Socialized Medicine: An Analysis of Bureaucratic Inefficiency

John J. Moran

Follow this and additional works at: http://elibrary.law.psu.edu/psilr
Part of the Health Law and Policy Commons, and the International Law Commons

Recommended Citation
Available at: http://elibrary.law.psu.edu/psilr/vol8/iss1/6
Socialized Medicine: An Analysis of Bureaucratic Inefficiency

I. Introduction

Health is undoubtedly a precious commodity. The extraordinary advances in medical technology of this century have created the emergence of a new "health consciousness," and with it increased expectations of health consumers. As a result, in order to protect and promote health, legislation has attempted to create a proper balance between the public interest and individual rights. The World Health Organization (WHO) recognized access to health as one of the fundamental rights possessed by every human being. In 1977, WHO proclaimed "[t]he main goal of [health legislation] in the coming decades should be the attainment of all citizens of the world, by the year 2000, of a level of health that will permit them to lead a socially and economically productive life."

This Comment focuses on a form of health legislation which attempts to meet these goals. In analyzing the health care systems of Great Britain and Canada, this Comment examines the policies and reasons behind the passing of legislation which led to the advent of socialized medicine in these two nations. In addition, a discussion of the operation of these socialized health systems illustrates the turmoil and complexity associated with government medicine, and the need for subsequent legislative reforms. As this Comment reveals, these socialized systems, where overriding political objectives create further misallocation of resources and decreased quality of care, fail to provide a viable solution to American health concerns. Instead,


3. Id.

4. In 1948, the United Nations created the World Health Organization (WHO), an international agency which specializes in health and deals with health issues on a global scale. The goal of the Organization is to lead the world toward a strong, new international health movement by way of a common health policy based on health care for all. See id. at 441-44. For a critical view of the policies of WHO, see LINDSAY, supra note 1, at 53. Here, the author states that of the studies conducted by WHO, which may serve as the bases of the Organization's policies, "should be taken with a pinch of salt," since the figures for these studies are supplied by the respective governments involved. Id.

5. CONSTITUTION OF THE WORLD HEALTH ORGANIZATION.

reforms should be undertaken within the present market system, a structure that remains flexible to change and promotes innovation.

II. Status of American Health Care

American medicine is in a state of unrest. In recent years, health care has progressed to the forefront of American concerns as medical costs continually soar and inequities in the accessibility of care multiply. 1. "Though it remains the most widely respected of professions, though it has never been more technically powerful, it is in trouble both from without and from within." 2 As a result of these increasing problems, health care has vaulted onto the political playing field. 3 Each year, political pressure on the United States government intensifies, urging for some form of universal and comprehensive government intervention into the health care market. 4 Would a socialized system, under the financial and decision-making control of government alone, be cohesive and effective in the framework of the American health care establishment?

In order to effectively assess the validity of such a proposal, it seems logical to analyze the experiences and lessons of countries already utilizing such socialized programs. 5 Throughout the world, health care is provided through the use of "varying combinations of government financing and control." 6 Yet for the most part, the relative youth of many of these systems renders an analysis of their performance most difficult and speculative at best. 7

The British system, however, provides an established model of centralized financing of health care for such an analysis. 8 Buttressed on the foundation of collective responsibility by the state to provide comprehensive medical care, 9 available on the basis of equal access

7. C. LINDSAY, supra note 1, at 11.
8. Id.
9. Id.
10. Id. at 12. "A right to health care is frequently claimed and embraced by politicians." Id.
12. NATIONAL HEALTH ISSUES, supra note 11, at 1.
13. C. LINDSAY, supra note 1, at 52; NATIONAL HEALTH ISSUES, supra note 11, at 1. "Most countries in the world today, including the United States, intervene and subsidize medical care to a larger or smaller degree." Id. The United States, for example, finances Medicaid (which provides health services for the poor and mentally indigent) and Medicare (which provides health services for the elderly). In addition, Massachusetts has instituted a government-financed health care system known as the Department of Medical Society (DMS). See the Health Security Act of 1988.
14. NATIONAL HEALTH ISSUES, supra note 11, at 1. Lindsay, as well as acknowledging the youth of such systems, points out that many of these new systems are still evolving, therefore rendering a determination of their respective effectiveness somewhat premature. Id.
15. C. LINDSAY, supra note 1, at 53.
16. J. ALLSOP, HEALTH POLICY AND THE NATIONAL HEALTH SERVICE 11 (1984) [here-
to all,17 the British system, initiated in 1948,18 exemplifies central-
ized medicine "approaching a state of long-run, full adjust-
equilibrium."19 In addition, Canada, sharing many of the same cul-
ture and values of the United States, provides another useful study
as a nation adopting elements of a national health insurance.20 Al-
though the advent of this system has been relatively recent, Canada’s
experiences can be educational to an American health care system
under fire.

