability and quality of care and to keep equipment, buildings, and technology current and operational. Financing modernization, growth, inflation, and debt service requires even more revenue.[54] If an organization plans only to break even financially, over time it will invest insufficient capital to continue providing services.[55] This basic economic principle cannot be nullified merely by rejecting a market economy, as evidenced by the collapse of the Soviet and East European economies and the demise of Britain's former state-owned industries.

Expectation #3: Politically driven inequalities.

While advocates of a single-payer system say that it will bring about equality in care, the reality is invariably different. For example, a significant proportion of Canadian doctors have allowed prominent people, wealthier residents, and personal contacts faster access to services.[56] Similar queue jumping by famous sports figures and politicians has also elicited complaints.[57]

There is, in effect, a three-tiered system in Canada. The wealthy jump queues by going to private clinics or the U.S. for rapid treatment, and a second tier of "the well-informed and aggressive can push their way to the front of the line"; those left in the third-tier queue are often the elderly, poor, and dis-

49. Sikora, "The Price of Life."

50. British Dental Association, "Response from the British Dental Association to Modernising NHS Dental Services in Scotland," 2004, pp. 2–20, at *www.bda.org/about/docs/Final_Response_to_SEHD.pdf* (October 1, 2005).

51. Malcom Dean, "The NHS—The Problem Is Capacity, Not Funding," *The Lancet*, March 23, 2002, p. 1043.

52. Nigel Hawkes and David Charter, "NHS Chief Says Hospitals Must Spend Less on Drugs and Staff," *The Times*, April 12, 2006, p. 8, at *www.timesonline.co.uk/article/0,,8122-2130210,00.html* (August 29, 2006).

53. Patrick Wintour, "Blair Faces Inquiry into NHS Crisis," *The Guardian*, April 19, 2006, p.1, at *www.guardian.co.uk/uk_news/story/0,,1756374,00.html?gusrc=rss* (August 28, 2006), and Chris Ham, "Creative Destruction in the NHS," *BMJ*, Vol. 332, No. 7548 (April 29, 2006), pp. 984–985.

54. Louis C. Gapenski, *Understanding Health Care Financial Management: Text, Cases, and Models*, 2nd ed. (Chicago: AUPHA Press/Health Administration Press, 1996), p. 317.

55. R. P. Fallon, "Not-for-Profit No Profit: Profitability Planning in Not-for-Profit Organizations," *Health Care Management Review*, Vol. 16, No. 3 (July 1991), pp. 47–61.

56. S. E. D. Shortt, editorial, "Waiting for Medical Care: Is It Who You Know That Counts?" *CMAJ*, Vol. 161, Issue 7 (October 5, 1999), p. 823, at *www.cmaj.ca/cgi/content/full/161/7/823* (October 1, 2005).

57. Walter Block, editorial, "Socialized Medicine Is the Problem," *Surgical Neurology*, Vol. 60, Issue 5 (November 2003), pp. 467–468; Randall Palmer, "Preelection Row Erupts over Canadian Health Care," *Forbes*, May 7, 2004, at *www.forbes.com/business/healthcare/newswire/2004/05/07/rtr1364269.html* (October 1, 2005); and Mary Anastasia O'Grady, "In Canadian Health Care Some Are More Equal Than Others," *The Wall Street Journal*, May 21, 2004, p. A11, reposted at *www.charterhealth.ca/news/2004may21.html* (October 1, 2005).

enfranchised.[58] With bureaucratically determined rationing of goods and services in Canada, this has "worsened rather than improved unequal access because socialism meant queues that the well-connected could jump."[59]

A 2002 investigation found that more than 10,000 private-pay patients were given preference over NHS patients in Britain's most respected national hospitals. Around half of the private patients came from overseas and were treated before NHS patients, who were left on waiting lists. For example, Britain's Royal Marsden hospital received almost a quarter of its income from private patients in 2001. During the year, this premier NHS cancer facility treated 2,277 private patients, including over 300 foreigners.[60] In 2003, Members of Parliament (MPs) were given exclusive access to an NHS primary care practice from which members of the public were barred. Unlike other NHS patients, MPs did not have to wait in a queue.[61]

In addition, British patients who can afford travel expenses are traveling to India for cut-rate surgeries. For example, heart surgery costs an average of £30,000 in Britain, but only £6,000 in Bombay.[62]

Expectation #4: Labor strikes.

Labor strikes are a common occurrence in state-operated enterprises. Canada's national public health insurance is publicly financed but privately run, and care is free at the point of use. In the past, strikes were considered "unthinkable" for Canadian doctors. "Now," according to the *CBC News*, "we've come to expect it as part of the negotiating process between doctors and governments."[63] To protest fee cuts triggered by budget caps, thousands of physicians undertook work stoppages in 1998 and 1999 for elective services in a series of 20 "Rationed Access Days," while others refused to work on weekends, holidays, or after 5 p.m.[64]

In 2004, in a wage dispute with the government, 800 New Brunswick hospital workers—including laundry, kitchen staff, licensed practical nurses, and cardiology technologists—walked off the job, forcing the cancellation of hundreds of surgeries and routine tests at area hospitals.[65] In April 2004, an eight-day strike by 40,000 members of the Health Employees Union in British Columbia forced hospitals to cancel 5,300 surgeries, 700 MRIs, 2,500 CT scans, and tens of thousands of lab tests. That same month, a strike by 20,000 civil servants in Newfoundland and Labrador lasted a grueling 27 days.

Patients suffered as a result. While urgent cases were "easy to decide," for doctors, "the nightmares lay in between, when they had to decide whether to cancel the bowel surgery of a cancer patient." Patients were said to be "a hardy bunch and are used to delays."[66]

In February 2005, upset about low pay and the lack of a new contract, some 250 Ontario anesthesiologists held a one-day "meeting" in

58. Lemieux, "Canada's 'Free' Health Care Has Hidden Costs."

59. Jagdish Bhagwati, *In Defense of Globalization* (New York: Oxford University Press, 2004), p. 15.

60. Anthony Browne, "Scandal of NHS Beds Auction," *The Observer*, January 6, 2002, at *http://observer.guardian.co.uk/nhs/story/0,1480,628437,00.html* (October 1, 2005).

61. Marie Woolf, "MPs Condemn Scheme Allowing Them to Jump NHS Queues," *The Independent*, December 15, 2003, at *http://news.independent.co.uk/uk/health_medical/article82560.ece* (October 1, 2005).

62. Nick Meo, "Tour Operators to Offer Cut-Price Surgery in India," *The Times Online*, February 13, 2004, at *www.timesonline.co.uk/article/0,,3-999258,00.html* (October 1, 2005).

63. Martin O'Malley and Owen Wood, "When Doctors Walk Off the Job," CBC News Online, February 24, 2005, and March 11, 2004.

64. Robert J. Reid, David Schneider, Morris Barer, Robin Hanvelt, Kimberlyn McGrail, Nino Pagliccia, and Robert G. Evans, "The Doctor Is Out: Physician Participation in the Rationed Access Day Work Stoppage in British Columbia, 1998/99," *Longwoods Review*, Vol. 1, No. 1 (2002), pp. 3–10; CBC News, "Quebec GP's Walk Off the Job," November 13, 1998, at *www.cbc.ca/story/news/national/1998/05/29/gp980529e.html* (September 28, 2005).

65. CBC News, "Striking N.B. Hospital Workers Target Premier's Riding," September 27, 2004, at *www.cbc.ca/story/canada/national/2004/09/27/newstrike040927.html* (September 27, 2005).

lieu of working to publicize a shortage of about 90 anesthesiologists in the province. The job action closed about 179 operating rooms at 27 hospitals to all but essential surgeries on that day; hundreds of elective surgeries were cancelled.[67] The protest was designed "to draw attention to the health-care system's lack of funding and resources"[68] and to expose critical issues "putting the health of patients at risk."[69] As of 2005, 43 percent of Ontario's 929 anesthesiologists were over the age of 50, and in addition to a regular 50-hour workweek, 40 percent of anesthesiologists worked every fourth night in hospital providing emergency coverage.[70]

Although labor costs in Canada had risen from 60 percent of the health budget in 1948 to 70 percent in 1975, pay was widely deemed to be poor for junior hospital doctors, nurses, and ancillary staff. This led to repeated strikes by health care personnel from 1972 to the early 1980s. Staff doctors joined the strikes when the government moved to limit pay increases and ban private practice in hospitals.[71] More recently, doctors in the Canadian system have threatened to use strikes and a work-to-rule strategy to limit the use of compulsory unpaid overtime to meet government waiting list targets.[72]

While the experiences of neighboring Canada are particularly instructive for Americans, they should know that physician strikes, work stoppages, and slowdowns have also occurred in the national health systems of France, Australia, New Zealand, and the Czech Republic.[73]

Expectation #5: Personnel shortages.

