

Testimony to the U.S. Committee on Energy and Commerce, Subcommittee on Health

By Sally C. Pipes, President & CEO, Pacific Research Institute, Tuesday, March 17, 2009

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I would like to thank the members of the Subcommittee for inviting me to testify on “Making Health Care Work for American Families: Ensuring Affordable Coverage”.

I think that everyone would agree that the goal for all Americans is affordable, accessible, quality health care.

The question is: how do we achieve that goal?

There are two competing visions when it comes to health care reform and achieving universal coverage.

One focuses on patient-centered solutions: empowering doctors and patients and encouraging innovation for new pharmaceuticals, biologics, and medical devices.

The other vision is increasing the role of government in our health care system through higher taxes, mandates, and subsidies.

This vision of a greater role for government is on the rise. In America today, government controls 47% of health care through Medicaid, Medicare, S-CHIP, and the VA system.

The long-term goal of the new Administration and the Democrats in Congress is “Medicaid for All.”

The U.S. spends about 16% of GDP on health care (\$2.3 trillion) and it is considered too high. Politicians say we need to get that percentage down if we are going to achieve universal coverage and reduce the number of uninsured from the 46 million Americans without health insurance.

Canada, my country of birth and where I spent a major part of my career as an economist, spends about 10% of its GDP on health care and has universal coverage. If Canada has universal coverage and only spends 10%, why can't we duplicate their model?

The Canadian government took over the health care system in 1974 and banned any private health care for procedures provided under the Canada Health Act. The government mandates that the share of spending on health care not exceed 10%.

Of course, the demand for health care is much greater and as a result, Canadians suffer long waiting lists, rationed care, and a lack of access to the latest technology.

I would like to provide some statistics that are not generally known to most Americans:

750,000 Canadians are waiting for procedures.

3.2 million out of a population of 32 million are waiting to get a primary care doctor.

Average wait from seeing a primary care doctor to getting treatment by a specialist in 2008 was 17.3 weeks.

Canada ranks 14th out of 25 OECD countries in MRI machines and 19th out of 26 countries in CT scanners.

When the government is the monopoly provider of health care, people wait and wait. When they get tired of waiting, or are too sick to wait further, they flee—if they can—to the United States for treatment.

Examples: Lindsey McCreith from Ontario had brain surgery in the U.S., former Canadian MP Belinda Stronach who had her breast cancer treated in LA, the Calgary quadruplets delivered in Great Falls, MT because no neo-natal units in Canada were available.

Dr. Brian Day, orthopaedic surgeon who is the immediate past president of the Canadian Medical Association and who runs the illegal Cambie Clinic in Vancouver told the New York Times, “Canada is a country where dogs can get a hip replacement in less than a week and where humans have to wait two to three years.”

In June 2005, the Canadian Supreme Court ruled on a case from Quebec: “the ban on private health care and private insurance is illegal because of the long wait times.”

Madame Chief Justice Beverly McLachlin said, “access to a waiting list is not access to health care.” Madame Justice Marie DesChamps reported, “the idea of a single payer system without waiting lists is an oxymoron.”

Canada is opening up its government-run health care system to private alternatives while the U.S. is moving, under the current Administration, to a system where government has more control in order to provide universal coverage at affordable prices.

President Obama has said that employers would have to provide coverage or pay a payroll tax so employees can get coverage in a new government-run insurance program that would be part of a newly-created National Insurance Exchange.

The National Insurance Exchange would also include private insurance companies in addition to the government insurance plan.

The government insurance and private plans would have to include guaranteed issue, community rating, and many mandates.

My view is that the government plan will be priced lower than the private plans. The result will be “crowding out” of the private plans and a fateful turn down the road to a Canadian style “Medicaid for All” program. We may have universal coverage but not universal access. Taxes will increase significantly and weaken the entrepreneurial spirit in this country.

Many Canadians and others from around the world come to the U.S. and pay out of pocket for the best health care procedures and treatments.

When we get totally socialized health care, where will “we” go?

If we could change the tax code to level the playing field by removing the tax advantage from those who get their insurance through their employer, reduce state mandates that add between 20-50% to the cost of a premium, allow the purchase of insurance across state lines, and have medical malpractice reform, we could reduce costs and significantly reduce the number of uninsured in this country.

Universal “choice” will lead to universal coverage for all Americans. And, we will have affordable, accessible, quality health care for all.

As P.J. O’Rourke says, “if you think health care is expensive now, just wait until it is free.”

Thank you for the opportunity to provide my perspective on health care reform in America.