III. Great Britain

The birth of the National Health Service21 in Britain evolved as
a result of a "broad consensus of public and political opinion in favor
of the establishment of a national health care system, free at the
point of service."22 With the public yearning for the organization of
medicine, three essential ideas emerged from this social uprising
which provided a foundation for the adoption of the National Health
Service:

(1) access to medical care should depend on need as op-
posed to means;
(2) the organization of resources in the health care arena is
achieved within a government framework where it can be explic-
itly "planned;" and
(3) health care is a right owed by the government to each
of its citizens.23

Clearly this notion exemplified the prevailing collective principle
at the time that the state is responsible for its citizens.24 Moreover,
this idea embraced the times and needs of a nation debilitated by the
scourge of the Second World War, and epitomized the social welfare
and service state being molded by post-war Labour government.25
Aneurin Bevan, the Minister of Health in 1946 stated:

Society becomes more wholesome, more serene, and spiritu-
ally healthier, if it knows that its citizens have at the back of

17. Id.
18. MEDICAL CARE IN ENGLAND UNDER THE NATIONAL HEALTH SERVICE, REPORT TO
   THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION, at 1 (1950) [hereinafter
   MEDICAL CARE].
19. NATIONAL HEALTH ISSUES, supra note 11, at 1.
20. C. LINDSAY, supra note 1, at 53.
21. This radical program, which changed the British medical system forever, was a
   product of the National Health Service Act of 1946, born on "The Appointed Day," July 5,
   1948. See MEDICAL CARE, supra note 18, at 1; National Health Service Act, 1946, 9 & 10
   Geo. 6, ch. 81 [hereinafter NHS Act].
22. J. ALLSOP, supra note 16, at 11; see NHS Act, supra note 21, at § 1(2).
23. NATIONAL HEALTH ISSUES, supra note 11, at 18-19.
25. Id.
their consciousness, the knowledge that not only themselves, but all their fellows, have access, when ill, to the best medical skills can provide. 26

Yet, the development of this social uprising found its origins much earlier. 27

A. History and Background of the Act

There is little doubt that, while the National Health Service (NHS) substantiated a sudden and radical change in the British health care arena, conditions favorable for its adoption had been developing for many years. 28 The British government's involvement in medical care dates back as far as the post-Napoleonic War era. 29 In contrast to the humanitarian ideals expressed by the subsequent drafters of the NHS, 30 this initial government intervention was motivated by economic factors. 31 Under the guise of the Poor Law, 32 the government provided basic health services 33 to the poor based on "the simple principle that early recovery from illness would return workers to the labor force and thus accelerate their departure from the welfare rolls." 34 This system of hospital care 35 grew concurrently with the voluntary hospitals 36 arising out of the monastic age, 37 which also provided "vestigial general-practitioner care to the very

26. Id. This quote from Bevan, the Minister of Health in the 1945 Labour government, represented the cornerstone of this socialist movement. Bevan maintained that the government had an obligation to provide free access to health care through collective action. In support of this belief, he likened health care to the railways. In both instances, he advocated the use of a strong centralized organization by the state to provide a service equally accessible to all citizens on the sole basis of need.

27. NATIONAL HEALTH ISSUES, supra note 11, at 5.
28. MEDICAL CARE, supra note 18, at 2.
29. NATIONAL HEALTH ISSUES, supra note 11, at 5.
30. This humanitarian view was clearly expressed by the earlier discussion of Minister of Health Bevan, see supra note 26.
31. NATIONAL HEALTH ISSUES, supra note 11, at 1.
32. Poor Law Act, 1927, 17 & 18 Geo. 5, ch. 14 [hereinafter Poor Law]. This law was later overturned in 1930.
33. Id. at § 2; see also NATIONAL HEALTH ISSUES, supra note 11, at 5. "Only the simplest treatments were provided, and the prescription of medicines was forbidden. Furthermore, Poor Law doctors were hired on the basis of 'competitive trade,' whereby the appointments went to physicians willing to do the work for the lowest pay, regardless of qualifications." Id.
34. NATIONAL HEALTH ISSUES, supra note 11, at 5.
35. Poor Law, supra note 32, at § 2(3); see also MEDICAL CARE, supra note 18, at 3. The care provided by this system varied considerably from hospital to hospital. In addition to the larger municipal hospitals that were utilized by this Act, many smaller "cottage hospitals" emerged throughout smaller towns, some of which were also created by local public health authorities. Id.
36. This system of hospitals provided a shelter of "refuge for the destitute sick." Despite a period of inactivity, during Henry VIII's seizure of the monasteries, these hospitals reopened and continued to predominantly serve the indigent of Britain. These hospitals were primarily supported through "permanent endowments, gifts and money derived from contributory plans." Patients, who were restricted to low incomes, were required to pay only the amount of money they could afford. MEDICAL CARE, supra note 18, at 2.
37. MEDICAL CARE, supra note 18, at 2.
poor."

This government intervention into the medical care system, expanding through involvement in the related problem areas of disease and sanitation, continued with the introduction in 1911 of the National Health Insurance Act. By this time, "the modern medical revolution had already begun." As a result, the demand for medical services increased, coupled with an increased standard of living, so citizens began to expect "better treatment and were prepared to pay for it, either directly or through taxes."

After the abolition of the Poor Law, the Local Health Authorities assumed control of this hospital system and began to expand and upgrade the services provided. This increased government involvement, strengthened by the British Medical Association's long-time urging for a coordination of the voluntary and municipal hospital systems and the national hospital service established during the Second World War, rendered the establishment of an even stronger centralized government medical plan an inevitable progression. As this brief history indicates, the British people had been provided with a great deal of medical social service, and had grown accustomed to relying on their government to provide the basics of health care.

