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Health Care Myths

by David Hogberg & Tonya R. Barr

When health care is made to seem "free" at the point of consumption, demand for health services will rise uncontrolled unless it is restrained by something other than cost. If market forces do not allocate health-care resources, then long waiting lists, limited access to specialized care, and government-rationed supply will characterize the health-care system. These consequences, described by **John C. Goodman**, Gerald L. Musgrave, and Devon M. Herrick in *Lives at Risk: Single-Payer National Health Insurance Around the World*, are endemic in nations that have adopted a system of single-payer national health insurance.

Lives at Risk takes on many beliefs about nationalized health care, dubbing them "myths." Consider the myth that citizens in nations with national health insurance have a "right" to health care. Goodman et al. note, "There is no such right in any sense that people ordinarily understand the meaning of the term. What the right to care means almost everywhere is

nothing more than the opportunity to get services for free." Patients only have a right to the services that the government says they can have. In Canada, for example, if you can't convince the authorities that you need an MRI scan, you are out of luck unless you can pay for it in another country. "In fact, in the 1980s some Canadian hospitals advertised in America in search of paying customers to help out with their cash-strapped budgets," according to Goodman et al. "Yet, it was illegal for Canadian citizens to pay for the same services." Until the practice was discontinued, "one could maintain that Americans had more rights in the Canadian health care system than Canadians did."

Or consider another myth, that all people in countries with national health insurance have equal access to care. The evidence simply doesn't support it. In 1980 the "Black Report" examined Britain's system of care and found that access to care had not become more equal since the National Health Service was established in the 1940s. A similar report about

two decades later found that access to care had become more unequal since the Black Report. Canada has fared no better; numerous studies from the University of British Columbia show that access to care varies widely across region. Not surprisingly, the proximity of one's residence to an affluent city is one of the best indicators of access to doctors of any sort, but especially to specialists. Hospitals are more likely to have more staff per hospital bed and patients are more likely to survive treatment if they are located in an affluent region. Worse, those few who are seriously ill do not receive adequate funding, as the majority of funds go to the relatively healthy many who seek cheaper procedures. To quote Goodman et al., "Foreign governments do not merely deny lifesaving medical technology to patients under national insurance schemes. They also take money that could be spent saving lives and curing disease and spend it serving people who are not seriously ill. Often the spending has little if anything to do with health care."

Goodman et al.'s analysis falls flat, however, when the authors try to design an ideal health system. While some of their ideas would lead to greater individual liberty, others continue government's meddling role. For example, they note that the current tax code's treatment of health insurance means that people who do not have insurance pay a "tax penalty." They argue that taxes the uninsured pay should go to government agencies to reimburse health care costs for the uninsured. When an uninsured person decides to purchase insurance, what the

government spends should be reduced by the amount the government spends per-capita. This may seem sensible in theory, but this nation's experience with Medicaid shows that government is unwilling to reduce spending, regardless of actual need. If anything, it demonstrates that state governments love to keep the Medicaid money rolling in because they find surreptitious ways to spend it on other priorities. Indeed, Goodman et al.'s desire to see a seamless transfer of tax money to government health insurance will always be weighed down

by meddling of politicians, bureaucrats, and interest groups.

Despite that shortcoming, *Lives at Risk* is a book that should be on every conservative's bookshelf. It provides abundant intellectual ammunition to use against those agitating for national health insurance, and does so in a lively, engaging style. As the cost of health insurance continues to rise, and the likes of the New York Times op-ed page uses it to advanced socialized medicine, *Lives at Risk* couldn't be timelier.

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