Beware of National Health Insurance

By John Goodman

As the United States wrestles with the problems of its own health care system, it is tempting to look toward the systems of other countries for solutions. In general, countries with national health insurance spend less on health care than the U.S. does. The mistake made by those who are unfamiliar with the health care systems of other countries is the assumption that the U.S. can control health care costs through national health insurance without any loss of health care benefits.

Bias Against Modern Technology

When governments take control of a nation's health care resources, they exhibit a strong and persistent bias against modern medical technology. For example, consider the availability of modern medical technology in the U.S. and Canada on a per-capita basis. There are eight times more MRI units (latest replacement for X-rays), seven times more radiation therapy units (used in the treatment of cancer), and about six more times lithotripsy units (used for nonsurgical removal of kidney stones) in the United States as there are in Canada. The U.S. also has about three times more open-heart surgery units and cardiac catheterization units (used to prevent heart attacks) per capita as Canada has.

It is sometimes argued that countries with national health insurance delay the purchase of expensive technology in order to see if the technology really works or to see if it is cost effective. If this observation is accurate, the downside of that approach is that patients are denied access to life-saving treatment while government bureaucracies wait to evaluate it. For example, during the 1970s life saving innovations were made in the fields of renal dialysis, CAT scan technology, and pacemaker technology. Yet implants of cardiac pacemakers in the U.S during the mid-1970s were more than four times the implant rate in Britain, and almost twenty times the rate in Canada. The availability of CAT scanners in the U.S. was more than three times the availability in Canada and almost six times the availability in Britain. Treatment rates for kidney patients in the U.S. were more than sixty percent greater than those in Canada and Britain.

Denying Treatment. Despite the official rhetoric of foreign governments, there is considerable evidence that cost effectiveness is not what causes their bias against modern medical technology. CAT scan technology was invented in Britain, and until recently Britain exported about half the CAT scanners used in the world – probably with government subsidies. Yet the British government has purchased only a handful of CAT scanners for use in its National Health Service (NHS), and has even gone so far as to discourage gifts of CAT scanners to the NHS by wealthy donors. Britain was also the co-developer of kidney

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dialysis, a lifesaving method of treating patients with chronic renal failure. Yet Britain has one of the lowest dialysis rates in all of Europe. As many as 9,000 British kidney patients per year are denied the treatment.

Rationing by Waiting

One of the cruelest aspects of government-run health care systems in other countries is the degree to which these systems engage in non-price rationing of health care services. The hospital does not give out tickets or numbers; it just places the people it is reluctant to serve on a waiting list. Take the health care systems of Britain and New Zealand, for example. In both countries hospital services are completely paid for by government. Yet both countries also have long waiting lists for hospital surgery. In Britain, with a population of about 55 million, the number of people waiting for surgery is almost 800,000. In New Zealand, with a population of three million, the waiting list is currently about 50,000. In both countries the adverse effect on patients is about the same. Elderly patients in need of a hip replacement may wait in pain and discomfort for years. Patients waiting for heart surgery are often risking their lives.

Canada is a country that has had a national health care program for only a few decades. But because the demand for health care has proved insatiable, and because the Canadian government has resolutely refused to increase spending beyond a level of about 8.5 percent of the GNP, the waiting lines for surgery have been growing.

In the province of Newfoundland the wait for a hip replacement is about six to ten months, the wait for cataract surgery is about two months, for pap smears up to five months, for "urgent" pap smears two months, and for CAT scans two months. All over Canada heart patients wait for coronary bypass surgery, and the Canadian press is frequently reporting episodes of heart patients dying while on the waiting list.

Inefficiency

How much does it cost a hospital to perform an appendectomy? Outside the U.S. it is doubtful there is a public hospital anywhere in the world that could answer that question. Nor do hospitals in other countries typically keep records that would allow anyone else to answer it. One of the reasons for Margaret Thatcher's health care reforms was that even Britain's best hospitals did not keep computer records, and it was not uncommon for the head of a hospital department to be unaware of how many people the department employed. When it comes to organizational skills and managerial efficiency, the public hospitals of other countries cannot begin to match hospitals run by Hospital Corporation of America, Humana, or American Medical International.