B. The National Health Service

1. Emergence of the Act.—With the nation engrossed in the turmoil of the Second World War, the social service movement emerged at the forefront of British existence. In 1942, as part of a government probe into the organization of domestic medicine, Sir William Beveridge produced the infamous "White Paper." This report called for a "reorganization of the industry into a highly centralized system directed by the Minister of Health through large regional administrative bodies." Beveridge proposed a broad

39. MEDICAL CARE, supra note 18, at 4.
40. National Insurance Act, 1911, 1 & 2 Geo. 5, ch. 55; see also J. ALLSOP, supra note 16, at 22. "The 1911 Act is significant as a first attempt by the state to cushion a section of the working class from the costs of illness and provided for personal medical care." Id.
41. J. VAIZEY, supra note 38, at 92.
42. Id.
43. MEDICAL CARE, supra note 18, at 5. In 1930, 146 separate health authorities operated in eighty-three towns and countries. They controlled the municipal hospitals and the environmental sanitation situation. Id.
44. Id. at 4. "The British Medical Association had long advocated some form of correlation, preferably on a regional basis, so as to establish a more coordinated system of hospitals." Id.
45. J. VAIZEY, supra note 38, at 92.
46. MEDICAL CARE, supra note 18, at 5.
47. MINISTRY OF HEALTH, A National Health Service, Cmd 6502, HMSO (1944); NATIONAL HEALTH ISSUES, supra note 11, at 12; J. ALLSOP, supra note 16, at 16.
48. NATIONAL HEALTH ISSUES, supra note 11, at 12. This report also designated that hospitals would fall under the administrative controls of government and that hospital invest-
comprehensive medical care system that "would prevent ill-health and rehabilitate the sick after illness and so make the nation fitter and more productive." This report not only recognized the collective responsibility of the government to provide health care to its citizens, but also asserted that "the impact of a health service would be to reduce the overall costs of social security by making people healthier."

Following the publication of this report, the Conservative coalition government accepted the principle of such a comprehensive national medical service, and began to research a health service which would please all parties involved. In the National Health Service Act of 1946, drafted by Minister of Health Aneurin Bevan of the newly elected Labour government, a tripartite system was proposed which offered a compromise. The Act placed the responsibility of operating this comprehensive plan on the Minister of Health, through the use of three main channels:

(1) The hospitals were nationalized and administered by the Regional Hospital Boards;
(2) The Local Health Authority was given administrative control over the local health and welfare service; and
(3) The general practitioners remained independent, self-employed, able to contract with the state (through local executive councils) on a capitation basis.

The proposed National Health Service gained virtually unanimous political support while the idea of a free health service on demand was understandably very popular with the public. As a re-

49. See National Health Issues, supra note 11, at 12-13. Beveridge urged his government to adopt such a national health care system. He stated in the "White Paper" that:
After a trial of a different principle, it has been found to accord best with the sentiments of the British people that an insurance organized by the community by use of compulsory powers, each individual should stand on the same terms; ... [t]he term "social insurance" to describe this institution implies both that it is compulsory and that men stand together as follows.

51. See supra note 39 and accompanying text.
53. Id. at 27. "The real arguments were now about the relationships between the medical profession and the state, and the extent to which different interest groups, within the profession, particularly the hospital doctors and the GPs would accept becoming employees of the state . . . ." Id.
54. See supra note 26 and accompanying text.
55. National Health Issues, supra note 11, at 17.
57. For more information regarding the powers and duties of the Minister of Health, see NHS Act, supra note 21, at §§ 1, 6.
58. See NHS Act, supra note 21; Medical Care, supra note 18, at 8; J. Allsop, supra note 16, at 27-28; J. Vaizey, supra note 38, at 92-93.
59. J. Vaizey, supra note 38, at 93.
suit, the Act was adopted by Parliament on July 5, 1948.60 Notably, the main structure of the system remained largely intact until the 1960s.61 Yet, the NHS, symbolizing Britain's high hopes for a better future in medical care,62 encountered an array of complex turmoil63 as it ventured out of the minds of its drafters into the harsh realm of the real world.64

2. Application of the Act.—The years following the adoption of the NHS can be divided into three distinct periods: the formative period (1948-60), the managerial period (1960-early 70s), and the period of reorganization (1974-present).65 The following subsections briefly detail the progression and performance of the service throughout these periods.

a. Formative Period, 1948-60.—Individuals in both the political and medical sectors had great expectations for the benefits of the institution they had created, but few had properly focused on the actual performance of this system in regard to the multitude of difficult and complex tasks it had been assigned on paper.66

On the demand side, the NHS would have to replace a price system in the rationing of available medical resources among competing demanders of medical care. On the supply side, the task was even more complex. First, total amounts of resources for medical services had to be determined. Then the total had to be parcelled out among literally millions of potential uses and users.67

Although a few benefits surfaced upon the introduction of the Act,68 the deficiencies associated with the operation of the system were abundant and readily apparent.