In 2002, the British NHS, a model of central planning, was found to be "critically short of doctors and nurses." This was blamed on "failure in the past to plan far enough ahead."[74] According to projections, the NHS will not reach the European average for physician staffing until at least 2024.[75] Not surprisingly, the remaining staff are "ludicrously overburdened."[76]

Similarly, Canada has a shortage of physicians, which has been blamed on an erroneous 1991 government prediction of oversupply. This estimate prompted mandatory reductions in medical school enrollment and postgraduate training sites throughout the provinces. These actions decreased physician supply while Canada's population grew by 300,000 to 350,000 per year. Meanwhile, the average workweek for Canadian physicians increased from 46.9 hours in 1993 to 53.3 hours in 1998.[77]

66. Deborah Jones, "'Playing God' During Labour Disputes Causes Stress," *CMAJ*, Vol. 170, Issue 13 (June 22, 2004), p. 1905, at *www.cmaj.ca/cgi/content/full/170/13/1905-a* (September 28, 2005).
67. Laura Eggertson, "Health Council: Shortages Critical," *CMAJ*, Vol. 172, Issue 6 (March 15, 2005), p. 734, at *www.cmaj.ca/cgi/reprint/172/6/734.pdf* (August 29, 2006).
68. CBC News, "Operations Cancelled as Doctors Attend 'Study Session,'" February 11, 2005, at *www.cbc.ca/toronto/story/tor-anesthesiologists22050211.html* (September 7, 2006).
69. Ontario Medical Association, "Anesthesiologists to McGuinty: The Time for Action Was Yesterday," February 11, 2005, at *www.oma.org/Media/news/pr050211.asp* (September 7, 2006).
70. *Ibid.*
71. Brian Edwards, "The First 50 Years of the NHS," *Student BMJ*, July 1998, p. 231, at *www.studentbmj.com/back_issues/0798/data/0798ed1.htm* (September 28, 2005), and *Microsoft Encarta*, on-line ed. (2004), s.v. "Welfare State," at *http://au.encarta.msn.com/encyclopedia_781539608/Welfare_State.html* (September 28, 2005).
72. John Carvel, "Work to Rule on Overtime, BMA Urges Consultants," *The Guardian*, May 16, 2003, at *http://society.guardian.co.uk/NHSstaff/story/0,7991,957063,00.html* (September 28, 2005), and "Consultants to Vote on Industrial Action," *The Guardian,* May 22, 2003, at *http://society.guardian.co.uk/NHSstaff/story/0,7991,961203,00.html* (September 28, 2005).
73. Reid *et al.*, "The Doctor Is Out," and Kay Grigar, "Czech Doctors 'Postpone' Services," Radio Praha, January 6, 2004, at *www.radio.cz/en/article/49112* (September 28, 2005).
74. Wendy Moore, "Wanless Report Outlines 'Rolls-Royce' Health Service for 2022," *BMJ*, April 27, 2002, p. 998.
75. Dennis Sewell, "A Question of Late Delivery," *New Statesman*, May 19, 2003, p. 27.
76. Phil Hammond, "The Ex-GP's Tale (NHS in Crisis)," *New Statesman*, February 4, 2002, p. 31.

As a result, some 18 percent of Canadians now have trouble finding a doctor. Shortages in rural primary care, radiation oncology, anesthesiology, radiology, psychiatry, and obstetrics have been reported. Indeed, nearly 60 percent of family physicians refuse to take on new patients or have limited their number.[78] Although the volume of work has increased significantly, the ratio of diagnostic radiologists per 100,000 population has not changed over the past decade. Similarly, the number of ophthalmologists is expected to fall by half over the next 20 years.[79]

Canada has 2.1 physicians (including residents) per 1,000 population compared to the OECD average of 2.8. To reach sufficient physician supplies, Canada would need to train 500 more physicians per year (a 25 percent increase). This shortage is exacerbated by government limits on residency slots and physician immigration and by the exodus of Canadian physicians to practice in other countries. Canada lost approximately 411 physicians annually to the United States from 1992 to 1998 but lost only 209 in 2002 and 80 in 2003. In 2004, for the first time in more than a decade, Canada registered a net gain of 55 physicians, with 262 migrating abroad.[80] From 1996 to 2002, according to the Canadian Institute for Health Information, there was a net migration of 49 neurosurgeons from Canada, a nation that then boasted only 241 neurosurgeons.

"It's not about the money," said Dr. Sriharan, a 38-year-old immigrant from Sri Lanka, "We can't do our job properly with operating room time so extremely limited here." He and his colleague could perform only one or two procedures on some days, so non-emergencies would go months or even years before getting necessary treatment.[81] In 1970, Canada ranked second in surveys measuring physicians per 1,000 people; but as of 2005, it had fewer physicians when compared with other nations, ranking 16th out of 23 countries. To rank as highly as first-ranked Austria, Canada would need to have 25,500 more doctors.[82]

In response to shortages in rural areas, recent proposals have included increasing the number of lesser-trained non-physician clinicians or "simply forcing new graduates to work in under-serviced regions."[83] Since 1993, the number of nurses per 100,000 Canadians has also dropped by more than 10 percent. Moreover, one in three is nurses is older than 50 years, but only one in 10 is under 30.[84]

77. Canadian Federation of Medical Students, "Physician Supply and Non-Physician Clinicians in a Changing Canadian Health Care System: Adjusting to the New Reality," Canadian Federation of Medical Students *Position Paper*, draft, August 13, 2003, at *www.cfms.org/representation/papers_view.cfm?id=4&what_section=representation* (September 28, 2005).
78. CBC News, "Crunch Looms for Access to Health Care: Doctors Survey," October 27, 2004, at *www.cbc.ca/story/canada/national/2004/10/27/physicians_study041027.html* (September 28, 2005).
79. Wait Time Alliance for Timely Access to Health Care, "It's About Time! Achieving Benchmarks and Best Practices in Wait Time Management," final report, Canadian Medical Association, August 2005, at *www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Media_Release/pdf/2005/wta-final.pdf* (September 1, 2006).
80. Lorne Tyrrell and Dale Dauphinee, "Task Force on Physician Supply in Canada," Canadian Medical Forum Task Force, November 22, 1999, pp. 1–25, at *www.cua.org/socioeconomics/physician_supply_2000.pdf* (September 28, 2005); Canadian Institute for Health Information, *Supply, Distribution and Migration of Canadian Physicians 2002*, August 27, 2003, p. 4, at *http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_47_E&cw_topic=47&cw_rel=AR_14_E* (September 28, 2005); Jeff Chu, "How to Plug Europe's Brain Drain," *Time Europe*, January 19, 2004, at *www.time.com/time/europe/magazine/printout/0,13155,901040119-574849,00.html* (September 28, 2005); Canadian Institute for Health Information, *Supply, Distribution and Migration of Canadian Physicians, 2003*, August 20, 2004, Table 2.2, Table 14.0, Table 17.0, and Table E2, at *http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_310_E&cw_topic=310&cw_rel=AR_14_E* (February 24, 2005); and Canadian Institute for Health Information, *Supply, Distribution and Migration of Canadian Physicians, 2004*, August 23, 2005, at *http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_385_E&cw_topic=385&cw_rel=AR_14_E* (October 3, 2005).
81. Clifford Krauss, "Windsor Journal; Doctors Eying the U.S.: Canada Is Sick About It," *The New York Times*, October 17, 2003, at *http://query.nytimes.com/gst/fullpage.html?sec=health&res=980CE0DE143EF934A25753C1A9659C8B63* (August 28, 2006).
82. Nadeem Esmail and Michael Walker, "Health Minister's Claims Do Not Appear to Be Based in Fact," CANSTATS, April 19, 2005, at *www.canstats.org/readmore.asp?sNav=pb&id=748* (September 1, 2006).

The Health Council of Canada recently warned that if the government does not address the shortage of doctors and nurses in Canada, "the scarcity of human resources will reach a crisis point."[85] For example, nursing shortages forced a Vancouver hospital to outsource 980 surgeries to private clinics in 2004.[86] In May 2006, a shortage of operating room nurses in a Calgary hospital meant no surgeries for eight operating days. Dr. Glenn Comm, president of the Calgary and Area Physicians Association, estimated that up to 64 hours of surgery time were lost.[87] In a recent needs assessment, Canada was found to have a current and worsening shortage of anesthesia staff, identifying a deficit of at least 656 full-time-equivalent anesthesiologists for the period 2000–2016.[88] To address physician shortages, the Canadian government spent an additional $27 million in 2005–2006, and $35 million in 2006–2007, to train up to 200 international medical graduates each year.[89]

For similar reasons, the recruitment and retention of general practitioners and specialists is considered a chronic and widespread problem in Britain as well.[90] Job dissatisfaction has grown due to low pay, overwork, stress, medical litigation, bullying, racism, and underfunding of the health service.[91] As a result, British physician and other staff shortages have forced the NHS to recruit abroad.[92]

In Britain, government directives reducing the hours that "junior doctors" may work and the total length of their training meant that new physicians had less experience, and hospitals had problems covering the work to be done. The NHS "streamlined" junior doctors' training by reducing the breadth and duration of clinical preparation required to become a consultant, dismissing fears that medical education was simply "being dumbed down" to address physician shortages.[93]

British shortfalls are exacerbated by an accelerating trend of early retirement among consultants and nontraditional work patterns among female physicians. (About half of female physicians work part-time, and many take a career

83. Canadian Federation of Medical Students, "Mandatory Return of Service," Canadian Federation of Medical Students *Position Paper*, August 22, 2003, at *www.cfms.org/representation/papers_view.cfm?id=9&what_section=representation* (September 28, 2005).

84. Press release, "Will a Nurse Be There for You?" Canadian Federation of Nurses Unions, December 14, 2004, at *www.nursesunions.ca/en/Press%20Releases/2004-12-14-CIHI.pdf* (September 28, 2005).

85. Allison Dunfield, "Canada Near Crisis over Doctors and Nurses: Report," *Globe and Mail Update*, January 27, 2005, at *www.theglobeandmail.com/servlet/story/RTGAM.20050127.whealth0127/BNStory/National* (September 28, 2005).

86. CBC News, "1,000 Surgeries Outsourced in Vancouver," November 3, 2004, at *www.cbc.ca/story/canada/national/2004/11/03/van_hospital041103.html* (September 28, 2005).

87. "Nursing Shortage Causing Operating Room Delays," CityTV (Calgary), May 24, 2006, at *www.citytv.com/calgary/news_29615.aspx* (August 28, 2006).

88. Douglas Craig, M.D., Robert Byrick, M.D., and Franco Carli, M.D., "A Physician Workforce Planning Model Applied to Canadian Anesthesiology: Planning the Future Supply of Anesthesiologists," *Canadian Journal of Anesthesia*, Vol. 49, Issue 7 (August/September 2002), pp. 671–677, at *www.cja-jca.org/cgi/reprint/49/7/671.pdf* (September 1, 2006).

