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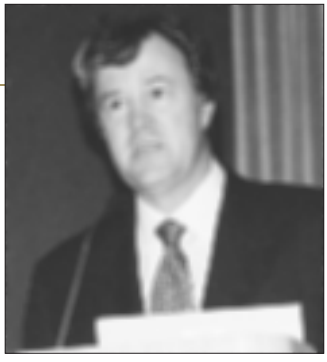
Five Myths of Socialized Medicine

John Goodman

In the United States there are about 14 million people—more than a third of the uninsured—who are, in principle, eligible to get free medical care by joining either the Medicaid program or the State Children's Health Insurance Program. And yet they don't bother to enroll.

To understand why they don't, you might go to the emergency room of Parkland Hospital in my hometown of Dallas. The uninsured and Medicaid patients come there to get their medical care. They all see the same doctors. They get the same treatment. If they're admitted to the hospital, they stay in the same beds. From the patient's point of view, there is no real reason to join Medicaid, because they get the same care whether or not they are formally insured. The doctors and nurses get paid the same regardless of who is enrolled in what plan.

The only people who really care whether or not someone is enrolled in Medicaid are the hospital administrators, because that determines how they get their money. So they actually have paid employees who go through the emergency room and try to get people to sign up for Medicaid. Over half the time they



***John Goodman is the founder and president of the National Center for Policy Analysis in Dallas. This is an excerpt from his remarks at a September 29 Cato Policy Forum, based on his new book,* Lives at Risk: Single-Payer National Health Insurance around the World.**

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fail. Then they literally go hospital room by hospital room, trying to get admitted patients to enroll in Medicaid. And even then they don't always succeed.

Now, it's not that unusual for people to go to hospital emergency rooms for their care. It's a common feature of health systems around the world. It may not be an efficient way to deliver health care, but the same thing happens in Toronto and London.

Canadians take pride in the fact that patients who get free care in Toronto emergency rooms are "insured." But in Dallas, we're ashamed to say that our patients are "uninsured," even though the care they receive in Dallas is probably better than the care they get in Toronto.

Myth: "A Right to Health Care"

People who believe in socialized medicine have come to believe many myths. One is that socialized medicine gives you a right to health care. If you ask the head of Parkland Hospital and his counterpart in Toronto or London what the difference is in these systems, I think all three would say that in Toronto and London people have a "right" to health care, whereas in Dallas they do not. That is just not true.

If you're a citizen of Canada, you don't really have a right to any particular health care service. You don't have a right to heart surgery. You don't even have a right to a place in the waiting line.

If you're the hundredth person waiting for heart surgery, you're not entitled to the hundredth surgery. Other people can and do get in ahead of you. From time to time, even Americans go to Canada and jump the queue, because Americans can do something that Canadians cannot—Americans can pay for care. Canadian hospitals love to admit American patients, because that means cash into their budgets.

The British government says that, at any one time, there are about a million people waiting to get into hospitals. According to the Fraser Institute, almost 900,000 Canadian patients are on the waiting list at any point in time. And, according to the New Zealand government, 90,000 people are on the waiting lists there.

Those people constitute only about 1 to 2 percent of the population in those countries, but keep in mind that only about 15 percent of the population actually enters a hospital each year. Many of the people waiting are waiting in pain. Many are risking their lives by waiting. And there is no market mechanism in these countries to get care first to people who need it first.

Myth: "Higher Quality"

Another myth has to do with the quality of care that patients receive. British ministers of health have told British citizens for years that their health system is the envy of

the world. Canadian ministers of health say much the same thing. In fact, Canadian and British doctors see 50 percent more patients than American doctors do, and, as a consequence, they have less time to spend with each patient. In Britain, the typical general practitioner barely has time to take your temperature and write a prescription. And even if they discover something wrong with you, they may not have the technology to solve your problem.

Among people with chronic renal failure, only half as many Canadians as Americans get dialysis, and only a third as many Britons on a per capita basis. The American rate of coronary bypass surgeries is three or four times what it is in Canada, and five times what it is in Britain.

Britain is the country that invented the CAT scanner, back in the 1970s. For a while it exported more than half the CAT scanners used in the world. Yet they bought very few for their own citizens. Today, Britain has half the number of CAT scanners per capita as we do in the United States. A similar problem exists in Canada.

