Joint Economic Committee
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3 Unwinding Obamacare
Exploring the Democrats' 2,800-page, $2.6 trillion takeover of health care

- *Britain's National Health Service employs a staggering 1.6 million people—more than most armies.*
- *Parliament is considering dramatic reforms.*
- *The bureaucracy would be cut, and 70% of the health care budget would be put into the hands of doctors and patients.*
- *So why is the US moving toward the model that Britons are moving away from?*

The UK De-Bureaucratizes Health Care
We Should Too

September 22, 2010

Since 1948, the United Kingdom has had a "single payer" health care system. The British government purchases and distributes 95 percent of all medical items and services in the country. One global budget, fixed by Parliament and distributed by the Health Ministry, provides for virtually the entire health care sector of the economy. Most hospitals are publicly owned, and most health care professionals are, in effect, public employees.

American progressives, led by President Obama, openly admire this 60-year experiment in government-run, single-payer medicine. They like its simplicity and what they imagine to be its superior efficiency and social equity. Indeed, the Democrats' Patient Protection and Affordable Care Act (PPACA), signed into law in March of 2010, clearly draws its inspiration if not all its details from the British health care model. PPACA, liberals in the US hope, is but the first step toward bringing that model to America.

But is this wise? The UK is currently trying to reform its health service, which has become bloated and inefficient. Six decades of socialized medicine have produced a system marked by long waits for certain services, explicit rationing, and often inferior medical outcomes.

To date, all reform attempts have fundamentally failed, providing persuasive evidence that you cannot fix a bureaucracy by giving it more money or moving the boxes on the organization chart.

Reality is forcing Britons to rethink their model. Why, then, are we moving toward that model?

Britain's Bold Proposal

There is one main alternative to the single-payer model, with its rationing and inefficiency; and that is to let informed patients allocate health care resources freely, directing their own care in consultation with their doctors and loved ones.

While true privatization of the National Health Service (NHS) isn't on the agenda in Britain, a consensus is emerging that major reforms are needed. The British seem to be waking up to the potential benefits of putting doctors and patients more in charge of their own health care spending. And in fact, this concept is at the heart of the radical new NHS overhaul plan proposed by the coalition government of Conservative and Liberal Democratic MPs led by Prime Minister David Cameron.

The coalition's bold plan would not reduce overall NHS spending, even though the debt-strapped UK government is under enormous pressure from global bond markets to dramatically reduce its expenditures. Rather, the plan attempts

to make the NHS more efficient by cutting decades of accumulated bureaucracy while simultaneously shifting money and decision-making power to doctors and patients. According to the *New York Times:*

> The [NHS], while protected from cuts, has been ordered to shed thousands of jobs. The coalition's plan is to hand real power—and 70 percent of the health budget—to general practitioners [i.e., local, non-specialist physicians], who, in the coalition plan, would decide for the first time in the health service's 60-year history what kind of treatment patients would get, and where they would get it.[1]

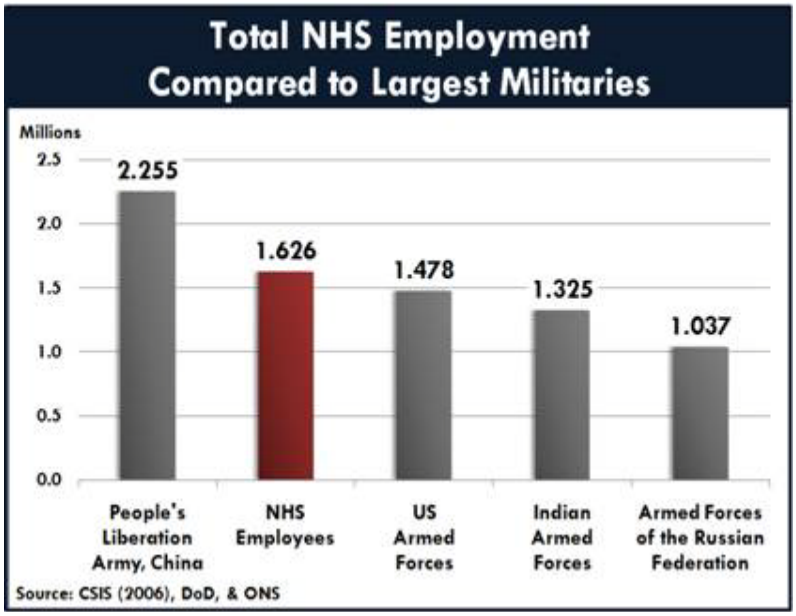
Under the plan, between $100 billion and $125 billion a year out of a total budget of $160 billion would be meted out to general practitioners, who would use the money to buy services from hospitals and other health care providers. More than 150 of NHS's local health care bureaucracies, called primary care trusts, would be abolished, allowing more choices to be made by patients instead of bureaucrats. Many current government-set targets, like limits on how long patients have to wait before receiving treatment, would also go away. The goal is to produce $30 billion in efficiency savings in the health budget by 2014 and to reduce administrative costs by 45 percent. Tens of thousands of middle management jobs would be eliminated.[2]

