



Is There a Role for Markets in Health Care?

Presented by
International Policy Network and Galen Institute

Summaries of remarks by international panelists

Helen Evans, Ph.D.
Director, Nurses for Reform (UK)

Johnny Munkhammar, M.Sc.
Program Director, Timbro (Sweden)

Brett J. Skinner, M.A.
Director of Health and Pharmaceutical Policy Research, The Fraser Institute (Canada)

June 14, 2007
National Press Club
Washington, DC

Markets are Compatible with Healthcare; Government is Not

**Helen Evans, Ph.D.
Director, Nurses for Reform**

Because patients personally value healthcare treatments, products and solutions, there is no reason why markets cannot efficiently deliver them as it does for every other kind of product and service.

Contrary to popular belief, healthcare provision can become more efficient, cheaper and more innovative if allowed to operate with a free market. Markets produce a greater diversity of goods and greater consumption by all levels of society than is possible under a centrally controlled, state-owned monopoly.

How do we know this? Britain has had a pure government healthcare monopoly for much of the past 60 years, which has proven to be one of the greatest public policy failures in modern history.

In Britain, the idea of monopoly state interventionism in modern healthcare can be traced back to 1858 and the establishment of the General Medical Council (GMC). Given monopoly legislative favour by the state, the GMC was granted the power to dictate who could practice medicine.

In 1901 the organised medical profession used its increased political status to persuade the government to outlaw medical advertising (or, as it was called at the time, canvassing). An essentially anti-competitive move sold in the name of the 'public good', doctors now used this ban to set themselves free from the pressures of local professional competition and informed consumers.

In 1911, the British Medical Association and the private for-profit health insurance industry combined forces to effectively hijack the National Insurance Bill as it went through Parliament. The act ended up massively undermining the friendly society and wider not-for-profit mutual healthcare movement. As a consequence of the 1911 Act, between 1911 and 1915 the average doctor doubled their salary. Now able to access tax funding while keeping their lucrative middle class market, doctors actively promoted the idea that state funding of healthcare was a good idea, particularly for the lower classes. This move subsequently contributed to the government establishing the Ministry of Health in 1919.

In the 1920s, local government was directed by central government to become formally involved in the provision of local hospital care. And by the 1930s, politicians across the political spectrum accepted a role for state intervention to stamp out "unnecessary duplication and competition".

In 1948, the state took into public ownership some 3,118 independent and locally administered hospitals, homes and clinics. In establishing the National Health Service (NHS) the government promised that "the NHS will provide all medical, dental and nursing care. Everyone – rich or poor – can use it."

However, after nearly six decades of epic Soviet-style failure, the NHS currently finds itself in a perilous state. As Britain enters the twenty-first century it has around one million people on its waiting lists and another 200,000 people trying to get onto them. In NHS hospitals, more than 10 percent of patients pick up infections and illnesses that they did not have prior to admission. According to the Malnutrition Advisory Group, up to 60 percent of NHS patients are under-

nourished during inpatient stays. In many areas, it is increasingly difficult for people to get an appointment with an NHS General Practitioner – or to even find an NHS dentist.

As a result of this situation, recent years have seen the re-birth of Britain's private healthcare sector. Today, more than 6.5 million people have private medical insurance, 6 million have private cash benefits, 8 million pay privately for a range of complimentary therapies and 250,000 self-fund each year for private acute surgery. Millions more opt for private dentistry, ophthalmics and long term care. Today, politicians determined to get themselves off the hook of past promises are increasingly relaxed about the idea of private companies delivering services for NHS funded patients. In 2000, Tony Blair's government signed an historic Concordat with the country's private hospitals, which meant that, for the first time, state funded patients could receive treatment and care in private hospitals. More recently, the government has made it clear that it would like to see all NHS hospitals return to the independent sector as Foundation Trusts able to attract private capital and investment.

Having spent decades arguing that healthcare is so important it is "beyond monetary consideration," politicians are now obsessing over value for money and seeking new ways to legitimise rationing. In Britain, Europe and the even the US, politicians who had previously promised various forms of socialised medicine in order to improve access for the poor, are now promoting the paradigm of Health Technology Assessments (HTA). Under HTA, the government invariably appoints a group of experts to dictate which drugs, procedures and treatments should be made available for public consumption. This means that a bureaucrat decides which medicines patients can get, on the basis of cost benefit calculations. In practice, this means European patients are routinely denied the latest, most innovative drugs.