89. Dwight Duncan, Ontario Minister of Finance, "2006 Ontario Budget: Budget Speech," 2006, at *www.ontariobudget.ca/english/statement.html* (September 1, 2006).

90. Adam Geldman, "NHS Staff: The Issue Explained," *The Guardian*, June 26, 2002, at *http://society.guardian.co.uk/NHSstaff/story/0,7991,460023,00.html* (September 28, 2005).

91. Rivett, "The Next Chapter."

92. Jo Revill, "Patients Left as Doctors Push Trolleys," *The Observer*, August 3, 2003, at *http://observer.guardian.co.uk/uk_news/story/0,6903,1011542,00.html* (September 28, 2005), and Press Association, "Consultant Numbers Fail to Keep Pace with Demand," *The Guardian,* December 11, 2003, at *http://society.guardian.co.uk/NHSstaff/story/0,7991,1104909,00.html* (September 28, 2005).

93. BBC News, "'Dumbed Down' Consultants Warning," March 6, 2004, at *http://news.bbc.co.uk/1/hi/health/3536243.stm* (September 28, 2005).

break.)[94] Separate European Union (EU) rules limiting doctors' hours threaten to create massive physician shortages and constrain crucial emergency access. As of August 2004, the EU Working Time Directive limits junior doctors to working 58 hours per week. The NHS estimated that the directive will cause a loss of 270,000 working hours per year, the equivalent of 3,700 physicians. Failure to comply can result in fines or employment tribunals.[95]

In the United States, the debate over physician supply has careened from dire predictions of oversupply to more recent predictions of shortages.[96] Where a normal market could easily manage supply and demand through prices, the central planners running a single-payer health care system find that the long lag time between policy interventions and the length of physician training makes even frequent assessments of the physician workforce "a critical, but elusive goal."[97]

Dental care in Britain is also burdened by the great demand that accompanies "free" health care in the NHS. Dentists are paid a fixed amount for each procedure—fees that have declined over time. To make a living, NHS dentists see an average of 30 to 40 patients per day, compared with the 12 per day seen by dentists in the United States. As a result, "ever fewer British dentists are willing to endure the grueling, assembly-line work required to participate in the National Health Service."

Despite an enlarging and aging population, Britain has fewer dental schools than before, and fewer dentists are being trained. Patients are forgoing routine dental exams and cleaning and are "waiting until the last possible minute to get their teeth fixed." Shortages are so severe that in August 2003, 600 people turned up outside a tiny dental surgery office in Wales to secure one of 300 appointments for the NHS dentist. Some had camped in tents overnight; half were turned away. A British patient remarked, "It was like a bread line."[98]

None of this should be surprising. Without the functioning of a real market and real prices, as Nobel Laureate Friedrich Hayek observed, a central planner faces an impossible task in attempting to allocate labor or other resources. It simply cannot be done efficiently.[99] Moreover, reduced and fixed salaries for nurses, mid-level providers, physicians, and pharmacists, among others, affect recruitment and retention across these professions.[100]

Attracting talented young people may prove more difficult with lower wages, especially considering the median medical student debt of $135,000.[101] Since the deregulation of Canadian medical school tuition in 1998, tuition fees have "skyrocketed," causing fears that lower-income students could not afford to become physicians because government fees would be insufficient for their debt load.[102] In Great Britain, there are simi-

94. Rivett, "The Next Chapter."
95. Marie Woolf, "EU Rules 'Will Cost the NHS Equivalent of 3,700 Doctors,'" *The Independent*, March 22, 2004, at *http://news.independent.co.uk/uk/health_medical/article65459.ece* (September 28, 2005); Sarah-Kate Templeton, "New Rules on Doctors' Hours Will Shut Half of Glasgow's Hospitals," *Sunday Herald* (Glasgow), December 7, 2003, at *www.sundayherald.com/38511* (September 28, 2005); and BBC News, "EU Law 'Threatens NHS Care,'" April 6, 2004, at *http://news.bbc.co.uk/1/hi/health/3605631.stm* (September 28, 2005).
96. R. A. Cooper, "Weighing the Evidence for Expanding Physician Supply," *Annals of Internal Medicine*, Vol. 141, Issue 9 (November 2, 2004), pp. 705–714.
97. David Blumenthal, "New Steam from an Old Cauldron—The Physician-Supply Debate," *New England Journal of Medicine*, Vol. 350, No. 17 (April 22, 2004), pp. 1780–1786.
98. Lizette Alvarez, "Britain's Dental System Taxed by High Demand," *The International Herald Tribune*, August 12, 2003.
99. Friedrich Hayek, *The Road to Serfdom* (Chicago: University of Chicago Press, 1944 and 1994), pp. 97–111.
100. Colin Brown, "NHS Beds Lying Empty in Shortage of Nurses," *The Independent*, January 20, 2000, p. 2, at *http://news.independent.co.uk/uk/health_medical/article287501.ece* (September 28, 2005).
101. American Medical Student Association, "Student Debt: What You Should Know," 2004, at *www.amsa.org/meded/studentdebt.cfm* (February 17, 2005).

lar concerns that increasing debt "will cause many students, particularly those from working class backgrounds, to decide against a career in medicine"[103] when 70 percent of medical students already come from upper classes.[104]

Bright students have numerous career alternatives. Indeed, Thomas Sowell, a prominent economist, argues:

> [M]edical school may no longer look like such a good investment to many in the younger generation. Britain, which has had government-run medical care for more than half a century, has to import doctors from the Third World, where medical school standards are lower.[105]

Moreover, as many as one in four medical graduates in Great Britain never practice medicine, opting for more lucrative careers in other fields.[106] According to the 2001 census, over 26,000 medical doctors in England and Wales were employed but not working as medical practitioners.[107]

To meet these shortfalls, the NHS has depended for many years on International Medical Graduates (IMGs), particularly in less popular specialties such as geriatrics, genitourinary medicine, and psychiatry.[108] This has increased substantially in recent years, with IMGs representing 15 percent of consultants appointed during 1964–1991 and 24 percent of those appointed since 1991. In addition, to meet NHS pledges for more physicians, the government began a world-wide advertising campaign for doctors in 2001.[109] By 2002, nearly half of the 10,000 new doctors in Britain were from non-EU overseas countries,[110] rising to more than two-thirds of a total of 15,000 in 2003.

While 22.7 percent of Canada's physicians earned their medical degrees outside of Canada, since the 1990s, the number of immigrants taking up practice in Canada has constantly declined.[111] Physician shortages and migration reflect a symptom "of a deeper malaise" in nationalized health systems: "planning failures, the inability (or unwillingness) to pay fairly, and lack of career prospects."[112]

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102. Lisa Clements, "Ontario Medical Student Bursary Fund Announces Inaugural Disbursement," *Ontario Medical Review*, December 2001, at *www.oma.org/pcomm/OMR/dec/01disbursement.htm* (September 28, 2005).
103. James Stockman, "Clinical Facts & Curios," *Current Problems in Pediatric and Adolescent Health Care*, Vol. 34, No. 7 (August 2004), pp. 273–279.
104. Daniel Gibbons, "Top Up Fees and Medicine: Ability to Commit to Unspecified Debt May Take Precedence over Ability," *BMJ*, Vol. 328, No. 7441 (March 20, 2004), p. 712, at *http://bmj.bmjjournals.com/cgi/content/full/328/7441/712-a* (September 28, 2005).
105. Thomas Sowell, "The 'Cost' of Medical Care," Townhall.com, May 4, 2004, at *www.townhall.com/opinion/column/thomassowell/2004/05/04/11577.html* (September 28, 2005).
106. Susan Mayor, "University Fee Changes May Deter Poor Students from Studying Medicine," *BMJ*, Vol. 328, No. 7432 (January 17, 2004), p. 128, at *http://bmj.bmjjournals.com/cgi/content/full/328/7432/128* (January 10, 2006).
107. Danny Dorling, letter to the editor, "Top Up Fees and Medicine: Waive Repayments Completely If Working Life Is Spent in the NHS," *BMJ*, Vol. 328, No. 7441 (March 20, 2004), p. 712, at *http://bmj.bmjjournals.com/cgi/content/full/328/7441/712* (September 28, 2005).
108. Michael J. Goldacre, Jean M. Davidson, and Trevor W. Lambert, "Country of Training and Ethnic Origin of UK Doctors: Database and Survey Studies," *BMJ*, Vol. 329, No. 7466 (September 11, 2004), p. 597.
109. Rivett, "The Next Chapter."
110. James Buchan and Delanyo Dovlo, "International Recruitment of Health Workers to the UK: A Report for DFID," *Health Policy and Development*, December 2004, pp. 180–182.
111. James Buchan, Renu Jobanputra, and Pippa Gough, "London Calling? The International Recruitment of Health Workers to the Capital," King's Fund, July 2004, pp. 1–12, at *www.kingsfund.org.uk/resources/publications/london_calling.html* (September 28, 2005).
112. James Buchan, "International Recruitment of Health Professionals," *BMJ*, Vol. 330, No. 7485 (January 29, 2005), p. 210.

Expectation #6: Outdated facilities and medical equipment.

