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# Rationing Health Care

Americans spend a larger share of national income on health care—some 15 percent—than any other people in the world. Moreover, for almost every one of the last 25 years, the price index for medical care has increased more rapidly than the price index for all goods and services in general. With spending on health care at record high levels, it is little wonder that some political leaders have labeled health care in the United States a "crisis," arguing we should implement government-mandated universal health care coverage. It is thus instructive to look at what has happened in other countries that have adopted some form of a national health care system.

We obviously cannot cover every aspect of health care here, nor can we demonstrate that one system of health care delivery is better than another. What we can do, however, is note the consequences of this critical point: In a world of **scarcity,** some form of rationing is inevitable. In the market system, that rationing is done by prices. Under the systems of government-mandated universal health care that now exist (or are likely to exist in the future), prices are not permitted to ration demands. Instead, these systems rely on another system of rationing: It is called *rationing by waiting,* because people are forced to wait—for weeks or months—for whatever level of medical care is offered them.

The most common form of government-mandated universal health care coverage found in the world today is the single-payer health care system that in essence offers universal health care to consumers at a money price of zero. (The term *single-payer* is used because the government writes the checks for the medical bills.)

Britain offers a typical example. The British National Health Service (NHS) has been in existence since 1948. Once touted as one of the world's best national health care examples, the NHS has deteriorated dramatically. Consider hospital beds: in 1948 there were ten hospital beds per thousand people. Today there are about five per thousand people. Since 1948 about 50 percent of Britain's hospitals have been closed for "efficiency" reasons—meaning that the British government cannot or will not afford to keep them open. Britain now has fewer hospital beds per capita than every other Western European country except Portugal and Spain.

Because patients in Britain do not pay directly for the services they receive, some other means of rationing must be used. In Britain, the rationing device is waiting, and as the number of hospital beds and other medical facilities has been cut relative to the population, it is little surprise that waiting times have increased. Currently more than a million British patients are waiting for hospital admission. Many others do not show up on waiting lists because they simply do not apply, knowing that the wait is so long. In some London hospitals, individuals routinely spend more than 12 hours waiting to see a physician.

The total staff in the NHS has, in contrast, skyrocketed. Whereas in 1948 the staff-to-bed ratio was .73 to 1 for each hospital bed, today it is 3.1 to 1 for each hospital bed; even with the drop in beds per capita, there are now twice as many staff members for each patient as there were in 1948. One would expect this would enhance medical care. Unfortunately, however, the staff, for the most part, do not deal directly with the treatment of patients. Rather, they have become part of the NHS bureaucracy. This is because the government-run NHS adds a new department or committee for every new aspect of medicine that develops. The NHS consists of a bureaucratic network unknown in the decentralized medical system in the United States.

In fairness to the NHS, some of the changes in the system over the last 50 years have been mirrored in health care systems elsewhere. For example, improvements in surgical techniques and pharmaceuticals have shortened hospital stays in most nations, resulting in a reduced demand for hospital beds. This surely helps explain at least some of the sharp cuts in NHS beds per capita. Nevertheless, horror stories of bungled operations and patients left untended in hospital hallways have become a regular feature in British

newspapers. Things got so bad by 2002 that Britain's Labor Party—the initial creator and steadfast supporter of the NHS—proposed that the poorest-performing NHS hospitals be handed over to the private sector.

The national health care system in Canada offers another example of the effects of nonprice rationing. In essence, under the Canadian system the government picks up the entire tab for all covered medical procedures. Currently, only 11 percent of Canada's national health care spending goes to administration, compared to 24 percent in the United States. Canada devotes 9.5 percent of its national income to health care, about a third less than in the United States. Perhaps because of the seemingly low cost of the Canadian system, many supporters of health care reform in the United States often point to Canada's system as one that the United States should emulate.

One impact of the lower level of spending in Canada is that their system does not provide the latest in medical technology. Although Canada ranks fifth highest among developed nations in health care spending as a share of income, it ranks in the bottom third of those countries in availability of technology. For example, compared to the United States, on a per capita basis Canada has far fewer computerized tomography (CT) and magnetic resonance imaging (MRI) machines, critical in performing sophisticated, difficult diagnostics. Similarly, Canadian medical facilities have almost none of the medical devices needed to remove kidney stones without painful and dangerous surgery. Moreover, operating rooms in Canada operate on strict financial budgets and are allowed to continue operating only if they are within those monthly budgets. What happens if an operating room exhausts its budget on, say, the 20th of the month? It shuts down until the beginning of the next monthly budget cycle.