To be sure, the plan does not "privatize" the NHS, nor change its essentially public character. But by shifting more money and power to doctors and patients, it moves in a hopeful direction and opens a pathway to a better system in the future that would be even more consumer-driven and patient-centered.

Why NHS Reform Is Needed

Will shrinking the NHS bureaucracy hurt patients? It's hard to believe that it will. The NHS is one of the world's five largest employers, with no less than 1.6 million employees.[3] (See figure.) If the NHS were an army, it would be the second largest on earth, behind only that of China.[4] Yet it serves an island population of just 62 million people. NHS employees now represent more than one-quarter (26.7 percent) of all public employees and more than one of every twenty workers employed in the UK—and a substantial majority are not health care providers but administrative personnel.

If the quality of British medicine were uniformly high, there might be no good argument for reducing bureaucracy or liberating doctors and patients. But the quality of British medicine is not uniformly high. In fact, the UK has a poor record relative to other European nations and the U.S. on several measures, including specialty access, cancer outcomes, patient-centeredness, life expectancy, and infant mortality for socially deprived populations.[5] [6] [7]



To take just one prominent example, while prostate cancer mortality has fallen dramatically in the US and other countries since the late 1980s, following the advent of widespread PSA (prostate-specific antigen) testing, the progress in the UK has been minimal by comparison, where the test remains relatively rare.[8]

Another example of room for improvement is a recent study of hospital competition in the UK. Until 2006, British patients had virtually no choice of which hospital to use. Their physician acted as "gatekeeper" and chose for them. In an experiment, the government decided to permit limited patient choice by requiring physicians, when referring patients for non-emergency hospital-based procedures, to give the patient a list of five hospitals to choose from. Health economists

studied the results of this new policy to see whether greater patient choice improved quality or reduced costs. The results of the study showed that in fact it did both. Increasing patients' choice of hospitals, the authors found, helped the NHS save an estimated 3,354 life-years and £227 million. More importantly, the introduction of hospital competition in the UK, limited though it was, led to a statistically significant increase in the quality of medical outcomes, as well as a statistically significant reduction in mortality, without a commensurate increase in expenditure.[9] (These results may come as a surprise to the Obama Administration, whose top Medicare administrator, Dr. Donald Berwick, famously exhorted NHS officials in 2008: "Please don't put your faith in market forces."[10])

Gammon's Law of Bureaucratic Displacement

The troubling combination that has characterized British medicine since 1948—massive bureaucratic expansion and yet declining quality of care—has been famously described as "Gammon's Law." Dr. Max Gammon worked in the NHS, and his study of it, beginning in the 1960s, led him to enunciate what he called "the theory of bureaucratic displacement." In his words,

> [In] a bureaucratic system . . . [an] increase in expenditure will be matched by [a] fall in production. . . . Such systems will act rather like 'black holes,' in the economic universe, simultaneously sucking in resources, and shrinking in terms of 'emitted production.'[11]

Dr. Gammon measured the NHS's productivity by comparing two simple variables: inputs (defined as the number of employees) and output (measured as the number of hospital beds). He found that while inputs had increased sharply, output had actually fallen. (Note: His research is on the NHS in England only, not the entire UK.) In a 2005 update of this research, he reported that the number employed by the NHS in England had more than doubled from 350,000 in 1948 to 882,000 in 2002, with the bulk of the increase coming at the levels of "senior manager" and "manager," and with large numbers of nurses being shifted from bedside to desk-bound activities. Meanwhile, he reported, the number of hospital beds in the NHS had fallen from 480,000 in 1948 to 186,000 in 2000. Remarkably, he found that there was "an almost perfect [statistical] correlation between the growth in numbers of administrators and the fall in numbers of beds."[12] While Gammon acknowledged that a statistical correlation, no matter how close, is not necessarily significant, he theorized that this near-perfect (0.99) correlation could indeed have explanatory value:

> [Assume] a progressive displacement of productive activity of all NHS staff [through] the proliferation of useless and often counterproductive bureaucratic activities throughout the whole organisation. In this way, an expanding workforce and increased spending would be matched by a fall in production; the more that was put into the system the less would come out of it.[13]

Gammon's Law suggests that a rise in systemic complexity and a proliferation of bureaucratic activities do not necessarily mean more resources available for care or better outcomes for patients. If anything, it can mean the opposite, as the system groans under the weight of added red tape and paper-shuffling.

