Lessons From Abroad

Written Testimony to the United States House of Representatives

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Thank you for the opportunity to testify today as Congress begins this critical debate. The decisions legislators may soon make will be critical, not only for the future of health care in the United States, but also for patients around the world who benefit from American innovations in health-care practice and medical technology.

My concerns about the option under discussion today are drawn from practical personal experience - as a physician born and trained in Canada, as the author of two books (and the editor of a third) on comparative health-care policy, and as a senior fellow at the Manhattan Institute. (For the record, the views I present are my own and do not necessarily represent those of the Manhattan Institute.)

The U.S. health-care system needs reform. But in the sincere search for a simple solution, many critics mistakenly believe the Canadian single-payer model represents a “magic bullet” alternative. Others believe a so-called “public plan option” will provide the benefits of a single-payer model without the usual disadvantages, ignoring the experience of other jurisdictions that learned that incrementally introducing publicly-administered insurance simply produces the same challenges at an incremental speed.

To understand the single-payer system, it is important to realize that in the Canadian model “single-payer” is really a polite euphemism for a government-funded, government-managed system. While American observers speak of Canadian medicare as if there is one federal insurance plan,

in truth, ten balkanized provincial insurance systems make different decisions on care and coverage in response to a general federal mandate. Insurance is nominally portable between provinces, but gaps in coverage have appeared when Canadians moved from one province to another.

Each provincial insurance plan is funded partly by generous federal transfers. The White House hopes that health reform will reduce health costs without damaging quality, but the story of the Canadian system is the story of provincial governments struggling to manage health-care costs alongside other budget priorities. When budgets are insufficient, the provinces lobby for more federal transfers, go into deficit, and/or limit care by managing supply.

Critics of the American system note that it fails to provide universal coverage to its citizens. But Canada's single-payer system also denies care; instead of denying insurance coverage, Canada's public insurance plans simply limit the supply of costly medications and capital-intensive procedures.

Shortly before Oregon's referendum on a single-payer health- care system, a man wrote to his local paper, claiming that under a single-payer system, "you just send your doctor's bill to the government and they pay it." But it is not so simple. Canadian governments all have a strong interest in managing cost, and so the gentleman from Oregon ignored two problems: first, he would have to get in to see the right doctor in the first place. Then, there are limits to what that doctor would permitted to bill for.

Even now, after a decade of joint federal-provincial efforts to reduce waiting lists, wait times for some procedures are still rising. The Canadian Institute for Health Information is the designated reporting agency for health-care wait times, and in several categories in 2008, provinces did not even meet the benchmark standard for service. To put that in context, the benchmark for "timely" service for coronary, bypass, hip replacement or knee replacement surgery is 75% or more of patients receiving treatment within 182 days.

In Alberta, Canada's wealthiest province, 50% of outpatients in 2008 had to wait more than 41 days for an MRI scan. In Saskatchewan, 10% of patients awaiting knee replacement surgery had

to wait 616 days or more. In Nova Scotia, 50% of patients needing hip replacement surgery waited 201 days or longer. These are the government's own numbers. Studies by the Fraser Institute and other health-care watchdogs often produce a more disturbing picture.

Timely service is not the only casualty of rationed care. Diabetic Canadians have been denied insurance coverage for insulin pumps available under HMO plans in the United States. Newer medications or orphan drugs available to insured Americans are routinely excluded from provincial formularies, often after decisions made in closed-door hearings by Canada's Common Drug Review process. Finally, Canadians often turn to the United States for life-saving diagnostic exams or surgical procedures at private expense, either to outflank waiting lists or avoid outright denials of coverage by their provincial insurance plans. In one tragic case in the 1990s, fifty Canadians died waiting for a basic cardiac test according to the *Canadian Medical Association Journal* in a 2002 article.

American advocates for a Canadian model repeatedly insist that "patients can choose any doctor they like." However, there is a shortage of doctors to choose from in Canada because governments forced medical faculties to reduce the supply of doctors graduating in the 1990s in an effort to contain costs. In June 2008, Statistics Canada reported that 4.1 million Canadians aged 12 and over were without a family doctor, rendering the freedom to choose a meaningless benefit.

Critics of the American system argue that health outcomes are unacceptable in part because Canada and other single-payer systems perform better on measures of life expectancy. But life expectancy is a product of a complex series of inputs, including wellness, fitness, and other environmental factors - like America's anomalously high homicide rate.

