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Nationalized Health Care: Cure Worse than the Disease

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"One of the great mistakes is to judge policies and programs by their intentions rather than their results."
–Milton Friedman

Introduction

Despite Americans' overall satisfaction with their current health care situations,[1] almost everyone agrees that the health care system itself is economically unsustainable.[2]

The ongoing and very public debate over health care centers on the question of how to decrease the number of uninsured Americans and lower costs while still maintaining an adequate level of care.

One common factor appears in every health care proposal gaining traction in Congress—more government control.

Nationalized health care systems exist all over the world, notably in Canada and the United Kingdom (UK). Various American policymakers want to emulate these systems to one degree or another. But does shifting to government-run health care really make sense? Those who believe so point to universality of insurance coverage as the reason for government-run superiority. Essentially, they assume health insurance coverage translates into better health care. Does it, in fact? This paper will examine nationalized health care systems to determine whether universal coverage *actually* translates into better health care outcomes for participants in such a system.

On the Road to Health Care Rationing

The economic stimulus bill enacted by Congress last winter provided $1.1 billion to create a national health care board designed to oversee the "effectiveness" of health services. This board was modeled on the UK's National Institute for Health and Clinical Excellence (NICE).*[3] The name of the American equivalent is the Federal Coordinating Council for Comparative Effectiveness Research (FCCCER), and its primary mission, as its name suggests, is to perform comparative effectiveness research.[4]

Comparative effectiveness research focuses on identifying the most effective and economical treatment options so doctors can have the most comprehensive data available to them when making medical decisions with their patients.

In theory, comparative effectiveness research could be valuable, but in practice it only lays the groundwork for extensive health care rationing. Experience shows rationing to be one of the few options available for lowering costs under government-run health care.[5]

Once fully in effect, the FCCCER will give a committee of appointed policymakers in Washington the power to decide what treatments are, and are not, acceptable, forcing physicians to comply with its decisions without taking into consideration the patient's ability to pay.

In the UK, NICE has come up with a mathematical formula to assist in rationing called a "Quality Adjusted Life Year" or QALY, which is "used to calculate the value of a patient's life" and to "determine if a medical intervention is a 'reasonable value for money.'"[6]

* The National Institute for Health and Clinical Excellence (NICE) is a branch of the National Health Service (NHS) in England and Wales. NICE publishes clinical appraisals of whether particular treatments should be considered worthwhile by the NHS. These appraisals are based primarily on evaluations of efficacy and cost-effectiveness in various circumstances.

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The World Health Organization, which typically favors universal health care systems, has estimated that "25,000 British cancer patients die prematurely every year because of restrictions" on various medical treatments.

Once these calculations are made, "if one intervention appears to be more effective than another, the government will have to decide whether the increase in cost associated with the increase in effectiveness represents reasonable 'value for money.'"[7] Most studies performed have concluded that an additional QALY is worth about 50,000 dollars.[8]

Even though rationing provides short-term savings, patients receive a lower quality of care, which means higher health care costs in years to come. Not only does rationing increase costs over the long term, it also has medical consequences.

Government-Run Health Care has Medical Consequences

Cancer Survival

In the United States, anyone who needs cancer treatment has access, for a price, to medically successful options. Because Americans have this opportunity, one could argue this is one reason our country's cancer survival rates are higher than in countries where health care is rationed.

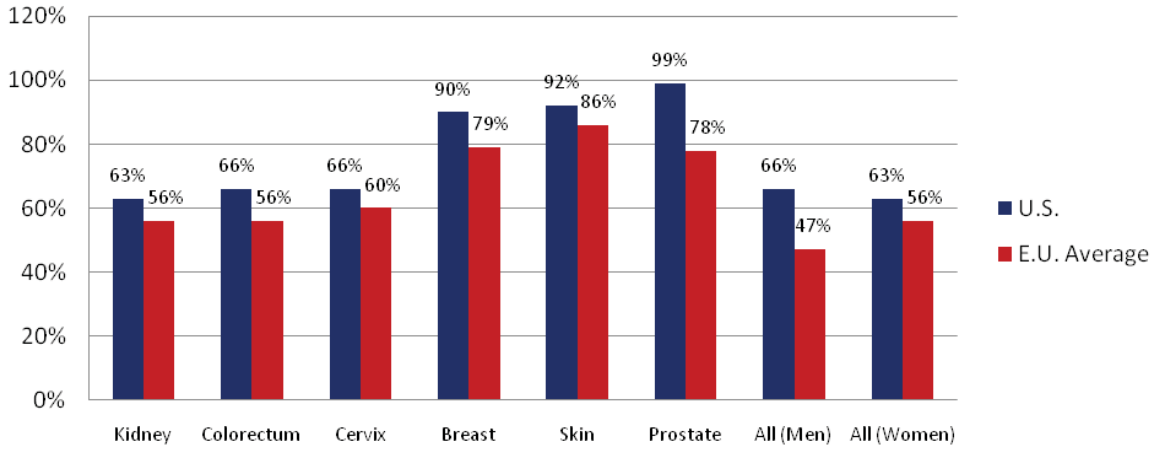
UK patients do not have access to as many effective cancer treatments. In fact, "61 percent of cancer treatments (27 of the 44 appraised) have been denied by UK's NICE" on the basis that they were not economically feasible despite their medical success.[9] The World Health Organization, which typically favors universal health care systems, has estimated that "25,000 British cancer patients die prematurely every year because of restrictions" on various medical treatments.[10]