In government-run industries, the equipment purchasing, facility upgrades, and technology investments are dependent on politics, either in the form of legislative determinations or through bureaucratic central planning. The consequences of this politicized process are particularly acute in Britain. Economists Daniel Yergin and Joseph Stalislaw note that:

> Every kind of decision [in Britain] ran the risk of becoming a political decision, driven not by the interests of the firm but by the desires of politicians in power, whether it was wage settlements or new investments in plant location, major projects, and equipment.[113]

By 2000, one-third of NHS buildings had been built before the NHS was created in 1946, and many were out of date and poorly located. The maintenance backlog was at $4.3 billion, because when NHS funding was tight, hospitals would reduce maintenance or postpone replacement, eventually leaving outdated equipment that was often in disrepair.[114] Frequently, the British facilities "leave a lot to be desired."[115]

Indeed, a shortage of intensive care unit (ICU) beds in the NHS has contributed to patient deaths. In 2000, the NHS had nine critical care beds per 100,000, compared to 31 per 100,000 in the United States. In a review of deaths following surgery in the NHS, some 40 percent of hospitals with perioperative deaths had no ICU beds at all. In 61 cases (5 percent of those who died), the patients were denied access to ICU beds because no bed was available.[116] In another study, patients undergoing major surgery in the NHS were four times more likely to die than were those undergoing surgery in the U.S. The difference in mortality rates was blamed on restricted ICU access and a shortage of units providing intermediate and intensive care.[117]

Although Britain has recently seen an increase in imaging technology, the number of MRIs in 2004 was five per million population, well below the OECD average of eight per million, and the number of CT scanners stood at seven per million, less than half the OECD average of 18 per million.[118] According to Henry Aaron, a prominent health care economist at the Brookings Institution in Washington, D.C., "the British spend too little on imaging, with the result that physicians often lack the information to provide patients lifesaving or pain-relieving care," and the scarcity of machines, staffing, and money has reduced availability and eroded quality.[119]

Researchers writing in a recent edition of *Health Affairs* were critical of U.S. health information technology (IT) efforts and touted Britain's National Programme for IT as "the most expensive and perhaps the most comprehensive HIT system in development worldwide," providing an integrated care record service, electronic appointment system, and electronic prescription system.[120] Yet after four years, the project has become a classic government boondoggle with missed deadlines and cost overruns. Two years behind schedule and more than

113. Daniel Yergin and Joseph Stalislaw, *The Commanding Heights: The Battle for the World Economy* (New York: Touchstone, 1998 and 2002), pp. 74–133 and 315–335.

114. Diane Dawson, "The Private Finance Initiative: A Public Finance Illusion?" *Health Economics*, Vol. 10, No. 6 (September 2001), pp. 479–486. The figures are based on the Canadian dollar–U.S. dollar exchange rate in 2000.

115. Phil Hammond, "The Ex-GP's Tale (NHS in Crisis)," *New Statesman*, February 4, 2002, p. 31.

116. Monty Mythen, Michael Grocott, and Andrew Webb, "The National Confidential Enquiry into Perioperative Deaths 2000: Then and Now," *British Journal of Hospital Medicine,* Vol. 62, Issue 5 (May 2001), pp. 262–263.

117. E. Bennett-Guerrero, J. A. Hyam, S. Shaefi, D. R. Prytherch, G. L. Sutton, P. C. Weaver, M. G. Mythen, M. P. Grocott, and M. K. Parides, "Comparison of P-POSSUM Risk-Adjusted Mortality Rates After Surgery Between Patients in the USA and the UK," *British Journal of Surgery*, Vol. 90, Issue 12 (December 2003), pp. 1593–1598.

118. Organisation for Economic Co-operation and Development, "OECD Health Data 2006."

119. Henry J. Aaron, "Health Care Rationing: What It Means," Brookings Institution *Policy Brief* No. 147, December 2005, at *www.brookings.edu/comm/policybriefs/pb147.htm* (September 1, 2006).

three times over the original £6.2 billion budget, it remains "a low-tech hotch-potch," and a recent audit found that "corners were cut so that political deadlines could be met." The final cost of the program is estimated to be £20 billion by 2010, the revised delivery date.[121]

The problems are similar in Canada. For example, Canada has fewer MRIs per capita than Iceland, Hungary, South Korea, and the Czech Republic.[122] Further, much of the country's diagnostic equipment is "so outdated it would be not be used by radiologists in the United States."[123] Indeed, it is estimated that 60 percent of radiologic equipment is technically outdated, and aging equipment is replaced only when it is no longer functional.[124] For example, a CT scanner in a Montreal hospital is so medically primitive that replacement parts are no longer available, including the on-off switch; thus it bears a note stating: "Please Do Not Shut Down," because once turned off, it cannot be restarted.[125]

Prominent Canadian radiologists report that despite $1 billion of federal spending, there remains a scarcity of new equipment and that monies earmarked to replace outdated and broken imaging machines were instead diverted to purchase new beds and increase wages. Dr. Paul LeBrun, chief radiologist at the Queen Elizabeth II Health Sciences Centre in Halifax, says that some of his colleagues are working with 34-year-old x-ray machines and estimates that almost half of the province's imaging equipment needs to be replaced. Dr. Giuseppe Tarulli describes "limping along" with 2,400 outdated imaging machines, and an experienced cardiologist described using "an ancient, fluoroscopic imaging machine" to insert a pacemaker:

> It was next to impossible to see anything.... I have never worked with a worse piece of equipment in my career, including cases I have done in small towns in Brazil, Chile, and Uruguay. It is unsafe.[126]

Some modern imaging procedures that are commonplace around the world either cannot be done or are rarely performed because of "dilapidated scanners" or equipment scarcity. The shortage of imaging technology "creates a dangerous backlog that is all too common across the country." Dr. John Mathieson says he has stopped reviewing professional radiology journals because the articles deal with procedures done on imaging equipment that is unavailable to him. He cites examples of old radiology equipment so outdated that he has never seen them used and equipment ready for replacement that is instead made to last at least another five years. "In effect," he says, "government policy was based on the assumption that medical equipment would last forever."[127]

Similarly, Canada's 16 medical schools and their associated teaching hospitals have been described as "saddled with outdated facilities and equipment." As a result, some $6 billion in tax increases was sought to finance capital and technology overhauls.[128] To trim $269 million from federal spending, Health Canada planned to cut the science

120. Gerard F. Anderson, Bianca K. Frogner, Roger A. Johns, and Uwe E. Reinhardt, "Health Care Spending and Use of Information Technology in OECD Countries," *Health Affairs*, Vol. 25, Issue 3 (May/June 2006), pp. 819–831.

121. "'Computer Says No' to Mr Blair's Botched £20bn NHS Upgrade," *Telegraph* (London), June 4, 2006, at *www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/06/04/nhs04.xml* (September 1, 2006).

122. David Gratzer, ed., *Better Medicine: Reforming Canadian Health Care* (Toronto: ECW Press, 2002), p. 53.

123. Heather Sokoloff and Sarah Schmidt, "Romanow's Remedy: A 47-Step Diagnosis," *National Post*, November 29, 2002.

124. Dr. John Radomsky, President, Canadian Association of Radiologists, in hearing, *Issue 5—Evidence*, Standing Senate Committee on Social Affairs, Science and Technology, Senate of Canada, March 29, 2001, at *www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/soci-e/05ev-e.htm* (September 1, 2006).

125. Tim Arnold, "X-Ray Labs Dangerously Outdated: Radiologists Sound Alarm," *National Post*, October 12, 2000, p. A1.

126. Andy Shaw, "Diagnostic Imaging Across Canada: The Emperors Still Have No Clothes," *Canadian Healthcare Technology*, January/February 2002, at *www.canhealth.com/jan02.html#anchor19080* (August 28, 2006).

127. *Ibid.*

library budget by 50 percent and reduce the number of staff members from 26 to 10 at department libraries over the next three years. Many of the journals are used for basic science research and are unavailable elsewhere.[129]

According to the Ontario Hospital Association, reductions in government funding and hospital capacity in the 1990s led to a decline in the physical condition of their hospitals. Due to aging facilities and deferred capital projects, the need for upgrades of buildings (including structures, electrical/mechanical systems, and information technology) was considered urgent. Implementing these changes in Ontario alone would cost an estimated $7.8 billion.[130]

In the past three decades, Canada has significantly underinvested in its health capital. Additions to Canada's medical infrastructure expanded rapidly between the mid-1950s and the early 1960s and then stabilized to just under 0.4 percent of GDP in the late 1960s. Since then, except for a brief jump in the early 1980s, hospital capital stock declined steadily as a share of GDP from 1970 to 2000, recovered slightly, and now stands at about 0.3 percent. This 0.1 percent reduction represents approximately $12 billion in hospital capital. Without exception, current capital commitments are relatively unplanned, primarily funded from year-end budget surpluses—when present.

The consistent decline in annual investment in public capital over a 25-year–30-year period has created a backlog of unmet needs for new hospitals, equipment, machinery, technology, and maintenance; and because rapidly evolving technologies have short economic lives, the capital investment shortages accelerate. According to Hugh Mackenzie, the weakness of Canada's "periodically rediscovered commitment to funding for health care" is that "it clearly fails to recognize that funding for hospital capital is an on-going requirement of the health care system."[131]

Expectation #7: Waiting times.

Queues indicate a shortage in a centrally planned economy, but they are inevitable when government sets prices at or below the equilibrium level.[132] According to the OECD, among countries that report significant wait times, reduced physician availability largely explains most variations in waiting, followed by lower funding and bed capacity.[133]

In Canada, queues are common. A survey of specialist physicians in Canada found that the waiting time for radiotherapy of non–small cell lung cancer rose from 27.3 days in 1982 to 42 days in 1999. In Ontario, the median wait for knee replacement surgery doubled from eight weeks in the late 1980s to 16 weeks by 1999. In 1990, median Canadian waiting times for angioplasty and coronary bypass were 11 weeks and 5.5 months, respectively. In comparison, 1999 median waiting times for angioplasty ranged from just 4.5 weeks in New Brunswick to 13 weeks in Newfoundland, and waits for elective coronary bypass ranged from 8.5 weeks in Ontario to one year in Newfoundland. International comparisons show that waits for elective car-

128. Standing Committee on Social Affairs, Science and Technology, Senate of Canada, speaking notes for the release of *The Health of Canadians—The Federal Role: Recommendations for Reform*, Vol. 6, October 25, 2002, at *www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/SOCI-E/press-e/notesoct02-e.htm* (September 28, 2005).