The disadvantages associated with the use of the tripartite system were obvious.69 An example clearly illustrates this point: "pa-

60. NHS Act, supra note 21.
61. J. VAIZEY, supra note 38, at 94; NATIONAL HEALTH ISSUES, supra note 11, at 17.
62. J. VAIZEY, supra note 38, at 92.
63. See NATIONAL HEALTH ISSUES, supra note 11, at 34-35.
64. Id.
66. NATIONAL HEALTH ISSUES, supra note 11, at 34.
67. Id.
68. MEDICAL CARE, supra note 18, at 40. The Act did accomplish some good for the British health care system:
1. It unified the disorganized hospital system and established a regional control oriented around teaching centers.
2. It removed the financial barrier to some extent.
3. It provided some financial support to some struggling municipal hospitals.
4. It made the services of consultants accessible outside of hospitals and clinics benefitting those who live in areas distant from the larger hospitals.
69. J. VAIZEY, supra note 38, at 92.
tients with chronic and handicapping conditions requiring both hospital and community-based services suffered from lack of communication between branches.\textsuperscript{70} Furthermore, the status of the general practitioner,\textsuperscript{71} once the "cornerstone of the service,"\textsuperscript{72} decreased in importance, as the hospital service rapidly became the vital cog in this centralized machine.\textsuperscript{73} As a result, although benefitted by better income levels in some instances, the hospitals, which lacked sufficient means for expansion and experienced an increase in operating costs, suffered from this massively increased work load.\textsuperscript{74} Consequently, long waiting lists for hospital appointments were created.\textsuperscript{75}

Essentially, in addition to its basic organizational deficiencies,\textsuperscript{76} the explosion of medical innovation, which coincided with the establishment of the NHS, created unforeseen problems for the system.\textsuperscript{77} This detonation created a tremendous expansion of costs, as a previously unmet demand became apparent and as the new medical techniques produced more treatable cases.\textsuperscript{78} It became evident that the British system lacked a strong structural basis. The NHS was based on two fundamental fallacies.\textsuperscript{79} First, there was a substantial "backlog" of untreated cases which would be eliminated by the more efficient system; thereafter, the workload would decrease as the nation got healthier.\textsuperscript{80} Second, the system was not prepared for the changes in medicine as the "new" enemies of health multiplied.\textsuperscript{81}

\textbf{b. The Managerial Period, 1960-Early 1970's.}---With more than a decade past since its inception in 1948, the political and med-

\textsuperscript{70} Id.
\textsuperscript{71} See MEDICAL CARE, supra note 18, at 40-41. The gap between the specialist and general practitioner (GP) grew, degrading the status of the GP. The system provided income incentives only to the specialists, essentially destroying the private practitioner. For further details regarding specialists and their incentives, see id. at 12-15.
\textsuperscript{72} J. VAIZEY, supra note 38, at 93.
\textsuperscript{73} Id.
\textsuperscript{74} Id.
\textsuperscript{75} MEDICAL CARE, supra note 18, at 40.
\textsuperscript{76} J. VAIZEY, supra note 38, at 94.
\textsuperscript{77} See MEDICAL CARE, supra note 18, at 40-41. The author further details the problems created by the operation of the Act, such as:
1. The removal of the financial barrier seemed to benefit the middle rather than the intended lower class.
2. Produced an unequal distribution of doctors in proportion to population.
3. Rendered the success of medicine dependent more on quantity rather than quality.
4. Created complete autocratic control of the system.
5. Added nothing to preventive medicine.
6. Added to the costs of medical care by applying a great additional load onto its medical facilities.
\textsuperscript{78} Id.
\textsuperscript{79} Id.
\textsuperscript{80} Id.
\textsuperscript{81} Id.
ical communities began to recognize and address the complexities prevalent in the system. "The major concern was that tripartite nature of the NHS, and the way in which power was freely delegated down the line from the centre, led to inadequate follow-through of particular patients." With the structure segregated into three distinct entities, the system lacked efficient cooperation and planning.

As a result, hospitals became the dominant form of medical care, though it was evident on account of the vast increase in treatable cases, that the majority of the medical treatment should take place outside of the hospitals and in the communities. Yet, the NHS, by offering only to the specialists various attractive incentives, had depleted the supply of general practitioners needed to adequately manage the task. There certainly appeared to be a misallocation of resources.

Consequently, during this period, many individuals began to realize that the workforce of the NHS was "continually increasing in size and in complexity in terms of the division of labour." Due to this increasing division and specialization of the medical field, the government looked to the use of scientific management as an answer to organize the work of these medical professionals and their relationship to each other. Various government studies and reports researched managerial methods which could improve the coordination and use of the professions and their resources. Undoubtedly, it was this managerialistic period which spawned the subsequent reorganizational period of the 1970’s and 80’s.

c. The Period of Reorganization, 1974-present.—The nature of the preceding period and its focus on the dilemmas associated with the operation of the NHS served as the impetus for its reorganization. What was once a symbol of the future of British medicine in 1948, developed into nothing but a system engrossed in disarray by
1973. Clearly, something had to be done to improve the efficiency and effectiveness of the service. Hence, the reorganization of 1974.

It [the reorganization] was based on the notion of the essential unity of the NHS and designed to transform it into a more efficient and effective service through a change in structure, the strengthening of management and the introduction of a planning system.

Unfortunately, what was to follow was complex; its complexity, in turn, explains its subsequent chaos.

The new structure was based on an integrated service dependent upon the organization of multi-tiered administrative units. The new structural mechanism sought to induce greater control from the top by strengthening the Department of Health and Social Security (DHSS), whose task was to ensure an efficient service and to maintain effectiveness in carrying out departmental policies. In effect, the DHSS was "the central policy-forming, monitoring and finding body of the Health Service, as well as having other national responsibilities."

The new structure was based on the Area Health Authorities (AHAs), local administrative units who had the responsibility of running the Health Service at the local level. The AHAs were under the direction of the same fourteen Regional Health Authorities (RHAs), whose responsibility was the strategic planning of community health service and hospital services, which were a part of the original NHS. This structured mechanism continued to the district level and added to the astounding complexity of the reorganization.