In Britain, the National Institute for Health and Clinical Excellence (NICE) is essentially a government body that seeks to provide a scientific basis to the rationing of drugs and other forms of treatment. This body has become increasingly controversial largely because it has tried to stop breast cancer patients from receiving Herceptin and patients with Alzheimer's disease from receiving Aricept. Meanwhile, the criteria by which this agency makes its decisions are kept secret from the general public. No one knows how it makes its decisions or the value judgements it makes in the process of its work.

Today, the slow and incremental privatisation of health provision is sadly being coupled with ever more subtle forms of imposed rationing and counter-productive public health campaigns. Because most forms of commercial health advertising have been banned and the NHS is still free at the point of delivery, people have little incentive to remain healthy by taking optimal life-style choices. Government advertising campaigns against smoking have resulted in delivering a new generation of counter-cultural teenagers – usually girls – determined to pick up a habit that is frowned on by on the establishment. Likewise, promising ever more lavish forms of welfare support, the government's campaign against teenage pregnancy has delivered little but a new wave of young mums "who know their rights".

To conclude, healthcare is compatible with the market and the profit-motive because it is the only economic system that provides the necessary incentives for efficiency, innovation, high quality and personal responsibility. State interventionism, on the other hand, is driven by the vote-motive and invariably leads to producer capture, monopoly, inefficiency and technological stasis. As the NHS has demonstrated, state health systems not only neglect the poor and chronically sick because of their relative lack of political voice but governmental public health initiatives are all too often counter-productive because their agents become institutionally addicted to the so called problems they are supposed to be solving.

As I look to the debate in the United States of America, I would urge you to use the market and not more state intervention to reform your healthcare system. Health savings accounts, moving the system away from an employer dominated insurance model and further de-regulation is the way to go. Whatever you do, be wary of HTA and the imposition of any politically driven reforms which purport to represent scientific and economic efficiency. Single-payer systems may offer at best uniform mediocrity. The market, by contrast, can provide choice, innovation and efficiency.

Additional information is available at www.NursesForReform.com.

Are Markets and Health Care Compatible?

**Johnny Munkhammar, M.Sc.
Program Director, Timbro**

Around the world, free markets have created prosperity and progress. The freer a country's economy, the more prosperous a country becomes. Goods and services become cheaper and better. Meanwhile, thanks to economic liberalisation, the global economy is booming, especially in Southeast Asia. Thanks to this process, poverty is decreasing around the world, and life expectancy is rising.

But in much of Western Europe, the free market is considered incompatible with the provision of welfare services. As a result, education, elderly care and health care are largely run by the state and almost exclusively tax-funded. There are strict limits to competition, entrepreneurship, free exchange, consumer choice and private funding. Together with social security, such as pensions, this is the sector where the now defunct centrally-planned economy is still alive and kicking.

In Europe, there are several historical reasons why welfare services are state-run monopolies. During the decades following World War II, when these services greatly expanded, there was a general belief that a centrally planned economy would be efficient. Today, we know the opposite to be true. And in building the welfare state – or the “social model” – politicians found a great task that would win elections for them.

Today, this model has severe problems, not least in health care. In a number of countries, there are waiting lists, where seriously ill people cannot access care for months or even years. There is inefficiency: a recent European Central Bank working paper showed that the bigger the public sector, the more inefficient it tends to be. Increased tax-funding to public health care in several European countries, such as Britain and Sweden, has not led to improvements. Indeed, in the UK, quite the opposite has happened with rapidly declining levels of productivity in the National Health Service.

One often stated aim of having health care run by and paid for by the state has been to ensure universal access to healthcare, particularly for the poor. In fact, the result has been the opposite. Due to a lack of competition, monopolies have no incentives to be efficient, adapt new technology, or reorganise. So the taxpayers get less for their money. And since tax pressure has definitely hit the ceiling in Western Europe, there will be no expansion of health care funding despite such services being highly in demand. Health care is in effect being rationed.

Demand for health care is rising. One reason for this is increased incomes, some of which we would like to use for better health care. Another reason is demographic changes, with a larger share of the population becoming elderly, though healthier than before. And at the same time, health care services tend to get more expensive, due to low productivity development, known as Baumol's Law. Public health care is insufficient today and is increasingly unable to meet those rising demands. This rationing will only get stricter.