What about bed management? Consider that while 50,000 people wait for surgery in New Zealand, at any point in time one out of every five hospital beds is empty. While nearly 800,000 people wait for surgery in Britain, at any point in time one out of every four hospital beds is empty. Moreover, in both Britain and New Zealand about 25 percent of all acute beds desperately needed for surgery are clogged by chronically-ill patients who are using the hospitals as expensive nursing homes – often at six times the cost of alternative facilities. In Ontario about 25 percent of hospital beds are occupied by elderly chronically-

ill patients. One explanation is that hospital administrators apparently believe that chronic patients are less expensive than acute patients (because they are mainly using only the "hotel" services of the hospital), and thus they are less of a drain on limited hospital budgets.

Unequal Access to Health Care

One of the most surprising features of the health care systems of European countries is the enormous amount of verbal attention that is given to the notion of equality and the importance of achieving it. Such rhetoric rarely has any relation to the facts. Britain is a country whose ministers of health for over three decades have been assuring the British people that they have been leaving no stone unturned in a relentless quest to root out and eliminate inequalities in health care. But, after an unofficial government campaign to suppress it, an official task force report concluded that there was little evidence of more equal access to health care in Britain in 1980 than there had been when the NHS was started in 1948. Virtually every scholarly study of the issue has pointed to a similar conclusion. Other studies have documented widespread inequalities in health care in Canada, New Zealand, Sweden, and elsewhere.

In general, low-income people in almost every country see physicians less often, spend less time with physicians when they see them, enter the hospital less often, and spend less time in the hospital. This is especially true when the use of medical facilities is weighted by the incidence of illness. Widespread inequalities in access to health care exist within metropolitan areas and across geographical boundaries. For example, people in rural, less-wealthy regions of Britain have less access to physicians and hospitals on a per-capita basis than people living in more densely populated and more wealthy areas.

There is substantial evidence that when health care is rationed, it is the poor who are pushed to the rear of the waiting line. The same is frequently true also of the elderly.

Discrimination Against the Elderly

If the experience of other countries is any guide, the elderly have the most to lose from the adoption of a program of national health insurance. In general, when lifesaving care is rationed to both young and old, the young are more likely to get preferential treatment. Take chronic kidney failure, for example. Across Europe generally, 22 percent of the dialysis centers reported that they refused to treat patients over 55 years of age in the late 1970s. In Britain, in 1978, 35 percent of the dialysis centers refused to treat patients over the age of 55; 45 percent refused to treat patients over the age of 65; and British patients over the age of 75 rarely received treatment at all for this disease.

How serious is the problem of the denial of lifesaving medical technology to elderly patients in other countries? Lacking hard data, one can only speculate. In general, health economists are reluctant to take population mortality rates as an indicator of the quality of health care patients are receiving. This hesitance is because whether a person lives or dies in any given year is far more likely to be determined by that person's life-style and environment than by anything that hospitals or doctors are likely to do.

Despite these caveats, international statistics on population mortality rates are consistent with the proposition that the elderly in other countries have less access to lifesaving medical care than the elderly in the U.S. For instance, a white, 65-year-old male in the U.S. can expect to live 1.3 years longer than a 65-year-old British male. A white 65-year-old female in the U.S can expect to live 1.4 years longer than a 65-year-old British female. In comparison with European countries, U.S. mortality rates are higher for middle-aged males. During the retirement years, however, when medical intervention may make much more of a difference, life expectancy is completely reversed: The U.S. mortality rate for elderly males is significantly below that of most European countries.

Misallocation of Health Care Resources

Countries with national health insurance do not merely deny lifesaving medical technology to patients under national insurance schemes, but they also take millions of dollars that could be spent to save lives and cure diseases and spend this money to provide a vast array of services to people who are not seriously ill. Often these are services which have little, if anything, to do with health care.

