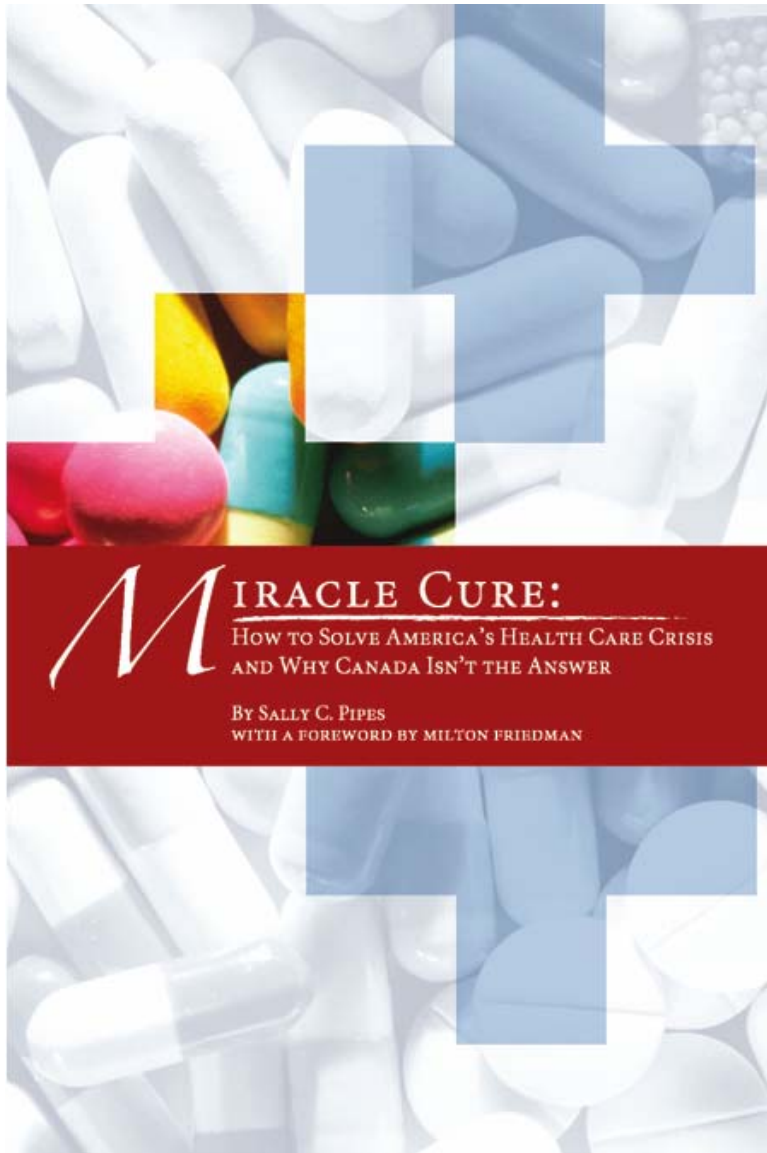


**MIRACLE CURE:
How To Solve America's Health Care Crisis
And Why Canada Isn't The Answer**



MIRACLE CURE: HOW TO SOLVE AMERICA'S HEALTH-CARE CRISIS AND WHY CANADA ISN'T THE ANSWER

by Sally C. Pipes
with a foreword by Milton Friedman

Miracle Cure explains why our health-care system is broken and how it can be fixed. The key solutions are to give consumers greater control over health-care spending and decisions, and to avoid the Canadian example of a government-run system.

Problems with the U.S. and Canadian Systems

- The U.S. and Canada suffer from excessive government regulation, causing both countries to sacrifice quality in their health care.
- In the U.S., one of the main reasons there are nearly 45 million uninsured Americans is because health insurance is linked with employment. The number of people covered by job-based insurance increases during economic booms but declines during periods of recession. This will only become a bigger problem as health-care premiums rise.
- In Canada, 30 years of government intervention have left the system plagued by long waiting times for critical procedures, lack of access to current technology, and a brain drain of doctors.
- In both countries, these problems originate from ill-conceived government intervention in the marketplace.