The district level was broken down into: (a) District Management Teams (DMTs), which managed and coordinated many of the operational aspects of the service within their areas and assisted in the formulation of future policies and planning; (b) District Medical Committees (DMCs) and (c) Health Care Planning Teams (HCPTs), both of which were made up of local hospital and community medical staff and carried the task of detailing local planning.

91. J. Vaizey, supra note 38, at 94-98.
92. See National Health Reorganization Act 1973, brought into force on November 1, 1974 by S.I. 1974 No. 1911.
93. J. Allsop, supra note 16, at 60.
94. J. Vaizey, supra note 38, at 94.
95. See The National Health Service (Transferred Local Authority Property) Order 1974, S.I. 1974 No. 330.
96. J. Allsop, supra note 16, at 60.
97. J. Vaizey, supra note 38, at 97.
98. Id. at 94. "The AHAs were corporately responsible for health care in geographic areas which were on the whole conterminous with local authority, metropolitan districts and nonmetropolitan counties . . . [i]n all there were ninety English AHAs, of which sixteen were in Greater London." Id.
and policies; and (d) Community Health Councils (CHCs), who were "public watchdogs" for the development of health services.\textsuperscript{100} The goal of the reorganization was to create an integrated planning system\textsuperscript{101} with an emphasis on management by objectives.\textsuperscript{102}

There is to be a fully integrated health service in which every aspect of health care is provided, so far as it is possible, locally and according to the needs of the people . . . throughout the new administrative structure there should be a clear definition and allocation of responsibilities, there should be a maximum delegation downwards, matched by accountability upwards, and a sound management structure should be created at all levels.\textsuperscript{103}

Yet, the 1974 reform proved to be an absolute disaster; "there were too many committees, too many administrators, too few quick decisions, and too much money wasted."\textsuperscript{104} As a result, the NHS, which had hoped the reorganization would improve its efficiency and effectiveness, was once again left searching for solutions. In 1982, another reorganization, aiming to simplify the complexity of the chaotic NHS structure, removed the AHA tier and gave its powers to the Districts; the rest of the system remained unchanged.\textsuperscript{105}

The reorganization period of the NHS resulted in more confusion, higher costs and a continued lack of primary care; "few had greeted [it] as an unqualified success."\textsuperscript{106} The multi-tiered structure seemed to delay decision-making and planning, cannibalizing the intent of the reorganization.\textsuperscript{107} This complex planning mechanism also increased the costs of administering and managing the service since more employees were needed and more resources were wasted.\textsuperscript{108} Furthermore, nothing was done to alleviate the domination of hospitals, leaving the much needed primary health care field (general practitioners) still in a state of depletion.\textsuperscript{109}

In sum, the reorganization of the NHS failed in its attempt to replace chaos with the use of calculated order.\textsuperscript{110} The central deficiency of the NHS remained as it failed to improve the fundamental function of allocating its resources efficiently.\textsuperscript{111}

\begin{footnotes}
\item 100. J. VAIZEY, supra note 38, at 95.
\item 102. J. VAIZEY, supra note 38, at 97.
\item 103. Id. at 97-98.
\item 104. Id. at 98.
\item 106. J. ALLSOP, supra note 16, at 70.
\item 107. See supra note 104 and accompanying text.
\item 108. J. VAIZEY, supra note 38, at 100-101.
\item 109. Id. at 101.
\item 110. NATIONAL HEALTH ISSUES, supra note 11, at 28.
\item 111. C. LINDSAY, supra note 1, at 83.
\end{footnotes}
3. **Overview of the NHS.**—In reviewing the framework and operation of the National Health Service since its inception forty years ago, the deficiencies seemingly outweigh the "theoretical" benefits. The concept behind this comprehensive "free-for-all" medical care service is undoubtedly admirable, but the practical application of such a system leaves much to be desired. The British system clearly illustrates this notion.

An analysis of the structure and performance of the National Health Service throughout its existence illuminates its distinct characteristics:

[I]t is free, for the most part, at the point of service; it tries to be uniform throughout; it is short on innovation; it is monolithic and bureaucratic; nowhere is it responsive to consumer demand; it is set up to handle "patients" (those who wait); and increasingly it is run for the benefit of those who work in it.

Undoubtedly, the NHS was able to organize and stabilize a troubled hospital system. Yet, by encouraging the specialization of the medical profession, the service created a misallocation of resources as its hospitals became the dominant force in health service. As a result, the hospitals were unable to handle the vast increase in demand, and due to the depletion of general practitioners, the primary health care sector was unable to adequately assist in solving the problem. Hence, the British public is forced to wait or seek treatment at expensive private clinics which seemingly undermines the purpose and intent of utilizing a "free-for-all" service which allows everyone the best treatment on the basis of need.

This multi-tiered bureaucratic mechanism not only slows down the decision and policy-making process, but also fails to adapt to the rapidly changing nature of the medical field. The depletion of the primary health care sector is a perfect example of this inelasticity of the NHS to meet changes in demand. The explosion in medical innovation created vast numbers of treatable cases; yet, the Service was unable to revitalize the much-needed general practitioner. More importantly, by prioritizing health care and limiting the profits of its participants, the result is an inevitable slow-

---

112. "The proclaimed case for the NHS is essentially moral rather than economics..." National Health Issues, supra note 11, at 103.
113. J. Vaizey, supra note 38, at 102.
114. See supra note 68 and accompanying text.
115. See supra notes 74-76 and accompanying text.
116. See supra notes 71-73, 84-86 and accompanying text.
117. See supra note 75 and accompanying text.
118. J. Vaizey, supra note 38, at 102.
119. See supra notes 104-108 and accompanying text.
120. J. Vaizey, supra note 38, at 102-103.
121. See supra note 109 and accompanying text.
down in medical progress. It is vital to "encourage freedom to experiment and innovate and to reward success."