A better measure of health insurance outcomes is to compare outcomes for people who actually need insured care. And in a paper entitled *Health Status, Health Care and Inequity: Canada versus the U.S.* (2007), June O'Neill and Dave O'Neill made just such a comparison.

The O'Neills concluded that, and I quote, "direct measures of the effectiveness of health care show survival rates for individuals diagnosed with various types of cancer are higher in the U.S.

than in Canada, as are infant survival rates of low-birth weight babies." Their study also found that despite "free" public insurance, Canadians in at-risk populations were significantly less likely to have had key preventative diagnostic procedures. Canadians in target groups were over 15% less likely to have ever had a mammogram than American patients, 10% less likely to have a PAP smear, 30% less likely to have had a PSA test for prostate cancer, and over 20% less likely to have ever had a colonoscopy test for colorectal cancers. The Canadian system is the best in the world, as long as you are not actually sick.

The limits of single-payer insurance are a consequence of a common political reality: if governments fund it, governments wear it. Once the so-called single-payer system is in place, government insurers are obliged to manage costs politically, making decisions about capital investments, technology, and even the supply of licensed medical professionals based on short-term budgetary or political priorities. So while Canada's health-care system was once supported by a healthy level of private capital investment, in many provinces, the politics of protecting the public system from the "threat" of competing market (e.g. patient) demands has led some governments to literally ban or buyout private providers wherever possible. For example, in 2004, the Ontario provincial government "repatriated" several privately-owned MRI clinics, despite the fact that all of them were providing publicly insured services. The reason given was ideology: it was unacceptable for a private firm to profit from diagnostic tests, even if the tests were provided at rates set by the government.

This cycle explains why Canada evolved from a universal insurance system delivered largely by private and non-profit care providers to a system that is largely publicly managed or administered in 2009. Pursuing a public option plan to provide single-payer service alongside private insurers is likely to lead inexorably to the same result as a pure single-payer model. The larger the public's share of the insurance system, the greater the demand on elected officials to wade in and control costs or deliver benefits directly.

These challenges appear in different forms across the single-payer world. Wait times, rationed care and inefficient public management is inevitable in single-payer systems because they all face the same health-care demands as the American system. No matter how tightly managed or

rationed, Western health-care systems are all under pressure to cope with rising costs from aging, new technology and competition for health care professionals.

Health care's share of the provincial budget is approaching 40% of the provincial budget in Manitoba, a Canadian province that already prides itself on generous social welfare benefits, college subsidies and other social programs. The province of Ontario created a new health surtax in 2004 - and the total budget for its single-payer health system is projected to grow by close to 6% annually in the next three years.

These are familiar stories in the United Kingdom and other single-payer systems. In the UK, the existence of a parallel private insurance system has not curtailed the explosive growth of the public system, nor the management problems that go hand in hand with public delivery. In 2007, a columnist for the *Times* of London quipped that "The [National Health Service] generates its own inflation as though it were a country in its own right." According to the NHS's own data, the Service's budget has on average exceeded inflation by 3% *annually* over the entire sixty-year lifetime of the Service. The 2009 NHS budget is over 56% larger than it was in the fiscal-year ending 2003, even after a round of "efficiencies" were built into the 2009 budget plan.

With all of this investment, the UK's NHS has finally achieved its best wait list results since it began tracking wait times in 1948. But once again, success is relative; the standard for timely care in the NHS is that patient treatment must wait no more than 18 weeks for treatment once referred by a general practitioner.

Many in the United States Congress hope to quickly solve America's complex health care challenges either by embracing a single-payer model now, or moving incrementally to the Canadian system through the back door with a public insurance plan in the private marketplace. But experience shows that sooner or later, these alternatives risk destroying the best features of the American system in order to remedy the worst.

Congress can instead choose options that will fight cost escalation, preserve innovation and protect the high quality of American health care. But before these options will ever be properly con-

sidered, supporters of the single-payer model must honestly face up to the realities of the system in Canada and elsewhere. Single-payer models are far more complex and inefficient than their American supporters believe them to be. They are managed and rationed much more aggressively than their supporters believe them to be. And a careful review of those challenges, I believe, would convince most observers that the single-payer model is not the 'magic bullet' that American policymakers are hoping for.