Solutions for both Countries

- In the U.S., the public needs to switch from employer-based health care to market-driven options such as Health Savings Accounts (HSAs), tax credits, and Association Health Plans.
- In Canada, the public needs to be weaned off a system in which there is no competition or innovation.

For each country, there are other solutions that need to be adopted. The following outlines just a few of the innovations that would improve health-care delivery in both countries.

Solutions for the U.S.

- Extend to individuals the preferential tax treatment that was given to employers as a concession at the end of World War II when wage and price controls were in effect. Individuals should be given the opportunity to purchase health care with pre-tax dollars regardless of whether they have a job or not. Such a legislative change would break down the third-party payment system and reform the way health-care costs are paid. Health insurance would be returned to its proper role of providing coverage for catastrophic events. Individuals could join all manner of voluntary groups, seeking the best deal and the health-care plan that is right for them.
- Move from low-deductible managed care - the dominant system of insurance in the U.S. – to a system of consumer-directed plans such as HSAs, defined contribution plans in which individuals are empowered to make the most important decisions affecting their health.
- Abolish state regulation and mandates that needlessly complicate health-care policy and make it more expensive. By opening up the market, insurance companies should be able to offer and consumers should be able to purchase insurance on a nationwide basis.
- Reform medical malpractice insurance and a system that currently encourages lawsuit abuse.
- Restructure Medicare into a menu of choices among privately run, competitive insurance programs similar to those enjoyed by federal employees.

Solutions for Canada

- Make provincial insurance plans - and the taxes that fund them - voluntary.
- Open government plans to direct competition from private, non-profit, and for-profit insurers.
- Allow doctors to charge whatever they like for their services and to organize their practices in any way they choose.
- Permit private companies to build and operate the necessary capital-intensive facilities that Canada currently lacks and to do so at a profit.

Support for “Miracle Cure”

“In this excellent book, Sally Pipes explains that the United States and Canada both display symptoms of the same disease—excessive reliance on third-party payment. She examines how they got into this fix and what they can and should do about it. I believe that you will find her analysis informative and lucid, and her recommendations attractive.”

Milton Friedman
Nobel laureate

“This is a brilliant and timely masterpiece that not only incisively dissects the increasing life-threatening ills of our health-care system but also gives us the right prescriptions to save it – and us.”

Steve Forbes
President and CEO, Editor-in-Chief
Forbes

“Ms. Pipes uncovers the years of mismanagement, inaccurate projections, and waste that abound in both the Canadian and U.S. health-care systems. Her solution is a consumer-driven approach that is innovative and compelling.”

Chris Ward
Former Ontario Cabinet Minister, and
President, Ward Health Strategies, Inc.

“Sally Pipes deftly and authoritatively skewers the government-controlled Canadian system for its cruel rationing of care. No booster of the U.S. system either, she tackles such problems as the uninsured, rising costs, and government’s ever-larger role in health care. With engaging style and clarity, she offers a consumer-driven policy prescription that could best cure these ills.”

Regina Herzlinger
Author, *Consumer-Driven Health Care* (2004) and Nancy McPherson Professor of Business Administration, Harvard Business School

“Miracle Cure asks the right questions at the right time about health care in America, while it also demonstrates that government-run health care à la Canada provides no answers to our woes.”

Chip Kahn
President, Federation of American Hospitals

“Miracle Cure offers a thoughtful prescription of sanity, savvy, practicality, and hope. In a time of hyperbole, Sally Pipes provides a well-argued, measured case for a classic American marketplace-based solution. Not bad for a Canadian.”

Peter Pitts
Former Associate Commissioner, U.S. Food and Drug Administration (FDA), and
Senior Vice President of Health Affairs, Manning Selvage & Lee

Sally C. Pipes

Sally C. Pipes is president and chief executive officer of the Pacific Research Institute, a San Francisco-based think tank founded in 1979. Prior to becoming president in 1991, she was assistant director of the Fraser Institute, based in Vancouver, Canada.

Ms. Pipes addresses national and international audiences on health care, women's issues, education, privatization, civil rights, and the economy. She has been interviewed on CNNfn, "20/20," "The Today Show," "Dateline," "Politically Incorrect," "The Dennis Miller Show," "Beyond the Beltway," "The Week in Review," and other prominent programs.