Instead, this authoritarian system determines what is "urgent" and demanded by its people while it is consistently constrained by the lack of public finances. The complexity of this monolithic system hinders the flow of quality information and communication throughout the system. As a result, the service lacks management innovation and development, as illustrated by the Royal Commission's assessment of the service in 1979: "Unfortunately the information available to decision makers in the NHS leaves much to be desired."

Clearly, a government-run system is a political tool first and foremost, and this political link undoubtedly influences resource allocation. Inevitably, the achievement of satisfying consumer needs will be overshadowed by some political objective, whether it is winning votes or meeting government budgets. Somewhere within this political game, the basis of creating such a service — to provide the best possible care to all — is diluted, and eventually lost.

IV. Canada

In order to conduct a fair analysis of adopting a centralized, government-controlled health care system, the United States can also look to our neighbor to the north. Canada, despite its much smaller population and relatively short experience with centralized financing, has adopted elements of national insurance and is economically and culturally the most comparable country to the United States. Although its short history with centralized health care prevents it from providing as complete a study as the British system, Canada's experience with this approach to medical care can still serve as a valuable learning tool for the United States.

122. J. Vaizey, supra note 38, at 90.
123. Id.
124. Id. at 102.
126. Id. at 101.
127. Id. at 4.
128. Id.
129. C. Lindsay, supra note 1, at 53.
A. History and Background

The Canadian health care system has undergone a relatively recent evolution from which a government medical network based on a universal comprehensive public hospital and medical care insurance plan has emerged.130 Today, the government has assumed the central role in the health care arena. The administration of Canadian health services falls primarily under the direction of the ten provincial governments which in turn delegate considerable responsibility for community health to the local and regional authorities.131 The federal government, in its role of promoting the health of Canadians, centers its concerns on health matters of a national and international scope.132 More importantly, it provides financial support to provincial medical and hospital insurance programs, and to the continuation of development of other health services.133

Seemingly, the underlying reasons for the inception of strong government intervention in Canada are not very different from those in Great Britain. Facing steady cost increases, inadequacies in its resource allocation, and non-accessibility of health care to the poor, Canada has searched for a solution to its troubled health care system.134 Consequently, Canada chose to spurn its reliance on the market to allocate its medical resources135 on the premise that the market system rations according to one’s ability, and willingness, to pay — wealth and information.136 Instead, Canada opted for an elimination of the price barrier in an attempt to bring medical care within the reach of all of its citizens.137

The policy underlying its system is premised on the assumption that an objectively identifiable relation between health care use and health status exists, both at the individual and collective levels.138

People have “needs” — as opposed to preferences, demands, or willingness-to-pay — for those forms of health care which would be judged, by an external, technically competent observer, to improve or maintain their health status. Further, the recognition of a need, unlike a more general want or demand, implies some degree of obligation on others in a commu-

---

130. Evans, Health Care in Canada: Patterns of Funding and Regulation, 8 J. HEALTH POL, Pol'y & L. 1 (1983) [hereinafter Evans].
131. CULTURAL, PUBLIC AND INFORMATION PROGRAMS BUREAU, GOV'T OF CANADA, HEALTH AND WELFARE 1 (1983) [hereinafter HEALTH AND WELFARE].
132. Id.
133. Id.
134. See Evans, supra note 130, at 1-3, 8-9.
135. Id. at 6. “[M]arket allocation of [the] benefits [of the scarce resources of human time, energy, capital and raw materials] is generally viewed as leading to individual and social outcomes inferior to those available through alternative rationing institutions.” Id.
136. Id.
137. C. LINDSAY, supra note 1, at 76.
138. Evans, supra note 130, at 8.
This “external, technically competent observer” in the Canadian system is the government; it makes the decisions as to what “needs” should be addressed, and which should be left unmet.\textsuperscript{140}

From this perspective, the primary test of a health care system is the quality of the match it achieves between needs and utilization: its provision of effective care to those who will benefit, and its avoidance of ineffective or harmful services. Secondly, it should be technically efficient in the use of resources. At yet another level, a system will influence patterns of income and wealth distribution — between providers and users or taxpayers, and among users/taxpayers — depending on how its funds are raised.\textsuperscript{141}

The Canadian system considers these to be matters of political judgment, warranting the government to classify these issues into “researchable questions and political choices” which focus on or even resolve these areas.\textsuperscript{142} These underlying principles served as the catalyst for government cost-sharing, via the provincial governing bodies, which dates back to the late 1950’s and subsequent federal cost-sharing which emerged in the late 1970’s.\textsuperscript{143}