Gammon's Law

"In a bureaucratic system, an increase in expenditure will be matched by a fall in production. Such systems act rather like 'black holes' in the economic universe, simultaneously sucking in resources and shrinking in terms of 'emitted production'."

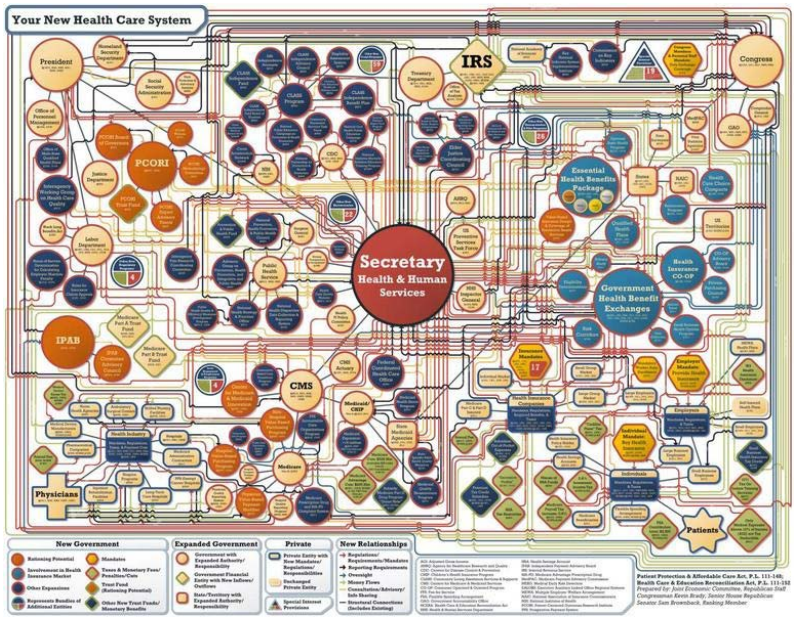
Bureaucratic Rationing

And then there is the problem of health care rationing. Since resources are not unlimited, the British approach necessitates explicit rationing of care by bureaucrats under the oversight of politicians.

In the UK, the rationing process is quite transparent. Indeed, the British have made a kind of fetish of transparency, actually putting a specific monetary value on human life, expressed in pounds sterling. The "Quality Adjusted Life Year" or QALY is the amount of money that NHS experts have determined an additional year of a human life is worth, based on various factors, such as one's

current age, medical condition, and the likelihood of benefitting from the treatment. Generally, if a treatment costs more than £20,000-30,000 per additional QALY gained through the treatment (an arbitrary limit determined by budgetary constraints), then it is deemed "not cost effective," and individuals and families who want those treatments are left to pay for them entirely out of pocket, sometimes by traveling abroad. [14]

To take just one recent example: the agency that devised and applies the QALYs, the National Institute for Health and Clinical Excellence (NICE), has rejected the use of the often life-extending drug Avastin (bevacizumab) for use in shrinking cancerous intestinal tumors, because "the cost . . . at about £21,000 per patient, does not justify its benefits." Avastin is used in the US and across Europe, but will now be effectively unavailable in the UK. NICE's decision, which came after a year of internal deliberation, will affect an estimated 6,500 NHS patients.[15]



Meanwhile, in America

What has all this to do with the United States? Thanks to PPACA, we are now clearly starting down a road that could easily take us to NHS levels of bureaucracy and NICE-style rationing.