She has written regular columns for *Chief Executive*, *Investor's Business Daily*, and the *San Francisco Examiner*. Her opinion pieces and letters to the editor have appeared in *The Washington Post*, *New York Times*, *Financial Times of London*, *Los Angeles Times*, *San Francisco Examiner*, *San Francisco Chronicle*, *Sacramento Bee*, and *Orange County Register*. She also co-authored with Spencer Star *Income and Taxation in Canada* and co-authored with Michael Walker seven editions of *Tax Facts*.

A Canadian residing in the U.S., Ms. Pipes writes, speaks, and gives invited testimony at the national and state levels on key health-care issues facing America. Topics have included the false promise of a single-payer system as exists in Canada, pharmaceutical pricing, solving the problem of the uninsured, and strategies for consumer-driven health care. Over the past year, she has participated in prominent debates and public forums, testified before five committees in the California Legislature, appeared on popular television programs, participated in talk radio shows nationwide, and written several dozen opinion pieces on the issue of drug importation.

Ms. Pipes has held a variety of positions in both the private and public sectors. In British Columbia, the Ministry of Consumer and Corporate Affairs appointed her director and vice-chairman of the Financial Institutions Commission. She also served on the Vancouver City Planning Commission.

Ms. Pipes serves on the board of the Independent Women's Forum, the national advisory board of Capital Research Center, the board of advisors of the San Francisco Lawyers Chapter of the Federalist Society, and the State Policy Network President's Advisory Council. She has served as a trustee of St. Luke's Hospital Foundation in San Francisco, as a commissioner on California's Commission on Transportation Investment (CTI), and as a governor of the Donner Canadian Foundation. She was a member of California Gov. Arnold Schwarzenegger's transition team in 2003.

Ms. Pipes is a member of the Mont Pelerin Society, National Association of Business Economists, and the Philadelphia Society. While in Canada, she was a member of the Canadian Association for Business Economics (president for two terms) and the Association of Professional Economists of B.C.

Top 10 Myths of the U.S. & Canadian Health Care

MYTH:

In the U.S., uninsured individuals have no access to health care.

FACT:

Not having medical insurance does not bar access to health care in the U.S. Uninsured Americans will consume an estimated \$125 billion in health services in 2004, according to the latest research. Of this, \$41 billion will be provided free of charge at hospitals, doctors' offices, and clinics, some of whom are obligated to provide free care.

The price of prescription medications is a problem.

Pharmaceuticals are comparatively inexpensive. Americans as a whole spend 1 percent of their income on drugs, according to the Bureau of Labor Statistics. Seniors over age 65 spend 3 percent of their income on drugs, less than the amount they spend on entertainment. Americans spend less on prescription drugs than they do on alcohol, tobacco, and admission fees to concerts, movies, and sporting events.

Prescriptions are driving health-care spending upward.

Spending on drugs as a share of total health spending is not significantly above historical levels. In 1960, Americans spent 10 percent of their health-care dollars on pharmaceuticals, roughly the same portion they spend today. Pharmaceutical spending actually lowers total health-care spending by replacing more expensive - and invasive - procedures. In a year-long disease management program, Humana Hospitals studied 1,100 congestive heart patients. While pharmacy costs increased by 60 percent, medications reduced hospital costs by 78 percent, resulting in net savings of \$9.3 million.

The U.S. is a free-market system.

The government has been the largest single player in the U.S. health-care marketplace since the 1960s. Today, the government directly pays for 45 percent of health-care spending. Additional interventions include tax subsidies, the imposed costs of regulations on private insurers, and the use of taxpayer funds to provide health insurance to federal government workers under the Federal Employees Health Benefits Program (FEHBP). Overall, U.S. health care is more socialist than not.

Canadian Medicare provides all necessary care.

Canadians face significant waits for even the most basic care. Consider the case of 58-year-old Don Cernivz, who noticed blood in his urine. It took him three weeks to get his first test, another month for an MRI, and treatment for his cancer didn't begin until nearly six months later. Perhaps this is why fewer than half of those polled by the Canadian Medical Association said they thought the health-care system would deliver the same level of quality to the next generation. In fact, they had more confidence in the sustainability of Canada's sewer system than in its health-care system.