The costs to the users of the Canadian system show up in other ways as well. Two Canadian economists, Cynthia Ramsay and Michael Walker of The Fraser Institute in British Columbia, have studied the waiting times across a variety of medical specialties. They discovered that many Canadians each year were not permitted to enter the hospital when they or their physician deemed best; instead they had to wait until facilities became available. Moreover, Canadians typically were not even able to get in to see their doctors when they wanted. Ramsay and Walker measured the delay from

**TABLE 12–1** Median Waiting Time for Treatment by a Specialist in Canada

| | (In Weeks) | | |
|---|---|---|---|
| *Specialty* | *Shortest Wait* | *Longest Wait* | *Canada Average* |
| Orthopedics | 24.9 | 63.4 | 32.2 |
| Plastic Surgery | 26.2 | 76.9 | 28.6 |
| Ophthalmology | 14.4 | 52.1 | 30 |
| Gynecology | 11.6 | 25.7 | 15.3 |
| Otolaryngology | 10.9 | 50.6 | 16.4 |
| Urology | 9.5 | 26.2 | 13 |
| Neurosurgery | 8.7 | 55.1 | 20.1 |
| General Surgery | 8 | 20.4 | 10.3 |
| Internal Medicine | 8.6 | 23.6 | 11.1 |
| Cardiovascular | 8.4 | 60.1 | 14.1 |

*Source:* The Fraser Institute, Vancouver, BC, Canada.

the time that a primary care physician referred a patient until a specialist actually treated the patient; they found that the demand for health care was rationed by waiting. Listed in Table 12–1 are the median waiting times in weeks for the services of various medical specialists. The three columns show the waiting times for Canada as a whole and the waiting times in individual Canadian provinces that had, respectively, the shortest and longest waiting times.

Two facts are apparent from the table. First, it is commonplace for Canadians to have to wait three or four months to receive health care that is anything beyond that offered by a nurse or primary care physician. Second, the Canadian system produces huge inequalities in the way people are treated, not only across illnesses, but also across provinces for the same illness. These long waits, and the extent of unequal treatment, have produced a regular stream of Canadians who come to the United States and spend their own money for medical care here, rather than await their fate at home. The waiting in Canada has gotten so bad that some provincial

governments ship heart-bypass patients and cancer patients needing radiation over the U.S. border to receive treatment. Although this practice is frowned on by the Canadian federal government, the alternative, it seems, is to let the patients die at home, waiting.

Another example of government-controlled health care involves the Netherlands. The government there decides on global budgets to control hospital expenditures. It also limits the number of doctors who may specialize in a given area and caps the number of patients they may see. In addition, the government controls physician fees. To help the government meet its budgets, many medical specialists have simply stopped working as much as they used to work. It is commonplace for highly trained surgeons to work only half-days or to take weeks off at the end of the year. The result is that typically there is about a three-month waiting list for coronary bypass surgery. Over 15 percent of the patients on the waiting list die before the operation can be performed. Diabetics wait an average of three months to obtain laser treatment for retinal hemorrhaging—and risk blindness in the process. The average wait for removal of gallbladder stones and repairs of hernias is from four to eight weeks. Some forms of reconstructive surgery require waits of up to four years.

Under Dutch law, companies must pay employees' salaries for the first two to six weeks of an illness, depending on the size of the company. This has generated an interesting incentive: The companies have discovered that they can reduce their costs by renting hospital rooms that they keep open for their employees. The companies thus do not have to pay employee salaries while those employees wait—disabled—for treatment. Although the Dutch system is supposed to provide equal treatment for all, treatment in fact has come to depend on the size and influence of the company for which a person works.

Although our analyses have involved three foreign countries, we need go no further than our own Veterans Administration (VA) to find similar examples. The VA operates a 100 percent government-owned and government-financed health care system. It is the largest health care system in our country and one of the largest in the world, with 163 medical centers housing more than 80,000 beds. It operates 362 outpatient and community clinics that receive 43 million patient visits a year. In addition, it has 137 nursing homes with over 87,000 patients. All of the states, plus the District

of Columbia and Puerto Rico, have at least one VA medical center, and the VA boasts almost 250,000 employees nationwide.

The General Accounting Office (GAO) did a study of the VA a few years ago, concluding that the VA system faces a growing demand for "free" medical services. Herein lies the rub: The quantity demanded of most services at a zero price will almost always exceed the quantity supplied. Consequently, because price is not used as a rationing device, some other method must be used to ration the scarce resources. Fifty-five percent of the patients who use the VA for routine medical problems wait three hours or longer and sometimes an entire day in order to be seen for a few minutes by a VA primary care physician. Even among patients requiring urgent medical care, one in nine must wait at least three hours. Patients in need of specialized care cannot even be *seen* by a specialist for 60 to 90 days. They wait months more if surgery or other special procedures are required.

Whether the location is Britain, Canada, Holland, or even the U.S. Veterans Administration, when prices are prevented from clearing the market for medical care, waiting time is the most commonly used means of rationing demand. As one unidentified U.S. veteran told the GAO, "I pack a lunch and take a book." Another veteran, retired 69-year-old Army Major Elmer Erickson, stated, "Be prepared to spend the day there. You will eventually see a doctor."

## DISCUSSION QUESTIONS

1. Suppose we had government-mandated universal access to food. How would the outcome likely differ from what is observed with health care systems of this type?
2. Under the Canadian system, those who are unhappy with the health care they receive can come to the United States for medical care if they can afford it. If the United States adopted a system similar to Canada's, where could Americans go if they were not satisfied with the medical care they were receiving?
3. Under the current U.S. health care system, insurance companies often perform the role performed by government agencies