129. CBC News, "Budget Cuts at Health Canada Gut Research Libraries," January 9, 2006, at *www.cbc.ca/ottawa/story/ot-healthcuts20060109.html* (August 26, 2006).

130. Ontario Hospital Association, Hospital Capital Funding Working Group, "Funding & Financing Hospital Infrastructure Renewal," April 2000, at *www.oha.com/oha/reports.nsf/($Att)/pspr4jtj9b/$FILE/fundingfinancinghospital.pdf?OpenElement* (October 1, 2005).

131. Hugh Mackenzie, "Financing Canada's Hospitals: Public Alternatives to P3s," October 2004, p. 22, at *www.forumonpublicdomain.ca/files/P3economistreportfinal.pdf* (August 25, 2006).

132. Thomas Sowell, *Basic Economics* (New York: Basic Books, 2000), pp. 22–47.

133. Luigi Siciliani and Jeremy Hurst, "Explaining Waiting Time Variations for Elective Surgery Across OECD Countries," Organisation for Economic Co-operation and Development *Health Working Paper* No. 7, October 2003, at *www.oecd.org/dataoecd/31/10/17256025.pdf* (August 28, 2006).

diac bypass or angiography were even longer in Britain and New Zealand (1995 data).[134]

More recently, the average wait between general practitioner referral and specialty consultation in Canada was 17.7 weeks, and the total wait time for treatment was 90 percent longer than in 1993. Delays such as 32.2 weeks for orthopedic surgery and 30 weeks for ophthalmology treatment were described as "beyond clinically reasonable."[135]

With regard to access to technology, Canada performs "dismally" when compared to other OECD countries. While ranking number one as a health care spender, Canada ranks 15th out of 24 in access to MRIs, 17th out of 23 in access to CT scanners, eighth out of 22 in access to radiation machines, and is tied for last in access to lithotripters. Lack of access to machines has meant longer waiting times for proper diagnosis.[136]

Studies have found waiting times to be longer in Canada than in the U.S. for a variety of elective surgeries. In comparing American Medicare patients to Canadian patients, researchers found that the average waiting time was twice as long for both the initial orthopedic consultation (four weeks vs. two weeks) and knee replacement surgery (eight weeks vs. three weeks) in Canada. A recent survey in Canada and four other countries showed that the average waiting time for elective surgery was more than one month, with 27 percent of people surveyed indicating that they had waited more than four months.[137]

In the end, "the corrosive and debilitating debate over money" in socialized medicine accounts for people having to wait for hours in crowded emergency rooms or for a year or more for surgery or diagnostic tests.[138] Between 1993 and 2003, average waiting times in Canada rose 70 percent despite a spending increase of 21 percent, from $1,836 to $2,223 per capita.[139] It should be noted, however, that lack of diagnostic equipment and limited operating room time are not merely evidence of poor planning, but often intentional mechanisms "used to control hospital costs, enabling administrators to meet their budgets."[140]

In Britain, the queue problem is legendary. Faced with hospital queues exceeding 1 million, with many patients waiting more than a year for inpatient treatment, the NHS increased spending by more than one-third since 1999.[141] The share of public spending in the United Kingdom rose from 80 percent in 1998 to 86 percent in 2004, well above the average of 73 percent for OECD countries.[142] However, only 2.4 percent was spent on new beds or surgeries. The bulk, 29 percent, went toward NHS personnel pensions, and 27 percent went to pay raises for physicians and nurses and to hiring new staff.

In 2006, the waiting list in Britain did fall below 800,000 for the first time, but 24,800 had waited more than six months, and the NHS overall experienced "a sharp fall" in productivity, declining to its

134. Martin Zelder and Greg Wilson, "Waiting Your Turn: Hospital Waiting Lists in Canada (10th Edition)," Fraser Institute *Critical Issues*, October 2000, at *http://oldfraser.lexi.net/publications/critical_issues/2000/waitingyourturn/section_06.html* (October 1, 2005).

135. Luma Muhtadie, "Wait Times on the Rise Across Canada, Report Says," *The Globe and Mail*, October 21, 2003, at *www.theglobeandmail.com/servlet/story/RTGAM.20031020.wwait1020/BNStory/National* (February 24, 2005).

136. Esmail and Walker, "Health Minister's Claims Do Not Appear to Be Based in Fact."

137. Christopher T. Erb and Robert F. Rich, "The Canadian Health Care System," Institute for Government and Public Affairs, University of Illinois at Urbana–Champaign, October 2005, pp. 15–16, at *www.igpa.uiuc.edu/publications/workingPapers/wp130.pdf* (September 1, 2006).

138. Brian Laghi, "Set Standards for Wait Times, Pettigrew Urges," *The Globe and Mail*, April 21, 2004, p. A5.

139. Nick Bosanquet, "The NHS in 2010," Reform, December 2004, at *www.reform.co.uk/filestore/pdf/The%20NHS%20in%202010.pdf* (September 1, 2006).

140. Wait Time Alliance for Timely Access to Health Care, "It's About Time!"

141. "National Health Service: Walking Wounded," *The Economist*, November 24, 2001, p. 31.

142. Organisation for Economic Co-operation and Development, "OECD Health Data 2006."

lowest level since 1990.[143] As of 2006, the maximum wait for surgeries remained at six months.[144] Moreover, the median waiting time between a decision to admit a patient to the hospital and actual admission for treatment actually *rose* from 43 days in 1999–2000 to 54 days in 2004–2005.[145]

All this effort has come at great cost. The cumulative deficit run up by Britain's NHS since 1997 is approaching £750 million. The NHS is now "facing the biggest financial crisis in its history after it emerged that front-line trusts in England ran up deficits of £1.27 billion last year."[146] As a result, "[w]ards are being closed, frontline medical staff cut, operations cancelled—and piles of unpaid bills are mounting up." Over the past seven years, the NHS has doubled the amount spent on health, but "much of it seems to have been dropped into a black hole." According to Chris Grayling, the Conservative Party health spokesman, "The reality is that much of the NHS is now bankrupt and all round the country hard decisions are being taken about cutting back services."[147]

Moreover, some of the wait lists have been reduced not by performing the desired services, but by simply refusing to make appointments available. Similarly, to ration care and save £25 million a year, local health trusts have been told to cut GP referral rates to match the lowest 10 percent nationally. Consultant-to-consultant referrals are also being limited, thus denying patients a second opinion. Emergency departments must redirect 40 percent–70 percent of patients back to GPs or walk-in clinics, as they will not be paid for any services rendered.[148]

Other countries reduce wait lists artificially by reducing demand. For example, in Spain, financial incentives induced specialists to contain demand, and in New Zealand, the booking system raised clinical thresholds for adding patients to waiting lists.[149]

According to Britain's Royal College of Radiologists, the lack of machines and greater patient complexity lengthened waiting times for radiotherapy. In 1998, 28 percent of patients waited more than four weeks to start potentially curative radiotherapy. In 2002, 81 percent of patients surveyed waited longer than four weeks.[150] By 2003, the median wait was five weeks. The percentage of patients waiting longer than national guidelines for radical treatments increased from 32 percent in 1998 to 72 percent in 2003; the percentage of patients waiting for adjuvant treatments during the same period rose from 39 percent to 62 percent.[151] As of 2005, there were *lotteries* in Britain for anti-cancer drugs, chemotherapy treatments, and even for a place in line waiting for diagnostic scans.[152]

New EU work regulations set for 2008 will restrict the use of MRI scanners in Britain, affecting

143. Nigel Hawke, "£5bn Injection Can't Lift NHS Debt," *The Times*, December 03, 2005, at *www.timesonline.co.uk/article/0,,2-1901828,00.html* (September 5, 2006).
144. U.K. Department of Health, "NHS Delivering on Care and Costs," June 7, 2006, at *www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4135905&chk=xZ5var* (September 5, 2006).
145. Reform, "Waiting Times," at *www.reform.co.uk/website/health/nhsperformance/waitingtimes.aspx* (August 25, 2006).
146. Graeme Wilson and Celia Hall, "Billions Injected But NHS Debt Hits New High," *Telegraph*, June 8, 2006, at *www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/06/08/nhs08.xml* (September 5, 2006).
147. Karyn Miller, "NHS Debts Soar to over £1bn," *Telegraph*, April 24, 2005, *www.telegraph.co.uk/news/main.jhtml?xml=/news/2005/04/24/nhs24.xml* (September 5, 2006).
148. Nigel Hawkes, "Secret NHS Plans to Ration Patient Care," *The Times*, April 7, 2006, pp. 1 and 2, at *www.timesonline.co.uk/article/0,,8122-2122800,00.html* (September 5, 2006).
149. Siciliani and Hurst, "Explaining Waiting Times Variations for Elective Surgery Across OECD Countries," p. 16.
150. Board of the Faculty of Clinical Oncology, "Equipment, Workload and Staffing for Radiotherapy in the UK 1997–2002," Royal College of Radiologists, September 2003, at *www.rcr.ac.uk/index.asp?PageID=149&PublicationID=185* (October 1, 2005).
151. D. Ash, A. Barrett, A. Hinks, and C. Squire, "Re-audit of Radiotherapy Waiting Times 2003," *Clinical Oncology*, Vol. 16, Issue 6 (September 2004), pp. 387–394, at *www.rcr.ac.uk/docs/oncology/pdf/RTWTarticleFINAL.pdf* (October 1, 2005).

as many as 300,000 procedures per year. Increased waiting times, lower quality, and increased risk from radiation exposure are expected results.[153]

Although the NHS promised that 95 percent of patients would start treatment for cancer within 62 days of being referred, June 2006 figures showed that 9 percent spent longer in queues, equating to around 12,000 people a year. The main delays occur in the wait for diagnosis, where lack of staff and equipment prevent completion of diagnostic tests. The biggest waits are for colon cancer, the third most common form of cancer in Britain, affecting 34,000 people a year, where insufficient access to colonoscopy delays diagnosis.[154]

Although patients prefer fewer barriers to specialty care, rationing by queues and rationing by means of gatekeepers are crucial methods by which officials control expenditures, rather than the effects of poor design or underfunding.[155] While the NHS has long used waiting lists and denial of coverage for treatment that health authorities "considered of doubtful benefit," it has preferred "to pretend this was not rationing."