Figure 1 shows that five-year cancer survival rates are significantly higher in the United States than in the European Union (EU). U.S. patients are not prevented by their government from seeking any type of cancer treatment regardless of whether it costs more than other options. EU patients are not afforded the same choice.

Overall cancer survival rates are also much higher in the United States than in the United Kingdom. Figure 2 shows that a woman with breast cancer in the United States is 21 percent more likely to survive her disease. Similarly, a man in the U.S. is 38 percent more likely to survive prostate cancer than his UK counterpart.

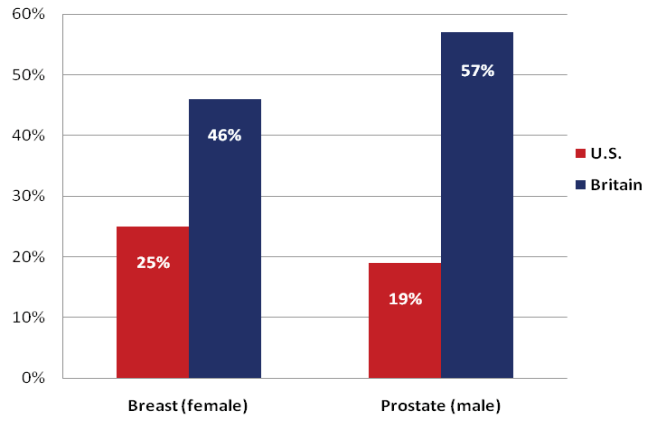
Some NICE regulations have come under legal scrutiny. Several young women in the United Kingdom who had

Figure 1: Five-Year Cancer Survival Rates



Source: Arduino Verdecchi et al., "Recent Cancer Survival in Europe: A 2000-02 Period Analysis of EUROCARE-4," Lancet Oncology 8 (Sept. 2007) 784-96.

Figure 2: Cancer Mortality Rates



Source: James Bartholomew, "Die in Britain, Survive in the U.S.," The Spectator, 2005.

been denied pap smears, sued their government upon discovering they had developed cervical cancer. This lawsuit arose due to the NICE policy that refuses to screen women under the age of 25 due to cost concerns and the need to reduce government health care spending.[11]

The United Kingdom is not the only nation with such problems. In Canada, 10,000 breast cancer patients have "filed a class action lawsuit against Quebec's hospitals because, on average, they were forced to wait 60 days to begin post-operative radiation treatments."[12]

Canada's Supreme Court has recognized that rationing has caused major problems for patients. The majority opinion in the 2005 case, *Chaoulli v. Quebec*, stated that "The evidence in this case shows that delays in the public health care system are widespread, and that, in some serious cases, *patients die* as a result of waiting lists for public health care." The court concluded that "the prohibition on obtaining private health insurance is *not constitutional* where the public system fails to deliver reasonable services [emphasis added]."[13]

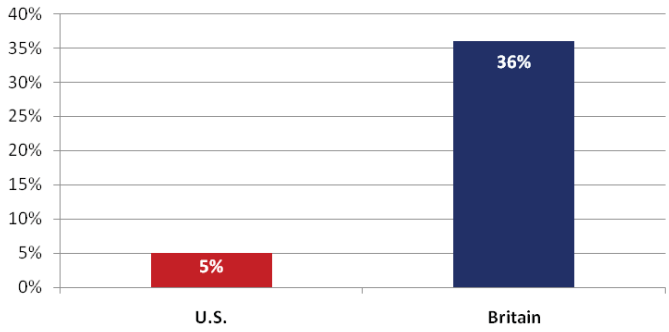
Overall cancer survival rates are much higher in the United States than in the United Kingdom. A woman with breast cancer in the United States is 21 percent more likely to survive her disease. A man in the U.S. is 38 percent more likely to survive prostate cancer than his UK counterpart.

