House Committee on Ways and Means

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Testimony Before the Full Committee
of the House Committee on Ways and Means

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Thank you for this opportunity to testify at this important time. My testimony is drawn from 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 choices Congress will make on this issue are critical both for the United States and for patients around the world who benefit from American advances in diagnostic technology, pharmaceuticals, biotechnology, surgical techniques, and medical device design.

It is not a coincidence that the United States is so productive in medical science. America's health-care system is unique in its capacity to mobilize private investment. Many critics of the system look at its rising share of GDP and see only cost. But we must remember in these discussions that American medicine is second to none. The achievements of the last sixty years have been amazing: polio is confined to the history books; death by cardiovascular disease has fallen by two-thirds; childhood leukemia, once a death sentence, is now treatable.

The U.S. system needs reform, yes. Costs continue to rise. Quality is uneven. Too many lack insurance. But in our effort to make a system with better coverage and access, we must not lose what is right and what is good.

1. BUILDING ON WHAT WORKS

U.S. lawmakers should be cautious about borrowing reforms from other countries; Congress must reform the health-care system with made-in-America solutions.

Congressional leaders would be wise to focus on simple, practical reforms that build on what works in this system.

- We must recognize the forgotten role of health in health care (*policy reform*);
- We should foster insurance competition in a larger marketplace (*regulatory reform*); and
- We must level the tax playing field for individuals seeking insurance outside the workplace (*tax reform*).

Supporters of a single-payer model repeatedly point to America's lower life expectancy as evidence of a systemic failure. As a physician, let me assure you that life expectancy is about much more than what happens in the doctor's office. Indeed, some of the biggest problems we face are due to choices and not (health) care. Americans live unhealthily – smoking, drinking, and eating more

than their neighbors to the north, or their Western European cousins. Consider that the percentage of obese Americans has doubled in the last quarter century.

The failure to prevent common illnesses like diabetes and lung cancer carries significant financial consequences for the health-care system. Both Democrats and Republicans can agree with this point. Significant government and private actions are needed – we must do more to promote wellness, provide incentives for prevention, and encourage Americans to take greater responsibility for their own health.

Market competition can contain the high cost of insurance – if Congress and the states would only allow it to take place. Efforts at creating equity and fairness in the health insurance market – done with the best of intentions – have created dramatic differences in price across the country. For example, a health-insurance plan for a family of four in New York can cost more than $12,000 a year, but a similar is about $3,000 in Wisconsin.

The federal government can promote regulatory strategies that will increase interstate insurance competition. Proposals to create a true national market for health insurance is on the right track, but Congress must go farther to level the tax and regulatory playing field for non-group insurance. Once the marketplace of individuals can compete fairly with employer-provided plans, they can serve as an ideal vehicle for broadening coverage to the uninsured.

2. THE SOCIAL RISKS OF GOVERNMENT-MANAGED CARE

Single-payer advocates and their allies insist that only government health insurance can solve America's problems. For example, when it comes to wellness, some claim – without evidence – that preventive care will be strengthened in a single-payer system.

In reality, preventive care has suffered in many single-payer systems because it is not urgent care. Governments in single-payer systems have tended to see 'elective' and preventative care as a safer target for rationing, in the much the same way that governments worldwide habitually underbudget for infrastructure maintenance.

For example, it's a common mantra that Canadians can choose their own family doctor in Canada's socialized health system. But as many as one-sixth of Canadians cannot find a family doctor. Canada has two-thirds as many doctors as the OECD average, with severe shortages in several areas of specialty (for example, gynaecology). When there are no doctors to choose from, the "freedom to choose" is a limited benefit. The doctor shortage is a direct result of government rationing, since provinces intervened to restrict class sizes in major Canadian medical schools in the 1990s.

To further inform Congress about the challenges of government-managed care, I cite Canadian-sourced data.

1) CIHI Reports on Provincial Wait-Times "Progress"

The Canadian Institute for Health Information (CIHI), a government-funded body, is the designated agency responsible for collecting provincial wait-times data. Their reports[*] paint a disturbing picture. Advocates for the Canadian system often cherry-pick broad averages or median wait time figures, but CIHI's most recent (2008) data gives a fuller picture of what service is like at the "back of the line." Consider just a few examples:

- In Alberta, Canada's wealthiest province, 50% of outpatients waited 41 days or more for an MRI scan. 10% of those patients waited four and a half months or longer.
- In Saskatchewan, 10% of knee replacement patients waited 616 days or more for surgery.
- In Nova Scotia, 25% of patients waited 199 days or more for cataract removal.

All of these and other figures reflect wait times after referral by a general practitioner. As noted earlier, millions of Canadians do not have access to a family doctor.

2) Canadian Wait Times Alliance: Annual Reports, 2004-2009

Canada's *Wait Times Alliance* offers a counterpoint to CIHI's reports. The Alliance consists exclusively of Canadian medical professional associations like the Canadian Medical Association. Their 2009 report, *Unfinished Business*, opens with the observation that "Canadians are used to waiting." The report[†] notes that provincial "progress" toward wait times targets often represents progress toward "minimum wait-times standards, rather than desired wait-times standards."

3) Chaoulli v. Quebec (Attorney General), 2005 SCC 35

This recent decision[‡] by the Supreme Court of Canada serves as a wake-up call to those who see the Canadian system as a utopian mix of public funding and private choice. The case centred on a patient who chose to sue for the right to use his own money to secure timely medical treatment, a right that was denied Canadians until the *Chaoulli* decision.