In 1998, Shadow Secretary of State for Health Ann Widdecombe argued that "it was unhelpful to deny the existence of rationing; it always had and always would exist."[156] Only in recent years has the Labour party acknowledged "that a tax-financed service cannot provide everything that the pharmaceutical industry and medical technology can create."[157] However, in nationalized health care systems, politicians and bureaucrats—rather than patients—continue to decide which health care options are available.

Expectation #8: Significant variations in patient care.

Single-payer proponents often promise national equality in patient care. The reality, however, is very different.

In Canada, the allocation of resources is skewed by a persistent socioeconomic bias against rural residents and the poor. (Presumably, national health care was meant to address this.)[158] A recent study found significant regional inequities in access to cardiac procedures after myocardial infarction (MI). In Alberta, 36 percent of people had bypass surgery or angioplasty within a year after MI, while only 6 percent of Prince Edward Island residents had one of the procedures. In Alberta, the average wait for surgery following a heart attack was found to be a mere eight days, compared to 29 days in Nova Scotia. Notably, elderly women tend to wait the longest for these procedures.[159]

152. BBC News, "MPs Attack Cancer Care 'Lottery,'" January 25, 2005, at *http://news.bbc.co.uk/1/hi/health/4203625.stm* (October 1, 2005).
153. Fiona MacGregor, "Doctors Say Patients' Lives Will Be at Risk If EU Enforces MRI Rules," *The Scotsman*, September 21, 2005, at *http://news.scotsman.com/health.cfm?id=1969902005* (September 28, 2005).
154. Jo Revill, "Cancer Queue Grows as Treatment Target Is Missed," *The Observer*, April 30, 2006, at *http://observer.guardian.co.uk/uk_news/story/0,,1764598,00.html* (August 29, 2006).
155. Wolfgang Himmel, Anja Dieterich, and Michael Kochen, "Will German Patients Accept Their Family Physician as a Gatekeeper?" *Journal of General Internal Medicine*, Vol. 15, Issue 7 (July 2000), pp. 496–502, at *www.blackwell-synergy.com/doi/pdf/10.1046/j.1525-1497.2000.10016.x* (January 18, 2006), and Mark Liebow, Arlene Bierman, and Oliver Fein, "The World We Live in: Health Policy from a Primary Care Perspective," *Journal of General Internal Medicine*, Vol. 15, Issue 7 (July 2000), pp. 519–520, at *www.blackwell-synergy.com/doi/pdf/10.1046/j.1525-1497.2000.05000.x* (January 18, 2006).
156. Rivett, "The Next Chapter."
157. *Ibid.*
158. David A. Alter, C. David Naylor, Peter C. Austin, Benjamin T. B. Chan, and Jack V. Tu, "Geography and Service Supply Do Not Explain Socioeconomic Gradients in Angiography Use After Acute Myocardial Infarction," *CMAJ*, Vol. 168, Issue 3 (February 4, 2003), pp. 261–264, at *www.cmaj.ca/cgi/reprint/168/3/261* (January 18, 2006).
159. L. Pilote, P. Merrett, I. Karp, D. Alter, P. C. Austin, J. Cox, H. Johansen, W. Ghali, and J. V. Tu, "Cardiac Procedures After an Acute Myocardial Infarction Across Nine Canadian Provinces," *Canadian Journal of Cardiology*, Vol. 20, No. 5 (April 2004), pp. 491–500.

In spite of an aging population, access to long-term care and home health services for the elderly has decreased significantly, and cuts in services affect some Canadian provinces more than others, creating "significant inequality in access to services between the health regions." Even after accounting for new assisted living units, there has been a net decrease of 1,464 long-term care beds since 2001. Home "personal care" services have also been cut, with a 13 percent decline in hours and a 21 percent reduction in clients. Home nursing hours and clients declined by 8 percent. Joyce Jones of the BC Seniors' Network states, "Those who can't afford to pay or who don't have families to support them often simply go without until they are admitted to a hospital emergency ward in crisis."[160]

In Britain, an analysis of the NHS showed that the location of the health board of first treatment independently predicted whether or not cancer patients would receive adjuvant systemic therapy (additional anti-cancer treatment given after a cancer is surgically removed). In fact, survival rates varied significantly among regional health boards, with estimated five-year survival rates ranging from 67 percent to 84 percent.[161] Similarly, NHS rates of cardiology consultations, heart bypass, and angioplasty are lower in poorer socioeconomic areas despite higher rates of heart disease. Residents of northern England, primarily the old and poor, were twice as likely to die of cancer as were patients from the south.[162] According to a report in *The Guardian*, "Where you live is a predictor of poor health over and above personal and social characteristics such as employment history."[163]

Other factors discriminate as well. In addition to laying off 1,000 hospital employees, North Staffordshire is tackling its £30 million of NHS debt by restricting access to surgery among obese patients. People classified as clinically obese will be denied hip and knee replacement surgery. The cutoff point will be a Body Mass Index measurement of 30, representing a quarter of joint replacement patients.[164]

Administration errors have also caused unwarranted variations in care. NHS price setting for surgeries has failed to account for orthopedic operations that incur extra costs and require more difficult work. As a result, the five specialist orthopedic hospitals in England may have to abandon more complex procedures on hips and bones due to insufficient reimbursement. For example, a four-hour hip operation followed by eight days of inpatient physiotherapy cost £13,791, but the Department of Health paid only £4,967.[165]

Expectation #9: Financial waste.

American physicians who favor a single-payer system argue that "public money now routed through private insurers would be used to fund public coverage" and that during a transition period, employers would simply transfer existing money for health benefits to the single-payer program. They argue further that a single-payer national health insurance system would be cheaper and more efficient and "would save at least $200 billion annually (more than enough to cover all of the uninsured)."[166]

This prediction of huge cost savings resulting from shifting current insurance premiums to new taxation and income redistribution, which would fund an

160. Press release, "Long-Term Care and Home Health Services in BC on Steady Decline," Canada Centre for Policy Alternatives, April 4, 2005, at *www.policyalternatives.ca/index.cfm?act=news&call=1067&pa=3bb76202&do=Article* (September 5, 2006).

161. Green and Casper, "Delay, Denial and Dilution," pp. 23–36.

162. BBC News, "MPs Attack Cancer Care 'Lottery.'"

163. David Walker, "What's Your Poison?" *The Guardian*, March 5, 2004, at *www.guardian.co.uk/analysis/story/0,3604,1162473,00.html* (October 1, 2005).

164. Dave Blackhurst, "Obese Patients to Be Refused Hip Operations," *The Sentinel*, April 29, 2006, at *www.thisisthesentinel.co.uk/displayNode.jsp?nodeId=158338&command=displayContent&sourceNode=158321&contentPK=14405926* (August 28, 2006).

165. John Carvel, "New Payment Rules 'Threaten NHS Operations,'" *The Guardian*, July 6, 2006, at *www.guardian.co.uk/medicine/story/0,,1813641,00.html* (August 28, 2006).

166. Physicians' Working Group, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance."

American version of national health insurance, is overly optimistic. An unavoidable loss of efficiency is inherent in the redistribution process and results in unanticipated losses. Arthur Okun, a nationally prominent economist, has observed: "The money must be carried from the rich to the poor in a leaky bucket. Some of it will simply disappear in transit, so the poor will not receive all the money that is taken from the rich." These losses are attributable to the administrative costs of taxing and transferring.[167]

Single-payer advocates also predict a dramatic reduction in administrative costs because administration costs in private insurance are reported to be higher than the costs of single-payer systems as a result of underwriting, marketing, and varied requirements from multiple insurers. They allege that implementing a Canadian-style health care system could save these "superfluous" administrative costs.[168] However, as Henry Aaron of the Brookings Institution has argued, this comparison is exaggerated and not terribly useful. A lower figure seems likely as current privatized expenses for meeting public regulations become nationalized.[169]

In 2001, for example, it was reported that the British NHS lost up to £7 billion annually through "waste, fraud and inefficiency," representing a stunning 20 percent of the total budget and consuming recent extra spending meant for improved services.[170] By 2004, this figure reached £15 billion, and it was estimated that "the NHS loses 16 to 20 percent of its budget through waste, mismanagement, incompetence and fraud."[171]

The NHS employs 1.3 million workers across England, including 679,000 clinical staff, such as doctors and nurses, and 220,000 support staff, such as managers, finance, and IT. Since 1997, the NHS has added 18,549 management positions, so there are now more administrators than consultants (39,391 administrators vs. 31,993 consultants). Nevertheless, NHS Confederation chief executive Gill Morgan said that "if anything the health service was under-managed."[172]

Single-payer advocates in the United States often point to the officially low administrative costs of Medicare and Medicaid, the huge federal government programs that cover the elderly and the poor. However, Medicare and Medicaid administrative costs have been seriously underestimated because their budgets omit the administrative expenses incurred by the legislative and executive branches at both the state and federal levels. Beyond these omitted costs, there are the administrative expenses borne by Medicare and Medicaid providers and, depending on the particular circumstances, the patients. If all of these currently omitted costs are factored into the computation, the costs are closer to 27 percent for these government programs, compared to 16 percent in private insurance.[173]

Some analysts believe that centralized and computerized health care records and billing would

167. Arthur Okun, *Equality and Efficiency: The Big Tradeoff* (Washington, D.C.: The Brookings Institution, 1975), pp. 19–63.

168. Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Costs of Health Care Administration in the United States and Canada," *NEJM*, Vol. 349, No. 8 (August 21, 2003), pp. 768–775, at *http://content.nejm.org/cgi/content/full/349/8/768* (October 1, 2005; subscription required).

169. Henry J. Aaron, "The Costs of Health Care Administration in the United States and Canada—Questionable Answers to a Questionable Question," *NEJM*, Vol. 349, No. 8 (August 21, 2003), pp. 801–803, at *http://content.nejm.org/cgi/content/full/349/8/801* (October 1, 2005; subscription required).

170. Rosie Waterhouse, David Cracknell, "Fraud and Waste Cost NHS £7bn a Year," *The Sunday Times*, December 2, 2001.

171. Fair Investment Company, "Howard Slams Brown's 'Credit Card' Budget," March 17, 2004, at *www.fairinvestment.co.uk/news-Howard-slams-Brown's-'credit-card'-budget-2997113.html* (October 1,2005), and Minette Marrin, "Everywhere We Turn, Nanny Is There and Ready to Hit Us," *The Sunday Times*, January 4, 2004, p. 13.

172. "We Need More Managers Not Fewer, Claims Morgan," *Public Finance*, April 28, 2006, at *www.cipfa.org.uk/publicfinance/news_details.cfm?news_id=27443* (September 5, 2006).

173. Mark Litow, "Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs," Council for Affordable Health Insurance, March 1994, at *www.heartland.org/pdf/32923a.pdf* (October 1, 2005).

reduce paperwork and costly medical errors, but careful estimates put the savings at no more than about 3 percent.[174] In addition, the burden of government regulation of health care is often neglected. While providing tangible benefits, the net cost to U.S. citizens is $169.1 billion—greater than the entire budget deficit in 2002. This amounts to $1,546 for each household annually and is blamed for 7 million people lacking health insurance.[175]

As some advocates of national health insurance frankly acknowledge, funding a single-payer system in the United States would likely require large income tax and other progressive tax increases. These tax increases would incur additional administrative costs and introduce negative incentives that, in turn, would reduce tax receipts. Little evidence suggests that ordinary taxpayers will view their payroll taxes for national health insurance as a simple exchange for employer-paid health benefits, which is currently a form of untaxed compensation. In other words, they may view national health insurance funding as a tax rather than as a benefit, a net loss rather than a net gain. This will limit future attempts to increase national health insurance outlays by further tax increases.

Higher taxes have an economic impact. They reduce revenues because higher marginal tax rates lower the incentive for the relatively better off to work as taxes take a larger fraction of their additional income. Indeed, European nations are currently wrestling over how to finance their large state health care and pension programs. The demographic trends of low birth rates and an aging population mean that these countries can no longer finance welfare state programs simply through the traditional means of increasing taxes on current workers.[176]

Spending on British health care has doubled since 1997, but the high rate of increase in health spending in England will not be sustainable if annual GDP growth falls to 2 percent or if other priorities emerge. Increases thus far have been funded in part "by a reduction in the growth of social security spending and an actual reduction in defence spending."[177] Public spending now consumes 42 percent of GDP, and estimates are that Britain may have to raise taxes by up to £7 billion to meet existing spending plans. As a result, households will have to "pay twice for a tax financed increase in health spending—they will have to pay the tax itself and then pay the economic cost in lower incomes or reduced job opportunities."[178]

Canada's health care spending reached an estimated $142 billion in 2005, up from $123 billion in 2003 and $90 billion in 1999. In 1975, health care expenditures in Canada accounted for 7 percent of GDP. This percentage increased for most of the 1970s and the 1980s and reached 10 percent in 1992. From 1992 to 1996, the health care to GDP ratio fell to 9 percent, but after 2000, the share of GDP devoted to health care rose again, reaching 10.2 percent in 2004 and 10.4 percent in 2005. In 1992, health care spending accounted for about 34 percent of all provincial–territorial program expenditures. By 2002, this ratio reached 41 percent.

Worse, health care spending by the public sector in Canada has risen at a much faster rate than government revenue. "The way things are going," observed Quebec Premier Jean Charest, "there will be just one government department in 15 years, the department of health.... [T]he others will no longer exist." According to the Department of Finance, "Cost increases that continuously exceed the growth of government revenues will eventually require gov-

174. Henry J. Aaron, "A Healthcare Prescription That's Hard to Swallow," *Los Angeles Times*, January 30, 2006, at *www.latimes.com/news/opinion/commentary/la-oe-aaron30jan30,0,3097774.story* (September 5, 2006).

175. Christopher J. Conover, "Health Care Regulation: A $169 Billion Hidden Tax," Cato Institute *Policy Analysis* No. 527, October 4, 2004, at *www.cato.org/pubs/pas/pa527.pdf* (September 5, 2006).

176. Almut Schoenfeld, "Germany Rethinks Generous Perks for Civil Servants," *The Wall Street Journal*, April 5, 2004, p. A17.

177. Bosanquet, "The NHS in 2010."

178. Reform, *Bulletin*, February 21, 2002, at *www.reform.co.uk/website/pressroom/bulletinarchive.aspx?o=12* (August 25, 2006), and "Public Spending," at *www.reform.co.uk/website/economy/publicspending.aspx* (August 25, 2006).

ernments to resort to tax increases, a move that could undermine Canada's competitiveness."[179]

Expectation #10: Loss of personal liberty.

While securing health care services can sometimes be an urgent necessity, on most occasions it is wholly discretionary. In a single-payer system, a person may not exercise such discretion.

The effectiveness of medical interventions is varied. Personal freedom in health care means that patients can choose their treatments, what they will pay for them, and which doctors will provide them. Freedom carries an element of risk. When patients can spend their own money as they see fit, they can choose to spend a great deal on medical services, even on treatments unrelated to clinical need and often without proven benefits. Yet health care necessarily involves fundamental questions about personal freedom: Who gets to decide? How should they decide? Why should a government official be preferred over an individual patient in making these choices?

Authoritarian governance is intrinsic to government central planning, and national health insurance is impossible without government central planning. Given widely varying opinions over what the "right" amount of health care is (or even whether such a term is meaningful), it is difficult for a government official, or a group of government officials, to decide on the quantity and the standard of care to be provided to millions of different patients.[180] Under single-payer systems, however, persons are often frustrated in pursuing personal choice in purchasing or producing novel health care products and services, except where approved by the government.

This occurs because under a government health care monopoly, unelected health authorities make the decisions, and patients are not customers to be served, but "negative burdens and cost centers."[181] For example, in Canada, the government is unaccountable for the allocation of funds and for policy choices, such as closing hospitals and setting medical school enrollment. Canadian regional health boards are appointed, not elected, and lack direct accountability to the public. The British Columbia Medical Association states that appointments to regional health authorities are often "based on gender, ethnicity and regional concerns rather then expertise" and are accountable only to the Ministry of Health.[182] Only very recently in Canada, as the result of an historic Canadian Supreme Court decision, have patients been allowed spend their own money on privately provided medical services of their choice.[183]

To reduce health care spending, officials in a single-payer system would likely increase controls over what previously were personal health choices. Traditionally, promoting public health referred primarily to controlling or preventing communicable diseases. However, private behavior is no longer simply private behavior when taxes are paying everyone's health bills. Smoking, overeating, and using alcohol become quite arguably everybody's business. Under a single-payer system, government officials would arguably have a direct interest in one's personal vices, including choices of food and drink.

Further, the demand for compliance in "public health measures" might engender a relentless expansion of government rules, such as requiring weigh-ins for the overweight or universal blood tests for drugs and tobacco. Indeed virtually any personal activity could be viewed through the public health care lens, and government officials might decide to

179. Vancouver Board of Trade, "Reforming the Canadian Healthcare System," May 2006, at *www.boardoftrade.com/policy/Healthcare_FINAL15may06.pdf* (August 25, 2006), and Canadian Department of Finance, *Budget 2006: Focusing on Priorities*, Chapter 4, at *www.fin.gc.ca/budget06/fp/fpc4e.htm* (August 25, 2006).

180. Peter L. Berger, *The Capitalist Revolution: Fifty Propositions About Prosperity, Equality, and Liberty* (New York: Basic Books, 1986), p. 181.

181. Vancouver Board of Trade, "Reforming the Canadian Healthcare System."

182. British Columbia Medical Association, "Accountability in Health Care," *Policy Backgrounder*, December 2000, at *www.bcma.org/public/news_publications/publications/policy_backgrounders/AccountabilityInHealthcare.asp* (September 5, 2006).

183. Jacques Chaoulli, M.D., "A Victory for Freedom: The Canadian Supreme Court's Ruling on Private Health Care," Heritage Foundation *Lecture* No. 892, July 22, 2005, at *www.heritage.org/Research/HealthCare/hl892.cfm*.

forbid, favor, or penalize anything that could reasonably be seen as a matter of "public" health.

Moreover, factors that might affect health or access to health care can also come under government control. A "determinants of health perspective" means that health care provided by hospitals and clinics is only one of many factors that influence health. Health care needs that are unmet due to a lack of transportation are one example. However:

> Health is also influenced by a broad range of community-based services, supports and programs, and by relationships between and among people's personal health practices and coping skills, living and working conditions, and socio-economic, political, and physical environmental contexts.[184]

Senator Hillary Clinton (D–NY) expanded on this concept of "our collective health." Citing productivity losses, health expenses, and national security, she endorsed a national policy to take into account social and environmental factors in designing neighborhoods and schools, to "control dangerous behaviors," and to implement "required responsibility" for individual health concerns.[185]

In Britain, the annual cost to the NHS of diet-related diseases is estimated to be in excess of £15 billion. "Eventually, the UK will not be able to afford the health care made necessary by inappropriate lifestyles and diet."[186] Thus, the British are seriously entertaining a proposal for a "national nutrition strategy," including an independent agency with regulatory powers. Quite beyond simple nutrition education, such a national approach would also consider a "fat tax" or imposing legislation on the food industry to achieve the desired product development, marketing, and pricing goals.[187] This might include "using government purchasing power to expand the market for fresh healthy foods while counteracting the current subsidies supporting the ingredients in high fat/sugar/salt products" and placing restrictions on "the marketing of junk food to children."