\textbf{B. The Evolution of Government Intervention}

In its attempts to implement these social policies based on “need,” the Canadian health care network has substantially differentiated itself from the American system in a crucial way. Although the delivery systems of the two nations, with medical services provided primarily by private practitioners reimbursed fee-for-service and hospitals owned on a voluntary or municipal basis, have remained broadly similar, the key divergence lies in the funding of the two systems.\textsuperscript{144} The Canadian funding mechanism is the universal public insurance programs on both the federal and provincial levels which reimburse all hospital and medical costs through budgetary allocation and fee-schedule negotiations, respectively.\textsuperscript{145} Essentially, “government in Canada has largely replaced private insurance funds as the paymaster of doctors and hospitals.”\textsuperscript{146}

\begin{enumerate}
\item \textsuperscript{139} Id.
\item \textsuperscript{140} Id. at 9.
\item \textsuperscript{141} Id.
\item \textsuperscript{142} Id.
\item \textsuperscript{143} C. LINDSAY, supra note 1, at 69.
\item \textsuperscript{144} Evans, supra note 130, at 3.
\item \textsuperscript{145} Id.
\item \textsuperscript{146} C. LINDSAY, supra note 1, at 72; \textit{see also} Evans, supra note 130, at 13. “One public agency, the provincial Minister of Health is responsible for all costs. Providers cannot play one reimbursers against another, or charge patients for amounts insurers refuse to pay.” Id.
The evolution of the government as curator of this system originated in 1958 under the guise of the Hospital Insurance and Diagnostic Services Act. This Act codified agreements between the federal and provincial governments to mandate provinces to provide an array of insured medical services to "all of its covered residents on uniform terms and conditions, without exclusion on grounds of age, occupation, income or pre-existing conditions." All provinces were required to provide standard-ward accommodation and normal hospital in-patient services to all residents covered on either a pre-payment or tax-financed basis. The provinces also began to insure a comprehensive range of out-patient services to its eligible citizens. However, these services are included in provincial insurance plans at provincial discretion; as a result, the services vary from province to province. The cost of these insured hospital services is all but entirely carried by the federal and provincial governments. The provinces raise their portion of these costs in a variety of ways based on local conditions and preferences, with at least some use of general tax revenues as a source to finance their shares.

In addition to the insured hospital services, the government expanded into the field of medical-care insurance. It began by insuring other services, mainly those of physicians with the inception of the Medical Care Act of 1968. This Act called for federal government

147. The Hospital Insurance and Diagnostic Services Act, 1958, CONSOLIDATED REG. OF CANADA ch. 936, (1978) [hereinafter Diagnostic Services Act].
148. HEALTH AND WELFARE, supra note 131, at 5; see also Diagnostic Services Act, supra note 147, § 3(2) at 7092. The Act provides care to "insured persons," defined as residents of a province — "persons legally entitled to remain in Canada who make their home and are ordinarily present in that province, but does not include tourists, transients or visits to the province" — who are eligible for and entitled to those insured services provided under the laws of their province. Id.
149. HEALTH AND WELFARE, supra note 131, at 4. Those hospital services normally supplied to in-patients include "meals, nursing care, laboratory, radiological and other diagnostic procedures and most drugs." Id. Services provided by mental and tuberculosis institutions, nursing homes, infirmaries or other custodial care institutions are excluded from the provisions of the Act. Id.
150. Id. See also Diagnostic Services Act, supra note 147, § 2 at 7091. The Act deals with two types of hospitals: (1) "contract hospitals" which are private or industrial hospitals which have contracted with the provinces to protect care; and (2) "financial hospitals," those owned or operated by the Canadian federal government. Id.
151. HEALTH AND WELFARE, supra note 131, at 4.
152. Id.
153. Id.
154. Id. Newfoundland, Prince Edward Island, New Brunswick, Saskatchewan, Manitoba and two territories entirely finance their portion of the program cost from this source. For more information regarding alternative sources utilized by Alberta, British Columbia, Quebec, Nova Scotia and Ontario, see id. at 5-6.
contributions toward costs associated with insured services of a national program provided by provincial medical care insurance plans which meet the following requirements:

a) A plan must be operated on a non-profit basis by a public authority responsible to the provincial government for its financial transactions.

b) It must make available all medically-required services rendered by medical practitioners, and these insured services must be provided on uniform terms and conditions to all residents of the province; there can be no exclusions because of age, ability to pay, or other circumstances.

c) The provincial plan must cover no less than 95 per cent of the total number of insurable residents of the province.

d) For persons normally resident in the province, the provincial plan must provide "portability" — that is: coverage during the waiting-period while a person establishes residence in another province; and coverage during periods of temporary absence from the province, generally up to one year.156

The Act allows the provinces to finance their portion of the service costs in any manner they wish, subject only to a provision "whereby no insured person may be impeded in the effort to obtain, or precluded from reasonable access to, insured services, either directly or indirectly, whether by charges made to the insured person or otherwise."157 Similarly, the Act also grants the provinces the freedom to choose a method to pay providers of services, "subject only to the provision that the provincial schedules of benefits are on a basis that assures reasonable compensation for the services rendered."158

The national government's role in contributing to this national medical plan has taken on various forms since the Act's adoption.159 Originally, the national government based its contributions to the provinces, with reimbursements approximating fifty percent of the share in costs.160 The open-ended cost-sharing arrangement changed with the onset of the Established Programs Financing Act (EPF) of 1977.161 “The main objective of the federal government in instituting the EPF was to create a reasonably predictable and stable close-en-

157. Id. at 7. “The significance of this requirement is that extra charges if imposed, must not be more than nominal.” Id.
158. Id. For a favorable view of the Canadian fee-schedule structure, see Evans, supra note 130, at 11-12.
ded fiscal transfer," no longer based directly on provincial costs. Instead, national contributions were approximated on the basis of the value of the "tax-room" transferred, and made in the form of per capita payments. As a secondary objective, the EPF was designed "to promote cost-cutting and greater efficiency in health, both by instituting a system whereby all the savings of a province's cost-cutting program would accrue to the province itself, and by giving the provinces much greater flexibility in general."