Writing for the majority, Justice Marie Deschamps concluded that:

"[T]he evidence in this case shows that delays in the public health care system are widespread, and that, in some serious cases, patients die as a result of waiting lists for public health care. The evidence also demonstrates that the prohibition against private health insurance and its consequence of denying people vital health care result in physical and psychological suffering that meets a threshold test of seriousness."

Chaoulli v. Quebec (Attorney-General) 2005

4) [Quebec] Task Force on the Funding of the Health System, 2008

Finally, consider the most recent report from Quebec, a comprehensive review of a government-managed system in peril. The government-appointed chair of the Task Force was M. Claude Castonguay, widely considered "the father of Quebec medicare," as he co-authored a report in the late 1960s that created Quebec's earliest single-payer model. Almost forty years later, this report[§] concluded that "there is no ideal system," called for an increase in private sector involvement and cited crippling cost inflation and poorly rationed care as major flaws in Quebec's single-payer model.

3. THE FISCAL RISKS OF GOVERNMENT-MANAGED CARE

These challenges are not unique to Canada. Around the world, the more public the system, the greater the challenge in managing it. For example, the United Kingdom recently increased the annual budget of the National Health Service (NHS) by tens of billions of pounds in an effort to bring wait times below their own targets. The effort succeeded, but only if you believe that the

NHS guarantee of care no later than 18 weeks after a referral represents timely service. Recessionary budget reductions are likely to limit further progress as the Brown government has ordered the NHS to prepare for increases below core inflation (1.6%) in fiscal year 2010-2011.

The White House is alarmed by private-sector health inflation, but it must also acknowledge the same trend in government-managed systems. Even with pharmaceutical price controls, technology rationing, and limited capital investments, almost all Canadian provinces carry substantial debts fuelled mostly by persistent health-care inflation. Ontario's health budget is projected to grow by 7% for each of the next three years. The 2008 Task Force calculated Quebec's annual health inflation rate at almost 6%. In Britain, the NHS admits to a sixty year *average* increase of 3% over inflation. Ireland's single-payer system has experienced constant price turbulence. Despite 3.5% *de*flation this May, Irish health costs still grew at an annualized rate of 4.5%.

What causes inflation in public health insurance programs? As government's role as the primary funder grows, the greater the political contradiction between demands for fiscal restraint and demand for service. The pattern is consistent across national boundaries: if governments provide the insurance, benefits come cheap and easy in the early years. When the cost of treating older citizens, serving new patients or providing new treatments climbs, policymakers face a devil's choice between rationed care or tax-funded cost inflation. Most often, they try to balance the two bad options, restraining inflation slightly below U.S. levels with ever-more painful restraints on capital investment, human resources, technology, and drug access. Waiting lists for treatment are the inevitable consequence.

4. A PUBLIC PLAN OPTION IS GOVERNMENT-MANAGED CARE

The Administration insists that support for a "public plan option" is not intended to serve as a 'Trojan horse' for a single-payer health care system. I can only reply with the time-honoured scientific observation that "if it walks like a duck, if it quacks like a duck…"

The historic reality is that even if the Administration sincerely does not want public insurance to serve as a Trojan horse for a single-payer system, the public plan option is certain to deliver exactly that result, just as more limited public insurance schemes in Canada, Britain, and other countries, came to dominate their own health sectors:

- As a government program rather than a state-regulated insurance plan, the public plan option has competitive advantages;
- If those advantages are removed, then there is no point in introducing the public plan when the proposed "Health Insurance Exchange" will increase competition anyhow;
- If the advantages are left intact, the United States will undermine its private-sector health care, as have other western countries.

The Administration believes a public option is needed to, in the President's words, "keep the insurance industry honest." If this argument is carried to its logical conclusion, the public plan must also be "honest."

Will the public plan be financed on a pay-as-you-go basis as many entitlement programs have been, or will it be properly financed to future insurance costs?

Will the public option pay market costs for capital, just as private insurers must?

Will the public plan comply with costly state mandates just as private insurers do, or will the federal government override them?

If the public plan has any built-in government advantages, it will build market share – not because it is necessarily better insurance, but because it is subsidized and legally privileged. As the plan grows in size, federal taxpayers will foot an ever-larger share of the system's increasing costs, and governments will be under ever-more pressure to ration care to contain them.

Further, if the goal of public competition is to reduce the impact of public health care costs on the U.S. Treasury, then the best policy choices are those which extend coverage and improve affordability without significant damage to the U.S. tax base. Will the public plan pay taxes to simulate the tax costs of a private insurer? If not, then every dollar attracted to the public plan is a dollar taken from the taxable private sector, reducing the economy's ability to carry the costs of public health programs in future.

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Let's be clear: American health care is in need of reform. But as any good doctor knows, it's not enough to get the diagnosis right, we need a treatment that makes sense. A massive expansion of Washington's role is not that treatment. Rather Congress should look to alternatives:

Prioritize regulatory reforms that will open up true competition between existing, fully-funded insurers.

Target direct government aid to individuals who really need it, with incentives for individuals to become a powerful competitive force in the insurance marketplace.

Promote rapid improvement in the personal health of Americans to reduce demand on the system's most costly health-care services.

These ideas would bring greater choice to American health care; they would also help instil in the system the oldest of American virtues: personal responsibility. While they may not be as catchy as promising Medicare for those who want it, these ideas have the benefit of pushing the system toward a sustainable future, not a government bureaucracy.

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[*] The latest CIHI reports on provincially-reported wait times are available at www.cihi.ca

[†] The 2009 Report is available, as are previous years' reports, at www.waittimealliance.ca

[‡] The *Chaoulli* decision is online at http://csc.lexum.umontreal.ca/en/2005/2005scc35/2005scc35.html

[§] The full report is online in English at http://www.financementsante.gouv.qc.ca/en/rapport/index.asp