Bureaucracy. PPACA creates 159 new bureaucratic entities, including: 68 new grant programs; 47 new agencies, boards, and commissions; 29 new demonstration and pilot programs; six new regulatory systems and compliance standards; four new loan forgiveness and easy loan-repayment programs; three reforms to existing Medicare reimbursement policies; and two massive new entitlement programs.[16] Another count, by the nonpartisan Congressional Research Service, declares the number of new bureaucracies created by PPACA essentially "unknowable."[17] [18]

How many bureaucrats will be needed to manage the system? An estimate for just one agency may be indicative. The U.S. Internal Revenue Service (IRS) will need an estimated 16,500 additional tax auditors just to collect the law's projected $569.2 billion[19] in revenues and penalties over the first decade.[20]

Rationing. While PPACA doesn't contain explicit rationing (and certainly no "death panels"[21]), it does establish the basic building blocks of a rationing infrastructure. Once the law is fully implemented in 2014, America will have in place a Patient Centered Outcomes Research Institute (PCORI),[22] determining the comparative cost effectiveness of medical treatments and therapies, while an Independent Payment Advisory Board (IPAB),[23] an unelected panel of health industry experts, will be using that cost-effectiveness data to impose hundreds of billions of dollars of Medicare cuts, which can only be stopped by a majority vote in both Houses of Congress. Given the enormous influence that Medicare's coverage and payment policies have on private health insurers and the new government controls over the private health insurance market, these two new agencies (PCORI and IPAB) together have the potential to constitute the American version of NICE.

Anyone who doubts that PPACA paves the way to bureaucratic rationing should consider the public statements of the aforementioned Dr. Berwick, Mr. Obama's controversial new Medicare chief, who has lauded Britain's rationing of medical care by highly trained experts and even defends the practice as unavoidable in America.[24] "The social budget is limited," he declared last year. "We have a limited resource pool. . . . The decision is not whether or not we will ration care. The decision is whether we will ration with our eyes open."[25]

Actually, the decision is *who decides*: patients or bureaucrats?

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[2] *New York Times,* "Britain Plans to Decentralize Health Care," Sarah Lyall, July 24, 2010.
http://www.nytimes.com/2010/07/25/world/europe/25britain.html?_r=3
[3] UK Office for National Statistics (http://www.statistics.gov.uk/statbase).
[4] Center for Strategic and International Studies; US Department of Defense; US Bureau of Labor Statistics; US Census Bureau.
[5] Donald Berwick, M.D., M.P.P., F.R.C.P., F.R.C.P.S., K.B.E., "A Transatlantic Review of the NHS at 60," speech at NHS Live, July 1, 2008.
http://www.defendyourhealthcare.us/images/Berwick_Speech.pdf
[6] Telegraph, "Life expectancy gap 'widest since Great Depression'," Rebecca Smith, July 23, 2010.
http://www.telegraph.co.uk/health/healthnews/7904294/Life-expectancy-gap-widest-since-Great-Depression.html
[7] For example, the UK seriously lags behind other nations on prostate cancer screening and mortality rates:
http://jec.senate.gov/republicans/public/index.cfm?p=Charts&ContentRecord_id=e0626621-2eac-4a45-b73d-47d6ea05eac5&ContentType_id=93fa2829-adbd-400a-933b-c99f81d9ad75&Group_id=5725d988-efed-45ef-890f-448172684d83&YearDisplay=2009
For more comparative information on various health input and output measures in the UK, US, and other countries, see charts produced by the Joint Economic Committee Republican staff, by searching under the "Resources" tab at the JEC Republican website:
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[8] See summary chart by Joint Economic Committee Republican staff, "Prostate Cancer and Mortality Rates," August 4, 2009.
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[10] Donald Berwick, M.D., M.P.P., F.R.C.P., F.R.C.P.S., K.B.E., "A Transatlantic Review of the NHS at 60," speech at NHS Live, July 1, 2008.
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[11] Milton Friedman, "Gammon's Law Points to Health-Care Solution," Wall Street Journal, November 12, 1991.
http://hadm.sph.sc.edu/Courses/ECON/classes/Friedman.html
[12] Max Gammon, "Gammon's Law of Bureaucratic Displacement: A Note From Max Gammon with Some Quotes From Milton Friedman," Australian Doctors Fund., January 24, 2005.
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The figures for hospital beds and NHS staff are updates from earlier studies by Dr. Gammon. See, for example, Max Gammon, "Growth of Bureaucracy in the British National Health Service," *Journal of Management in Medicine,* 1993, p. 58.
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[16] Senate Republican Policy Committee, "159 Ways the Senate Bill Is a Government Takeover of Health Care," gop.gov, February 25, 2010.
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[20] House Ways & Means Committee Republicans, "The Wrong Prescription: Democrats' Health Overhaul Dangerously Expands IRS Authority," 2010-03-18.
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[21] *Politico*, "Palin doubles down on 'death panels'," August 13, 2009,
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