Long Waits and Physician Shortages

Another drawback experienced by nations with government-run health care is excessive wait times, both to see a doctor and to receive treatment. A patient who has endured a long wait just to see a doctor may encounter a much longer wait for any surgery the doctor prescribes. Among Canadians who experienced problems accessing a specialist consultation, "68 percent indicated that waiting was the problem, followed by 32 percent who indicated that they had difficulties getting an appointment."[14]

As Figure 3 indicates, just 5 percent of Americans wait more than four months for surgery, compared to 36 percent in Britain.

Figure 3: Percentage of Patients Waiting More Than Four Months for Surgery



Source: James Bartholomew, "Die in Britain, Survive in the U.S.," The Spectator, 2005. Note: Figure includes non-emergency surgeries only.

As if delayed treatment were not a large enough problem, 1.5 million Canadians either do not have or cannot find a general practitioner or primary care physician because of medical personnel shortages.[15] In fact, a recent American news special videotaped a "physician lottery" in the town of Norwood, Ontario. The winners were awarded the services of a primary care physician. The losers had to continue waiting to see a doctor.[16]

Wait times in Canada have become so insufferable that many sick Canadians come to America for surgery. Canadian Shirley Healy was told by her doctor in British Columbia that she had only weeks to live because a blocked artery kept her from digesting food. Astonishingly, her surgery was considered "elective." Instead of waiting for death, Ms. Healy traveled to

Just 5 percent of Americans wait more than four months for surgery, compared to 36 percent in Britain. And, on average, Canadians wait 90 days for an MRI machine to become available.

America for surgery and survived. "The only thing elective about this surgery was I elected to live," she said.[17]

Worse than mere inconvenience is that excessive wait times affect survival rates for various medical conditions, including cancer and heart disease. Frequently, these illnesses progress rapidly and become life-threatening when left untreated.

Outdated, Inadequate Medical Equipment

Insufficient access to the best medical equipment afflicts patients in countries with government-run health care systems. Figures 4 and 5 show that the United States has 25 percent more CT scanners per million people than Britain and almost 21 percent more MRI scanners. Also, the United States has more than seven times as many lithotripsy units (used for treating kidney stones) per million of population than does Britain.[18]

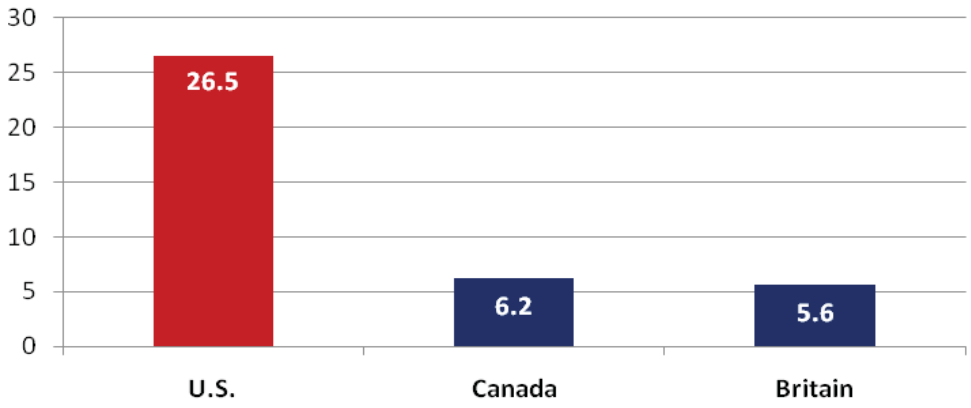
Canadian patients are similarly afflicted. On average, Canadians wait 90 days for an MRI machine to become available.[19]

In Britain, not only is the medical equipment in short supply, but a significant amount of this equipment is either outdated or unsafe. An audit by the World Health Organization discovered that "over half of Britain's x-ray machines were past their recommended safe time limit, and more than half the machines in anesthesiology required replacing." The report also showed that "the majority of operating tables were over 20 years old—double their life span."[20]

It seems countries with government-run health care systems do not supply their health care providers with either an adequate amount or an acceptable quality of medical

