OPINION | COMMENTARY

The False Promise of 'Medicare for All'

Cost is only part of the problem. Single-payer systems create long waits and delays on new drugs.

By Scott W. Atlas
Nov. 12, 2018 6:48 p.m. ET

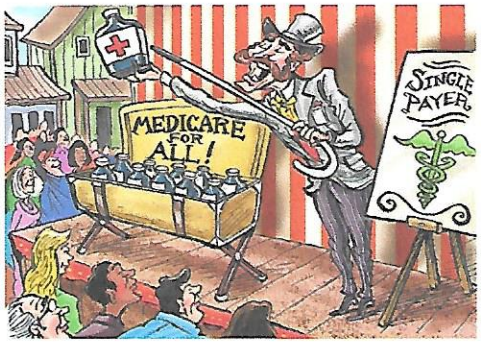

ILLUSTRATION: CHAD CROWE

Health care was a priority for midterm voters, and for good reason. In nearly five years since ObamaCare's major provisions came into effect, insurance premiums have doubled for individuals and risen 140% for families, even while deductibles have increased substantially. Hospitals and doctors continue to flee ObamaCare's coverage network, to the point that almost 75% of plans are now highly restrictive. ObamaCare also encouraged a record pace of consolidation among hospitals and physician practices. All these developments will raise health-care prices, as fewer hospitals compete for payers.

The Democrats' solution would make the problem far worse. Single-payer health care is an alluringly simple concept: a government guarantee for all medical care. Advocates insist that such care is "free." The constitution of Britain's National Health Service states: "You have the right to receive NHS services free of charge"—ignoring that the U.K. funds the program by taxing citizens some $160 billion a year, even with its severe limits on access to specialists, drugs and technology.

For California alone, single-payer health care would cost about $400 billion a year—more than twice the state's annual budget. Nationwide "Medicare for all" would cost more than $32 trillion over its first decade. Doubling federal income and corporate taxes wouldn't be enough to pay for it. No doubt, that cost would be used to justify further restrictions on health-care access.

But the problems with single-payer go well beyond cost. In the past half-century, nationalized programs have consistently failed to provide timely, high-quality medical care compared with the U.S. system. That failure has countless consequences for citizens: pain, suffering and death, permanent disability, and forgone wages.

Single-payer programs usually impose long waiting lists and delays unheard of in the U.S. Last year, a record 4.2 million patients were on England's NHS waiting lists; 362,600 patients waited longer than four months for hospital treatment as of that March, and 95,252 waited longer than six months. By this July, 4,300 people had been on the wait list more than a year—all after receiving their diagnosis and referral—according to NHS England's "Referral to Treatment" waiting-times data.

In Canada last year, the median wait time between seeing a general practitioner and following up with a specialist was 10.2 weeks, while the wait between seeing a doctor and beginning treatment was about five months. According to a Fraser Institute study, the average Canadian waits three months to see an ophthalmologist, four months for an orthopedist and five months for a neurosurgeon.

In single-payer systems, even patients referred for "urgent treatment" often wait months. More than 19% of patients in Britain's NHS wait two months or longer to begin their first urgent cancer treatment, while 17% wait more than four months for brain surgery. In Canada the median wait for neurosurgery after seeing a doctor is about eight months. Canadians with heart disease wait three months for their first treatment. And if you need life-changing orthopedic surgery in Canada, like a hip or knee replacement, you'll likely have to wait a startling 10 months.

America's system is much quicker. Aside from transplants, one paper by the Organization for Economic Cooperation and Development states, "waiting lists are not a feature in the United States."

A study in Health Affairs found that "in contrast to England, most United States patients face little or no wait for elective cardiac care." The Agency for Healthcare Research and Quality has said that low-risk U.S. heart patients "sometimes have to wait all day or even be rescheduled for another day" for catheterization—that is, a wait for even one day is considered unusual.

Calls for reform were widespread in American media in 2009, though waits for appointments at that time averaged 21 days for five common specialties. With the exception of orthopedist appointments for knee pain, those waits were for healthy checkups, the lowest medical priority. In the U.S. even waits for checkups are usually far shorter than waits for seriously ill patients in countries with single payer.

Single-payer systems also impose long delays before debuting the newest drugs for cancer and other serious diseases. A 2011 Health Affairs study showed that the Food and Drug Administration approved 32 new cancer drugs in the decade after 2000, while the European Medicines Agency approved 26. All 23 drugs approved by both Europe and the U.S. were available to American patients first. Two-thirds of the 45 "novel" drugs in 2015 were approved in the U.S. before any other country.

These waits and restrictions have severe consequences for patients. Single-payer systems have proved inferior to the U.S. in outcomes for almost all serious diseases, including cancer, diabetes, high blood pressure, stroke and heart disease.

Meanwhile, the nations most experienced with single-payer systems are moving toward private provision. Sweden has increased its spending on private care for the elderly by 50% in the past decade, abolished its government's monopoly over pharmacies, and made other reforms. Last year alone, the British government spent more than $1 billion on care from private and other non-NHS providers, according to the Financial Times. Patients using single-payer care in Denmark can now choose a private hospital or a hospital outside the country if their wait time exceeds one month.

A single-payer "guarantee" is no promise of access to quality medical care. If brought to the U.S., the only reliable promises of single-payer would be worse health care for Americans and higher taxes. America's poor and middle class would suffer the most from a turn to single-payer, because only they would be unable to circumvent the system.

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Appeared in the November 13, 2018, print edition.