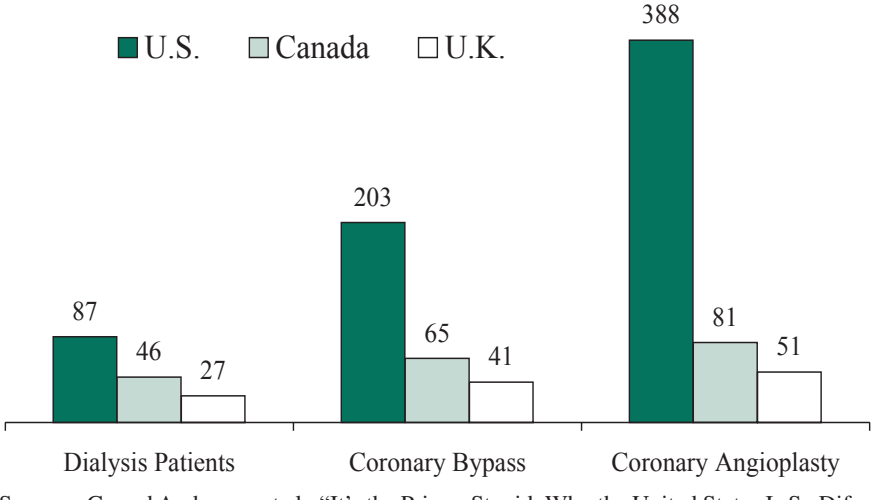
Myth: "More Bang for the Buck"

Yet another myth is that although the United States spends more on health care, we don't get more. That argument is often supported by pointing to life expectancy, which is not that much different among developed countries, and infant mortality, which is actually higher in the United States than it is in most other developed countries.

What do we get for our money? The first thing we need to do is separate those phenomena that have little to do with health care from those that do. In the United States, life expectancy at birth for African American men is 68 years, while for Asian American men it's 81 years. We find wide differences in life expectancy among women, too. Nobody thinks that those differences are due to the health care system.

What, then, would we want to look at if we really wanted to compare the efficacy of health care systems? We would look at those conditions for which we know medical services can make a real difference. Among women who are diagnosed with

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



Sources: Gerard Anderson, et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 21, no. 3 (May/June 2002): Exhibit 5.

breast cancer, only one fifth die in the United States, compared to one third in France and Germany, and almost half in the United Kingdom and New Zealand. Among men who are diagnosed with prostate cancer, fewer than one fifth die in the United States, compared to one fourth in Canada, almost half in France, and more than half in the United Kingdom.

Myth: "Equal Access"

Perhaps no notion is more closely tied to national health insurance than the idea of equal access to health care. Every prime minister of health in Britain, from the day the National Health Service started, has said that is the primary goal of the NHS. Similar things are said in Canada and in other countries.

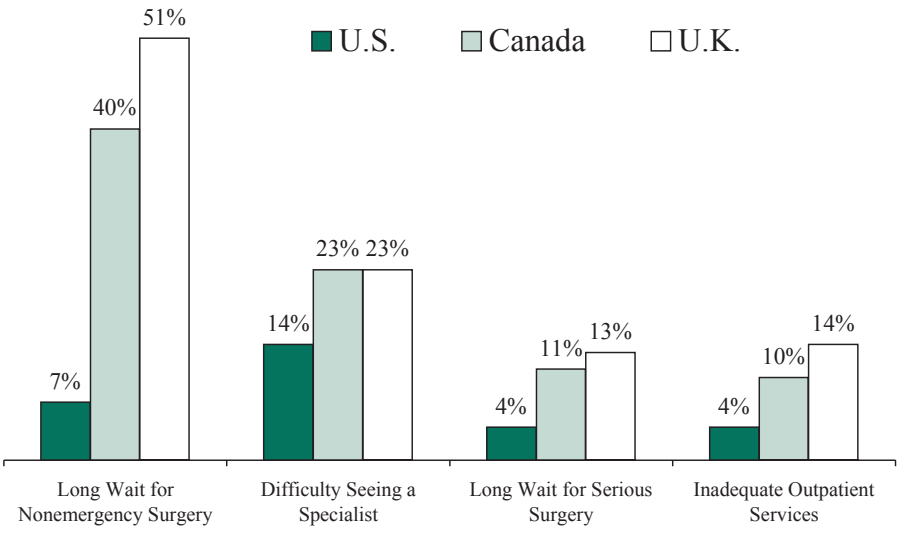
The British government—unlike most other governments—studies the problem from time to time to see what kind of progress they're making. In 1980, they had a major report that said, essentially: "We really haven't made very much progress in achieving equality of access to health care in our country. In fact, it looks like things are worse today, in 1980, than they were 30 years ago when the British National Health Service was started."