Health care in Canada is free.

Nothing of value is free. Canadians pay dearly for health services in Canada, just not at the time of eventual delivery. Canadian physician Dr. David Gratzer figures that government-provided Medicare costs working Canadians \$.21 for every \$1 earned. Gratzer writes, "This means that Canadians earning \$35,000 a year pay \$7,350 for Medicare."

U.S. Medicare is administratively efficient.

A study by the consulting firm PricewaterhouseCoopers found that for every hour hospital physicians devote to caring for a Medicare patient, hospital administrators spend 30 minutes dealing with Medicare paperwork. The ration of time on patients to time on paperwork jumps to 1 to 1 for emergency room care. To claim that Medicare is administratively efficient while ignoring the costs it imposes on private parties is similar to calculating the costs of the tax system while ignoring the time spent complying with the system.

Global budgets control costs.

Global budgets merely limit the money that governments must spend in any given year. In so doing, they ration care and shift non-monetary costs in the form of pain and suffering, lost wages for employees, and lost productivity for employers onto others.

Canada has a single-tier system.

Where one receives treatment and how quickly varies in Canada based on a number of factors, including wealth and political connections. "Canada has a multi-tiered system," writes Keith Martin, a medical doctor and member of Parliament. "If you get sick at work, are rich, connected, a prisoner, over the age of 65, or aboriginal, you get different care than the average person on the street."

More money will solve the problems with the Canadian health-care system.

The Canadian system is not underfunded. The nearly 10 percent of GDP Canada devotes to health care is exceeded only by Germany, Switzerland, and the U.S. The system's rationing, queuing, and lack of technology stem from the incentives of a government controlled single-payer system in which patients and procedures represent only centers of costs to be limited rather than centers of revenue to be served.

U.S. Health Care: Problems and Solutions

Problems with the U.S. Health-Care System

The Uninsured. Roughly 15 percent of Americans, 45 million in 2003, lack health insurance. Some of these individuals will be uninsured only for a few months while in between jobs.

Many others work for small companies that are unable to offer group health insurance. They earn too much for Medicaid, but they either cannot afford to purchase private insurance or do not believe that such a purchase is in their economic interest. This applies to approximately 40 percent of young adults ages 19-34.

Although uninsured Americans purchase less health care than those with insurance, they do not go without health care. In 2004, the uninsured used \$125 billion in health care, \$41 billion of which was provided to them for free.

Third-Party Intervention. The once sacrosanct doctor-patient relationship has been seriously undermined by recent developments in the health-care system.

Whether by a Medicare bureaucrat determining how much rehabilitation a stroke victim can receive or a managed-care bureaucrat determining which specialist is on a preferred list, doctors and patients all too often find that they must ask permission from some gatekeeper before they can proceed with treatment.

In addition, the paperwork and administrative burden diverts energy and resources that could be better used to serve patients.

Health “Insurance”. HMOs exist to offer insurance and to coordinate and deliver health care at an affordable price. HMOs, in essence, control costs and access. To add to the dilemma, people must purchase the insurance in advance, which gives individuals the incentive to use it even if they do not require any services.

“[Medical insurance] contains a built-in contradiction,” writes District of Columbia Insurance Commissioner Lawrence Mirel. “The insurance system works best when the fewest people use it (i.e. make claims); the health-care system works best when the most people use it (i.e. get checkups, tests, and vaccinations). The goals are incompatible.”

Medicare. The U.S. Medicare program is outdated, expensive, and bureaucratically brutal on doctors. Its antiquated benefits structure prompted one financial planner to quip “It’s the worst health coverage that money can’t even buy.”

Taxpayers spend \$154 billion annually on the program yet Medicare recipients face significant co-payments if seriously ill *and* they are not covered if they remain in the hospital for more than 150 days. It’s only now starting to cover outpatient prescription drugs.

Doctors find it difficult to comply with some 110,000 pages of regulations on what is and is not covered by Medicare. To top it off, Medicare is set to go broke in 2019.

High Litigation Costs. The U.S. litigation system is costing patients dearly. Medical malpractice costs have increased at 11.9 percent a year, compounded, since 1975.