Britain, once again, serves as a classic case of this tendency. Throughout the National Health Service (NHS), there is a systematic and pervasive tendency to divert funds away from expensive care for the small number of people who are seriously ill toward the large number of people who seek relatively inexpensive services for a variety of minor ills. Take the British ambulance service, for example. English "patients" take more than 21 million ambulance rides each year – about one ride for every two people in all of England. About 91 percent of these rides are for nonemergency purposes (such as taking an elderly person to a local pharmacy) and amount to what an official task force report described as little more than a "free taxi service." Yet for genuine emergencies the typical British ambulance has little of the modern, lifesaving equipment considered standard in most large American cities.

While as many as 9,000 people die each year for lack of treatment for kidney failure, the NHS provides a wide array of comforts for a large number of chronically-ill people whose kidneys are in good working order. Each year, about 3.8 million people in England are treated in their homes by "health visitors"; more than 1.1 million are treated in their homes by chiropodists; and "meals on wheels" serves almost 29 million meals in people's homes. Social workers attending to the needs of the elderly and handicapped help with the installation of more than 17,000 telephone and telephone attachments, help arrange more than 93,000 telephone rentals, help more than 49,000 people with home alterations, assist in arrangements for 63,000 vacations, and help an additional 346,000 people with other personal appliances and aids.

"Caring" vs. "Curing." While tens of thousands of people who are classified by their physicians as being in "urgent need" of surgery wait for hospital beds, the NHS is spending millions on items that have only marginal effects on health. On the average, the NHS spends more than $70 million each year on tranquilizers, sedatives, and sleeping pills; almost $19 million on antacids; and about $21 million on cough medicine. About 9.7 million people receive "free" eyesight tests every year, and of these about 4.5 million receive free or subsidized eyeglasses.

If the NHS did nothing more than charge patients the full costs of sleeping pills and tranquilizers they consume, enough money would be freed to treat 10,000 to 15,000 additional cancer patients each year and save the lives of an additional 3,000 kidney patients. Yet options such as these are not even seriously considered by the British National Health Service. A telephone-sized book would be needed for a full description of the many ways in which "caring" services take priority over "curing" services with the British National Health Service. Suffice it to say that the tendency is endemic and pervades every aspect of British medicine.

The Politics of Medicine

The characteristics of national health insurance described above are not accidental byproducts of government-run health care systems. Instead, they are the natural and inevitable consequences of politicizing medical practice.

Why are low-income and elderly patients so frequently discriminated against in the rationing of acute care under national health insurance? Because national health insurance is at all times and in all places a middle-class phenomenon. Prior to the introduction of national health insurance, every country had some government-funded program to meet the health-care needs of the poor. The middle-class working population not only had to pay for its own health care, but also to pay taxes to fund health care for the poor. National health insurance extends the "free ride" to those who pay taxes to support it. Such systems are created in response to the political demands of the middle-class working population, and they are designed to serve the interests of this population.

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

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

In conclusion, the reason why national health insurance "works" in other countries, and the reason why it remains popular, is precisely because it does not function the way that advocates of national health insurance believe it should function. National health insurance works in other countries for three reasons: 1) the wealthy, the powerful, the most sophisticated, and those who are most skilled at articulating their complaints find ways to maneuver to the front of the rationing lines; 2) those pushed to the end of the rationing lines are

generally unaware of medical technologies they are being denied; 3) there are no contingency fees, no generally recognized right of due process, and no cadre of lawyers willing to represent those who are systematically discriminated against.

Pushed Around. National health insurance "works" in other countries because those who have the ability to change the system are the ones who are best served by it. If a member of the British Parliament, the CEO of a large British company, or the head of a major British trade union had no greater opportunity to obtain renal dialysis than any other British citizen, the British National Health Care Service would not survive for a week.

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