In the end, it is patients who suffer from European governments' ideological attachment to centrally planned healthcare. In my home country, Sweden, this has recently resulted in some perverse outcomes. Patients have been sent to veterinarians in order to cut waiting lists, since veterinarians are private and there is a large supply. Many people go to neighbouring countries for dental care, despite having paid taxes to the public care. The number of consultations by a patient per doctor has

fallen from, on average, nine per day in 1975, to four per day in 2001. Doctors devote 80 per cent of their time to administration.

There have, however, been some reforms in Sweden and other European countries to ease some of the problems. Competition from health care entrepreneurs has been allowed, though they are still tax-funded. This has increased efficiency, according to studies. Today, there is also an increasing number of people who buy private health care insurance and they go directly to private clinics. The current government in Sweden is making it easier to start health care companies and will allow public hospitals to be sold.

The US health care system is commonly perceived in Europe to be a complete free market, in which the poor are left to die on the streets if they cannot afford coverage. True, there is competition and much of it is privately funded, but still it is not a free market. It is a mix of market and state interventions, which has undeniably created problems. But similar to the situation in Europe, it is generally the state interventions that have caused the problems.

American health care consumes twice as much GDP per person as the average Western European country, and GDP per person is some 35 per cent higher. Many have claimed that this reflects extreme wastefulness on the part of the American system, but it may be a reflection on the high quality of US healthcare – and much higher wages for health care staff. In Europe, employees in health care are a low-wage group, which can deter higher quality candidates.

What we need in European health care are reforms that open up it up to competition, rather than shield it. Entrepreneurship and competition would increase efficiency. Private funding, such as the stock exchange, would increase levels of funding and diversity in health care. In turn, this would create new incentives to service the needs of the patient who is suddenly a valuable client rather than just an expense for the state.

Why should health care be a political problem at all? Why couldn't it just be another expanding and dynamic export industry? Increased trade in services combined with new technology could do wonders for the health care of tomorrow. But the way to achieve this cannot be through greater state intervention and control.

When European kids wanted to start sending pictures with their cell phones, billions were invested and they got what they wanted. But when Europeans want more and better health care, and are ready to pay more, the state prevents this from happening. This is the difference, in essence, between having something delivered in the free market or by a public monopoly. For anyone interested in improving health care, the market should be embraced, not demonised.

Additional information is available at www.timbro.se/EnglishDefault.aspx.

Canada's single-payer health system is sick and Americans should avoid it like a plague

Brett J. Skinner, M.A.

Director of Health and Pharmaceutical Policy Research, The Fraser Institute

Canada has the only single-payer health system in the world among developed nations. No other country has tried to copy the Canadian system because it is a failure. Even Canadians are beginning to reject it. Americans would be making a huge mistake if they adopted Canadian-style health policies for the United States. The Canadian experience shows that a single-payer health insurance system will damage the quality and availability of medical care in the United States, just as it has in Canada. Americans are rightly concerned about escalating costs and gaps in health insurance coverage at home, but the Canadian system is not a solution.

Despite the fact that Canadians spend less of their national income on health care than Americans, the Canadian health insurance system is still among the most expensive in the world and does not return good value for money spent. Health care only appears to cost less in Canada than in the United States. This is because Canadian public health insurance does not cover many advanced medical treatments and technologies that are commonly available to Americans. Canadian patients do not get the same quality or quantity of care as American patients. On a comparable basis, Canadians have fewer doctors, less high-tech equipment, older hospitals, and get fewer advanced medicines than Americans.

Here are just a few facts to wake up the advocates of single-payer health insurance. In 2004, Canada had 2.1 practicing physicians per 1000 population, compared to 2.4 in the United States—equivalent to 300 fewer doctors for every 1 million residents. In 2003 four percent of the Canadian population was unable to find a regular family physician. Since the 1990s, thousands of Canadian-trained and previously active physicians have left Canada for better opportunities and working conditions in the United States. Importantly, American doctors do not leave the U.S. to work in Canada.