In 2002, malpractice costs totaled \$25 billion, or \$250 per U.S. household. That's more than half of what the average household spent on prescription drugs.

These costs are passed on to consumers. In some extreme cases, hospitals have quit delivering babies.

Prescription Drug Prices. Prescription drugs play a larger role in health care than ever before, with hundreds of treatments for deadly diseases such as AIDS, heart disease, cancer, and arthritis. Although spending on pharmaceuticals has increased, it is not out of control on a national level, at just 10 percent of total spending.

Nor is it a problem for the average American, who spends more money each year at entertainment events. It is a burden for a small number of Americans without insurance who rely on expensive medications.

Solutions to the U.S. Health-Care Problems

Increase the Role of Private Markets. Making individual purchases of health insurance, tax deductible will lower premiums. This tax incentive, combined with newly available Health Savings Accounts (HSAs), will make health insurance a more attractive purchase. To date, 43 percent of HSAs are purchased by the formerly uninsured.

Association Health Plans, which allow non-employment-based groups to purchase group policies, will make insurance more affordable, extending lower rates to more people.

Both of these reforms will allow people to keep their insurance when they change jobs.

Keeping it Simple. Doctors and patients are returning to an older model of medicine: smaller practices with fee-paying patients. Doctors are opening "boutique" or "concierge" practices in which they limit the number of patients and charge flat annual fees in addition to payment for actual treatment for 24/7 access to care.

Doctors participating in the SimpleCare network agree to offer the "best price" for their services and patients pay fees at the time of service. Patients also pay an annual membership fee of \$20 a person or \$35 a family to enroll. They are encouraged to purchase high-deductible insurance for true medical emergencies.

Restoring the True Purpose of Insurance. A return to high-deductible, catastrophic insurance policies would put the "insurance" back into health insurance.

This is exactly what HSAs for individuals and Health Reimbursement Account plans for employer-based coverage promise to do.

By coupling a catastrophic insurance policy with a tax-free savings account to cover the deductible, consumers will have an incentive to pay attention to the prices they pay for medical services. Perhaps more important, they will have a greater range of choice.

Let Competition Begin. Medicare's benefits structure and delivery arrangements must be modernized. Fortunately, a model exists right in our nation's capitol – the Federal Employees Health Benefit Program (FEHBP), which offers a menu of health-insurance choices to federal employees.

Under a FEHBP-style Medicare program, private health insurers would design packages to compete for the business of seniors. The government would set minimum standards and establish a base level of premium support.

Consumer demands in the marketplace, not bureaucratic edicts, would determine the benefits packages. Under this system, seniors would not have waited more than 40 years for a prescription drug benefit.

Tort Reform. Policymakers must put an end to the lawsuit lottery. Sensible reforms include capping non-economic damage awards, informing juries if patients have access to other sources of money for their injuries, allowing defendants to pay large awards in periodic payments, moving to a system of binding arbitration, and placing reasonable limits on attorneys' fees.

The department of Health and Human Services estimates the right policy changes could reduce total health-care costs by up to 9 percent. This would translate into a savings of \$60 to \$108 billion and could make health insurance affordable for up to 4.3 million more Americans.

Drug Discount Programs. Widespread, government facilitated importation of drugs from Canada won't lower prices in the U.S. for the simple reason that the entire Canadian drug market could be consumed in one U.S. state.

Pharmaceuticals are expensive to develop. Unless they can be priced competitively, we won't enjoy the next generation of innovative drugs. It's unfair for the U.S. consumer to bear the burden of R&D for other wealthy nations. Trade negotiators should encourage other advanced countries to loosen their price controls.

Low-income and uninsured Americans should take advantage of the numerous discount programs pharmaceutical companies offer, ranging from a free month's prescription to a 25-percent discount, depending on income.

Canadian Health Care: Problems and Solutions

Problems Plaguing Canada's Health-care System

Government Dominance. In Canada, federal and provincial governments dominate the health-care system. Governments set the budgets for hospitals and then provide the funding. They determine the fee schedule for physicians and determine how much they can earn annually. They determine which drugs will be available and then set the initial prices at which they can be sold.