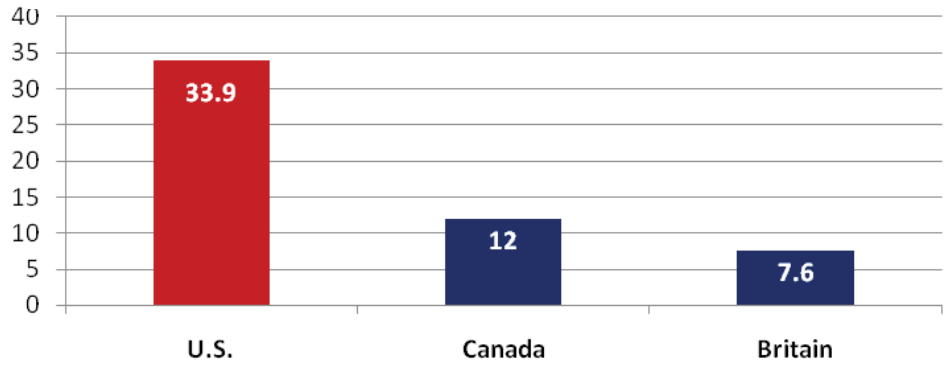
An audit by the World Health Organization discovered that "over half of Britain's x-ray machines were past their recommended safe time limit, and more than half the machines in anesthesiology required replacing."

Figure 4: MRI Machines (per million people)



Source: Organization for Economic Cooperation and Development.

Figure 5: CT Scanners (per million people)



Source: Organization for Economic Cooperation and Development.

equipment in an effort to curb excessive costs. Outdated and insufficient quantities of medical equipment can have an impact on health care outcomes, as unsafe equipment can lead to injuries and wait times inevitably cause some medical problems to progress without treatment.

Conclusion

Evidence demonstrates that countries with nationalized health care engage in medical rationing and have poor medical outcomes compared to the United States, long wait times both to see a doctor and to receive treatment, physician shortages, and outdated and inadequate medical equipment.

Government-controlled health care is neither the only, nor the best, solution to our present health care system insufficiencies. Rather, patient-centered reforms are the key to avoiding the inferior medical outcomes seen in countries with government-run health care. Policymakers must learn from others' mistakes and not repeat history. Government-run health care has been tried before and has only led to poorer quality of care, decreased access to treatment, and increased costs. ✯

Endnotes

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[3] Conservatives for Patients' Rights, "Is Congress Importing Health Care Rationing from Britain? A national health board is a first step to picking winners and losers among patients, saving money instead of lives" (Summer 2009).

[4] United States Health and Human Services website, (Aug. 2009) http://www.hhs.gov/recovery/programs/os/cerbios.html.

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[6] Ibid.

[7] National Institute for Health and Clinical Excellence, "The Guidelines Manual" (Jan. 2009) http://www.nice.org.uk/aboutnice/howwework/developingniceclinicalguidelines/clinicalguidelinedevelopmentmethods/GuidelinesManual2009.jsp.

[8] Peter Pitts, "Denying Care: How Comparative Effectiveness Research Really Works," *The Insider* (Spring 2009).

[9] Conservatives for Patients' Rights, "Facts about the Canadian and United Kingdom Health Care Systems," (Summer 2009).

[10] John C. Goodman, "How Will They Ration Health Care?," National Center for Policy Analysis (July 2009) http://www.ncpa.org/sub/dpd/index.php?Article_ID=18235.

[11] "Of NICE and Men," *The Wall Street Journal,* http://online.wsj.com/article/SB124692973435303415.html (July 2009).

[12] "Statist Health Care, by the Numbers" (July 2009) http://www.liberty-page.com/issues/healthcare/socialized.html#britain.

[13] Clifford Kraus, "Canada's Supreme Court Chips Away and National Health Care," *The New York Times* (June 2005) http://www.nytimes.com/2005/06/09/international/americas/09cnd-canada.html.

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[15] Ibid.

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[18] James Bartholomew, "Die in Britain, Survive in U.S.," *The Spectator* (Feb. 2005).

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[20] James Bartholomew, "Die in Britain, Survive in U.S.," *The Spectator* (Feb. 2005).

About the Author

Elizabeth Young joined the Texas Public Policy Foundation in March 2009 as a Higher Education Policy Analyst for the Foundation's Center for Higher Education and in June 2009 added health care policy to her portfolio. Her research focuses on consumer driven solutions for health care policy reform and higher education costs, affordability, value, and transparency.

Prior to joining the Foundation, Elizabeth worked as a Legislative Assistant for State Representative Phil King. During that time she analyzed Texas legislation and policy in areas such as abortion, property taxes, energy, education, and welfare.

Elizabeth graduated *magna cum laude* with a B.A. in Government from the University of Texas at Austin. Currently residing in Austin, she grew up in Kingwood, Texas.

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