In 2003, 45 in-patient surgical procedures per 1000 population were performed in Canada, compared to 88 – or twice as many in the United States. In 2004, 25.5 MRI exams per 1000 population were performed in Canada, compared to 83.2 – or three times as many in the United States. In 2004, 87.3 CT exams per 1000 population were performed in Canada compared to 172.5 – or twice as many in the United States. In 2003, the average hospital in Ontario (Canada's largest province) was 40 years old while the average hospital in the United States was 9 years old.

The single-payer system in Canada also does not cover out-patient drug expenses on a universal basis. Only about one-third of the population is eligible for various government funded drug programs in Canada. The rest of the population has private insurance or pays cash for out-patient drugs. In Canada it takes government between two and three years on average to reach a decision about whether to pay for new drugs. And in Canada, government often refuses to cover many new drugs at all.

The truth is, if Canadians had access to the same quality and quantity of health care resources that American patients enjoy, the Canadian single-payer health insurance system would cost a lot more than it currently does. These are just a few of the hidden costs of a single-payer health insurance system.

Not surprisingly, Canadian patients also wait much longer than Americans for access to medical care. In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2006, that wait had nearly doubled to 17.8 weeks. Median wait times in Canada are almost double the wait that physicians consider clinically reasonable. The Canadian government does not publish the number of patients who wait and are not able to get necessary medical treatment within each year. But in 2005, a Statistics Canada survey showed that, of the patients who finally did get access to health-care services within the year, 11 percent waited longer than three months to see a specialist; 17 percent waited longer than three months to get necessary non-emergency surgery; and 12 percent waited longer than three months to get necessary diagnostic tests.

It is important to realize that many Canadian patients wait so long for treatment that in practical terms, they are no better off than uninsured Americans. Access to a waiting list is not the same thing as access to health care. Even worse, Canadian patients are prohibited from paying privately for health care services (above what they pay in taxes) to escape delays in the single-payer system. Canadian patients are unable to buy quicker access or better care than what the government's health-insurance program provides. Canadian patients on waiting lists are therefore worse off than uninsured people in America, who can at least gain access to health care by paying cash (or credit) for it.

Americans concerned about health care costs should know that the Canadian single-payer system is not financially sustainable. There is a growing consensus among government and private-sector researchers in Canada that because public-health spending is growing so much faster than public revenue, every one of Canada's 10 provinces is on a path to fiscal disaster. Between the fiscal years 2001/02 and 2005/06, on average across all 10 Canadian provinces, government spending on health care grew at a rate of 7.3 percent annually, compared to 3.9 percent for total provincial revenue, 2.3 percent for general inflation and 4.9 percent for economic growth.

This means that in Canada government spending on health care is growing faster than the ability of the government to pay for it. It is estimated that in 6 out of the 10 Canadian provinces public health spending is on pace to consume more than half of total revenue from all sources by the year 2020, two-thirds by the year 2035, and all of provincial revenue by 2050. These estimates do not take into account the added pressures from an aging population. As of 2003, the unfunded liabilities of future government funding obligations for health care in Canada reached 46 percent of the country's 2003 total economic output (or GDP) —growing 29 percent since 1999.

American health professionals ought to be very afraid of a single-payer system. After adjusting for the purchasing power of the currencies, Canadian nurses earn only two thirds as much as American nurses and Canadian physicians earn only 42 percent as much as American physicians. After adjusting for inflation, average income for physicians in Ontario (Canada's largest province) has actually declined to 75 percent of its peak 1972 level. Canada's public monopoly exploits the services of medical labor by holding down wage rates below what they would normally be if there wasn't a single-payer system.

Finally, in a 2005 case challenging the province of Quebec's government-run health insurance monopoly, the Supreme Court of Canada struck down the single-payer system as a violation of patients' rights to preserve and improve their own health because of long waits to get treatment. A similar case is currently underway in two other Canadian provinces where the plaintiffs are seeking to expand the Quebec precedent on the basis of nationally applicable constitutional rights.

Canadians are currently witnessing the failure of their health insurance system and are beginning to reject it. The Canadian experience shows that a government-run single-payer monopoly is the worst way to achieve universal health insurance coverage. There are better international examples for achieving universal health insurance coverage if that is what Americans want.

All facts and figures cited here are excerpts from a major paper published by The Fraser Institute called *California Dreaming: The Fantasy of a Canadian-Style Health Insurance Monopoly in the United States*. The paper is available for free download at www.fraserinstitute.ca.