Canadian governments brook no competition. Amazingly, Canada joins Cuba and North Korea as countries where it is a crime to provide and accept private payment for health-care services ostensibly provided by the government. The government's monopoly on the health-care delivery system drives each of the following problems that plague it.

Rationing: Everybody Waits. "Everything is free, but nothing is available." This certainly summarizes the Canadian health-care system, where it is increasingly difficult for Canadians to see even a general practitioner. A 32-year-old man was recently told he would have to wait five years for a routine checkup at his wife's doctor's office.

To keep the money from running out, the government must strictly ration the number of procedures provided. According to the Vancouver-based Fraser Institute, between 1993 and 2003, the median waiting time for referral by a general practitioner to treatment by a specialist increased 90 percent, from 9.3 weeks to 17.7 weeks.

In some cases, the rationing appears absurd. In December 2001, bureaucrats in Queens Park instructed the Queensway-Carleton Hospital in Ottawa to ration babies. The facility was set to deliver 2,700 babies, but that's expensive in a system in which deliveries are "free." So the hospital set a quota at 2,100 newborns. "They figured they'd save \$600,000," says Dr. Paul Legault, the hospital's chief of obstetrics, who fought the quota and got it raised to 2,500.

Retro Medicine. "Canada has some of the best medicine the 1970s can provide," quipped one Canadian doctor. This highlights a critical issue in the government-dominated health-care system – it limits innovation and slows the adoption of cutting edge technology. Canada ranks 16th among 25 OECD nations in the availability of MRIs and 20th in CT scans. And, the equipment it does have in service often suffers from a lack of repairs.

"Our radiology equipment is in bad shape," says the CEO of the Canadian Association of Radiologists Normand Laberge. "Without immediate action, radiologists will no longer be able to guarantee the reliability and quality of examinations." That may already be the case, at least in instances where Positron Emission Tomography machines, or PET scanners, are needed. Although widely used in the United States, the Canadian government has decided that the expensive machines are experimental and has severely restricted their use.

Brain Drain. Canada faces a shortage of doctors and nurses, in part, because so many move south to practice in the U.S. “The number one problem facing Canadians is the lack of doctors, nurses, and techologists,” says Canadian Medical Association (CMA) President Dr. Sunil Patel.

According to the CMA, Canada is losing as many as 250 physicians a year to the United States. Some doctors surely move for the money. Others, however, move simply for the chance to have access to the tools necessary to practice their profession at the highest level.

Solutions to Canada’s Health-care Problems

Legalize competition. Nothing spurs creativity, creates opportunity, or solves problems like open competition. Canadians need to be free to build, operate, and pay to use private health-care facilities, including outpatient surgery centers. This would provide greater access to treatment, prevent trips to the United States for care, and relieve pressure from the public system. Canadians should also be free to purchase private health insurance.

Make provincial health insurance voluntary. Legalizing private insurance is the first step. Allowing Canadians to reject their government insurance in favor of private coverage is the next step. Faced with the possibility that its citizens might take their business elsewhere, this would spur the public system to improve its product and become more consumer focused. Nothing improved the U.S. Postal Service as much as competition from Federal Express did.

Put the “insurance” back into health insurance. “(Medical insurance) contains a built-in contradiction,” writes Lawrence Mirel, the insurance commissioner for the District of Columbia. “The insurance system works best when the fewest people use it (i.e. make claims); the health-care system works best when the most people use it (i.e. get checkups, tests, and vaccinations). The goals are incompatible.”

This universal truth applies to Canada as well as the United States. There is no reason that trip to the doctor, however necessary, should be free anymore than a trip to the grocery store to acquire food should be free. Insurance exists to allow individuals to transfer risk to third parties that would be catastrophic to the individual should they occur. To ensure freedom, protect the doctor-patient relationship, and free up access to health-care providers, insurance for the average person should not cover routine health-care procedures. Making high-deductible Health Savings Accounts (HSAs) an option available to Canadians is a critical first step in addressing the issue.

Dismantle physicians’ price and practice controls. The only way to stop the brain drain is to ensure that individuals in the health-care field feel properly compensated for their work and can structure their business in the matter of their choosing.