In addition, television shows and Internet sites would be altered "to ensure the support of active, healthy lifestyles."[188] This might also entail compulsory consumption of a specified diet or, as suggested in the NHS, population-wide use of a "Polypill"[189] or even a "Polymeal"[190] to reduce the national rate of heart disease. Expansion of government control over "transport and rural development policies" was also recommended to increase the level of physical activity.[191]

184. Deanna L. Williamson and Miriam J. Stewart, "Low-Income Canadians' Experiences with Health-Related Services: Implications for Health Care Reform," *Health Policy*, Vol. 76, Issue 1 (March 2006), pp. 106–121.

185. Hillary Clinton, "Now Can We Talk About Health Care?" *New York Times Magazine*, April 18, 2004, at *www.nytimes.com/2004/04/18/magazine/18POLICY.html?ei=5007&en=04fab51c50c58daf&ex=1397620800&partner=USERLAND&pagewanted=all&position=* (October 1, 2005).

186. News release, "Why the UK Needs a National Nutrition Strategy," Institute of Food Research, September 8, 2003, p. 2, at *www.ifr.bbsrc.ac.uk/Media/NewsReleases/SPASFT.pdf* (October 1, 2005).

187. BBC News, "Government Unit 'Urges Fat Tax,'" February 19, 2004, at *http://news.bbc.co.uk/1/hi/health/3502053.stm* (October 1, 2005), and Sue Fairweather-Tait, "Healthy Diet, Healthy Body, Healthy Economy," *pH7 Magazine*, December 11, 2003, at *www.epolitix.com/EN/Publications/PH7/8_1/BA960509-1E9C-42ED-8BCD-FC01942031EB.htm* (February 28, 2005; unavailable January 20, 2006).

188. Press statement, "UK Parliamentary Inquiry into Obesity, International Association for the Study of Obesity," International Association for the Study of Obesity, January 29, 2004, at *www.iotf.org/media/iotfjan29.htm* (October 1, 2005).

189. N. J. Wald and M. R. Law, "A Strategy to Reduce Cardiovascular Disease by More Than 80%," *BMJ*, Vol. 326, No. 7404 (June 28, 2003), p. 1419, at *http://bmj.bmjjournals.com/cgi/content/full/326/7404/1419* (October 1, 2005).

190. Oscar H. Franco, Luc Bonneux, Chris de Laet, Anna Peeters, Ewout W. Steyerberg, and Johan P. Mackenbach, "The Polymeal: A More Natural, Safer, and Probably Tastier (Than the Polypill) Strategy to Reduce Cardiovascular Disease by More Than 75%," *BMJ*, Vol. 329, No. 7480 (December 18, 2004), pp. 1447–1450, at *http://bmj.bmjjournals.com/cgi/content/full/329/7480/1447* (October 1, 2005).

191. Press statement, "UK Parliamentary Inquiry into Obesity."

Indeed, a program of government surveillance of all children is being introduced in Britain: "a £224 million database tracking all 12 million children in England and Wales from birth." Doctors, schools, and the police will have to alert the database for a wide variety of concerns, including information on whether children are eating five portions of fruit and vegetables a day. If a child fails to meet state targets, this could start an investigation. The information gathered "would include subjective judgments such as 'Is the parent providing a positive role model?', as well as sensitive information such as a parent's mental health."[192]

The political demand for public regulation of private behavioral choices may be expanded to meet certain economic targets as well. In Britain and Canada, for example, options for health care such as renal dialysis are restricted by age.[193]

Traditional medical ethics are likely to be subordinated to political fashions. For example, euthanasia is often promoted by its champions as a last resort to alleviate suffering, but the Netherlands already has moved "from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia."[194] Such "termination without request or consent" has been applied to Dutch infants as well. The concern has been that public health system rationing may exert pressure not just to limit spending on certain individuals, but also, either subtly or overtly, to coerce them to be euthanized.[195]

Conclusion

Once again, prominent health policy experts are calling for the establishment of national health insurance through a single-payer health care system. In effect, these experts want the government to control the financing and delivery of health care services for the American people. They favor such an alternative because, among other things, they believe that government control of health policy and funding would result in a superior system of universal coverage, eliminate the selfish pursuit of profit that characterizes capitalist economic arrangements, and provide equality of access and care for all Americans.

Yet the striking feature of the command economy, as Alain Enthoven has observed, is "the contradiction between system and pretensions on the one hand, [and] performance on the other."[196] The single-payer approach has detrimental secondary effects far in excess of the primary beneficial effects alleged by its proponents.

192. Sarah Womack, "Family Life Faces State 'Invasion,'" *The Daily Telegraph*, June 26, 2006, at *www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/06/26/ndata26.xml* (August 25, 2006).

193. Shahid M. Chandna, Joerg Schulz, Christopher Lawrence, Roger N. Greenwood, and Ken Farrington, "Is There a Rationale for Rationing Chronic Dialysis? A Hospital Based Cohort Study of Factors Affecting Survival and Morbidity," *BMJ*, Vol. 318, No. 7178 (January 23, 1999), pp. 217–223, at *http://bmj.bmjjournals.com/cgi/reprint/318/7178/217.pdf* (September 7, 2006); Alzheimer's Disease International, "NICE Guidelines: Dementia Drugs to Be Denied to Those in the Mild and Severe Stages of the Disease," January 23, 2006, at *www.alz.co.uk/media/nr060123.html* (September 7, 2006); Reinhold P. Grün, Niculae Constantinovici, Charles Normand, and Donna L. Lamping, "Costs of Dialysis for Elderly People in the UK," *Nephrology Dialysis Transplantation*, Vol. 18, No. 10 (October 2003), pp. 2122–2127, at *http://ndt.oxfordjournals.org/cgi/reprint/18/10/2122.pdf* (September 7, 2006); and Murali Krishnan, Charmaine E. Lok, and Sarbjit V. Jassal, "Epidemiology and Demographic Aspects of Treated End-Stage Renal Disease in the Elderly," *Seminars in Dialysis*, Vol. 15, No. 2 (April 2002), pp. 79–83.

194. Herbert Hendin, "Suicide, Assisted Suicide and Euthanasia: Lessons from the Dutch Experience," in oversight hearing, Subcommittee on the Constitution, Committee on the Judiciary, U.S. House of Representatives, April 29, 1996.

195. Herbert Hendin, C. Rutenfrans, and Z. Zylicz, "Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons from the Dutch," *JAMA*, Vol. 277, No. 21 (June 4, 1997), pp. 1720–1722; Lonnie R. Bristow, "Physician-Assisted Suicide," statement before the Subcommittee on the Constitution, Committee on the Judiciary, U.S. House of Representatives, April 29, 1996, at *http://web.acc.qcc.cuny.edu/SocialSciences/ppecorino/MEDICAL_ETHICS_TEXT/Chapter_11_Termination_of_Life/Readings-Physician-Assisted-Suicide.htm* (June 26, 2006); and Agnes van der Heide, Paul van der Maas, Gerrit van der Wal, *et al.*, "Medical End-of-life Decisions Made for Neonates and Infants in the Netherlands," *Lancet*, July 26, 1997, pp. 251–255.

Policymakers should go beyond the promises of single-payer advocates and closely examine the performance of these systems. The empirical evidence generally shows that such a system would result in government rationing and waiting lines for care, reductions in the quality of care, chronic funding crises, slower adoption of and reduced access to advanced medical technology, labor strikes and personnel shortages, creation of new sources of inequality in access to care, expanded bureaucratic power, politicization of personal health care decisions, and a loss of personal freedom.

Professor Michael Porter of the Harvard Business School and Professor Elizabeth Teisberg of the University of Virginia argue that "a single-payer system would create serious, and in our view fatal problems for health care value." Because of skewed incentives and irresistible budget pressures, a single payer would inevitably ration services, compromise patient care, limit patient rights, retard improvement and innovation, and shift costs to providers, suppliers, and patients. They add:

> It simply strains credulity to imagine that a large government entity would streamline administration, simplify prices, set prices according to true costs, help patients make choices based on excellence and value, establish value-based competition at the provider level, and make politically neutral and tough choices to deny patients and reimbursement to substandard providers.[197]

Given the persistent call for a nationalized health care system despite the evidence, economist Charles Schultze once observed that this demand appears to be "more for the purpose of gaining social control over the health care system than of providing better financial insurance."[198]

There is an abundance of practical alternatives to a single-payer system. Policymakers could adopt new policies that would dramatically expand coverage, promote innovation and economic efficiency, and eliminate existing market distortions in the health care system. There are comprehensive policy initiatives that would accomplish these objectives. Real market competition would allow more efficient and productive providers to thrive, while less productive providers would either become more efficient or go out of business.

Americans would benefit significantly from this liberalization as medical goods and services improved and prices stabilized or even declined. Where the market fails to reach the uninsured, direct government help can fill the gaps. Only reliance on the market can create enough wealth to fund care for the poor and uninsured properly. Meanwhile, the American people should not be asked to repeat the unavoidable lessons of socialism.

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196. David S. Landes, *The Wealth and Poverty of Nations: Why Some Are So Rich and Some Are So Poor* (New York: W. W. Norton & Co., 1998), pp. 495–498.

197. Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006), pp. 88–90.

198. Charles L. Schultze, *The Public Use of Private Interest* (Washington, D.C.: The Brookings Institution, 1977), pp. 11–108.