Everybody deplored the results of that report, and they all promised to do better. There were a lot of articles written, a lot of conferences, and a lot of discussions. Another 10 years passed and they pondered another report, which said that things had deteriorated further. Today we are long overdue for a third report, but no one expects the situation to have improved.

It's true that racial and ethnic minorities are underserved in the United States. But we are hardly alone. In Canada, the indigenous groups are the Cree and the Inuits. In New Zealand, they are Maoris. In Australia, the Aborigines. Those populations have more health care problems, shorter life expectancies, higher infant mortality, more health care needs, and they get less health care. When health care is rationed, racial and ethnic minorities do not usually do well in the rationing scheme.

A Canadian study showed vast inequalities among the health regions of British Columbia. In some cases, there were spending differences of 10 to 1 in services provided in one area compared to another. That probably would not surprise most health policy analysts; you just don't usually get this kind of data. But if we had the data, we would probably find similar inequalities in access to health care all over the developed world.

I'm especially interested in the elderly, because I find that—not only in Britain and Canada, but also in the United States—when people have to make decisions about who is going to get care and who is not, they frequently choose the younger patient. Surveys of the elderly



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

show that senior citizens in the United States say it's much easier to get surgery, see doctors, see specialists, and enter hospitals, than say seniors in other countries.

Myth: "Less Red Tape"

Then we have the myth that national health insurance is an efficient way to deliver health care. I hear this frequently repeated by advocates in the United States. Probably the most telling statistic for hospitals is average length of stay. In general, efficient hospitals get people in and out more quickly. By that standard, the U.S. hospital sector is the most efficient in the world. And I think by many other standards it would not be much in dispute that the U.S. hospital sector is far more efficient than the hospital sectors of other countries.

In Britain, where at any one time there are a million people waiting to get into British hospitals, 15 percent of the beds are empty, and another 15 percent are filled with chronic patients who really don't need the services of hospital; they're simply using the hospital as an expensive nursing home. So, effectively, almost one-third of the beds are closed off to acute care patients.

A study compared Kaiser in California with the NHS and concluded that, after you make all of the appropriate adjustments, Kaiser spends about the same per capita on its enrollees as Britain spends on its population. But the Kaiser enrollees were getting more care, more access to specialists, and other services.

We often hear that Medicare and Medicaid are efficient. The government says Medicaid only spends about 2 percent of its budget on administration. But that ignores all the costs that are shifted to doctors and hospitals. When you incorporate all those costs, it turns out that actually Medicare is not very efficient at all.

What's Missing Is Capitalism

While our health care system is more

market-oriented than in most industrialized nations, we don't really have a free market in health care in the United States. Half the spending is done by government. Most of the rest is done by bureaucratic institutions. The cosmetic surgery market is about the only market where patients are really spending their own money. And guess what? It works like a real market. People get package prices. They can compare prices. And over the decade of the 1990s, the average price of cosmetic surgery actually went down in real terms, even as there were all kinds of technological innovations that we are told drive up costs elsewhere.

Most of what I'm telling you here today I learned, not from right-wing critics of national health insurance, but from people who believe in it. If you look at my book, there are probably a thousand different references, and 95 percent of them are references to government reports, academic studies, and newspaper investigations. And in almost every case, the author of those reports is someone who believes in national health insurance. No matter how many problems they document, no matter how many failures they write about, they don't give up their faith in the system.

They all believe that all the failures that they write about can be reformed away. They all believe that we just haven't tried hard enough to reform the system and make it work. Sadly, they are wrong. Virtually all of these problems are inevitable consequences of the politicization of medicine. Why do these systems overprovide to the healthy and underprovide to the sick? Well, in the United States, about 4 percent of the patients spend half the money. If you're a politician allocating health care dollars, you cannot afford to spend half your money on 4 percent of the voters—4 percent who may be too sick to go to the polls and vote for you anyway.

"Virtually all of these problems are inevitable consequences of the politicization of medicine."

Why is the hospital sector so inefficient? Because it's in the self-interest of hospital managers to be inefficient. The chronic care patients and the empty beds are the cheap beds. It's the acute care patients that cost money.

Why can the rich and powerful jump to the head of the waiting lines? Because those are the people who control the system. They can change the system. If members of parliament, the wealthy, and the powerful had to wait for care along with everyone else, these systems would not last for a minute.

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