The years following the adoption of the EPF held nothing but disagreement and turmoil between the national and provincial governments, as the national government continually complained that its contributions to the costs were too excessive. As a result, the Act was amended on various occasions and presently employs a complex "tax-room" arrangement limited by various financial factors. Consequently, as the national government substantially decreased its contributions and shifted most of the burden to the provincial level, the provinces have, in turn, shifted some of the weight onto municipalities and the public in the form of budget cutbacks, tax increases, or increased user charges.

In spite of this, many assert that the Canadian system has been a success. This belief is based on two notions: "a single source of funding; and the location of that source at an appropriate level of government." Advocates of this system contend that "the provincial governments, which are [now] responsible for virtually all medical and hospital funding, have the political legitimacy, technical expertise, and financial leverage and incentives to offset the influence of providers of care." In sum, supporters of this system believe that through utilization of this balanced political market, health care expenditures can be controlled. Despite support from some public health administrators and academics, the problems and developing trends of the Canadian system confirm the inadequacies of a central-

162. Weller & Manga, supra note 159, at 507.
163. Financing Act, supra note 161, § 18. "Tax-room" equals the amount "by which the entitlement in respect of that established program applicable to the province for that fiscal year exceeds the total equalized tax transfer in respect of that established program applicable to the province for that fiscal year." Id.
164. HEALTH AND WELFARE, supra note 131, at 2. "These payments increased yearly in accordance with changes in the gross national product, and were adjusted gradually so that all provinces, at the end of five years, were receiving equal per capita cash contributions." Id.
165. Weller & Manga, supra note 159, at 507.
166. Id.
167. See Financing Act, supra note 161, § 19.
168. Weller & Manga, supra note 159, at 507.
169. Evans, supra note 130, at 13.
170. Id.
171. Id.
172. Id.
SOCIALIZED MEDICINE

ized structure of health care.\textsuperscript{173}

C. Overview of the Canadian System

It seems evident that Canada's short experience with a centralized, government-funded mode of medical care, hospital insurance, and extended care broadly confirms the tensions and inadequacies associated with such a system.\textsuperscript{174} Throughout the evolution of this health network, intergovernmental conflict has vastly increased\textsuperscript{175} as the system failed to provide an adequate solution to the Canadian health dilemmas. Instead, the government, unable to carry the weight of rising medical costs, has continually shifted the cost burden onto the individual or, even more likely, reduced services.\textsuperscript{176} As a result of these strains, "[m]edicine seems to have taken second place, as the patient has been seen not as a citizen requiring medical care but as a taxpayer perhaps willing to pay for medicine, whatever government could extract in taxes."\textsuperscript{177}

Canadian health care has been caught in a vise, similar to the British system, as services are "squeezed between federal financial controls [such as limits of government contributions and ceilings on fee-schedules] and increasing demand from patients, rising costs, advancing techniques, and a growing population."\textsuperscript{178} Moreover, and even more importantly, as greater emphasis is placed on meeting budgetary decisions, centralized health networks short on finances will opt for a shift of available resources from long-term investment to everyday services utilized by voters.\textsuperscript{179} Consequently, the critical area of medical innovation is tragically neglected as "medical research, new techniques and treatments, hospital laboratories and hospitals are left underfunded."\textsuperscript{180}

In addition, the "free-for-all" basis of this centralized system has led to obvious increases in demand, an occurrence similarly ex-
perceived in Britain. Since the consumer pays little or nothing when he uses the system, it only stands to reason that its idea of “free” care will vastly increase the use of the health structure and promote abuse through overuse. As the demand side of this system continues to increase and the supply side stays the same or decreases (especially in light of government cuts in expenditures concerning medical facilities and decreased incentives in the profession as a result of constricting fee-schedules), the quality of care will inevitably suffer.

An important effect of reducing the price of care to zero is that the ensuing scramble for physician care puts doctors under pressure to hurry their patients through, to have their nurses and orderlies perform more tasks, and in general to reduce the quality of the care provided. Long lines in the waiting room and the lack of competition among physicians for patients will in the long run yield a product worth exactly what it is paid for.

Furthermore, one of the underlying premises of adopting the centralized system — making health care more accessible to all based solely on need, not wealth — is undermined upon application of this “socialized” approach. The reimbursement system utilized by the provinces eliminates the differences in compensation associated with practicing medicine in particular areas; this is a natural consequence of fee patterns under a market system. “Fewer physicians will choose to practice in less-amenable communities since a particular service commands the same fee regardless of where it is delivered.” In effect, the Canadian system has driven its physicians away from the poor. This misallocation of resources, coupled with the government’s increasing shift of the cost burden onto the public, creates a miserable situation for its consumers, especially those with lower incomes. More and more, those individuals with the financial means are choosing to visit extra-billing physicians, who have opted out of the national insurance plan, in search of higher quality care and less rushed and more personalized care. Thus, the system based on need, not wealth, is rendered all

---

181. See supra notes 113-18 and accompanying text.
182. C. Lindsay, supra note 1, at 78.
183. See supra notes 61-63 and accompanying text.
184. C. Lindsay, supra note 1, at 79.
185. See supra notes 12-15 and accompanying text.
186. Id. “A market pricing structure provides that physicians who practice in unattractive, poor, remote locations earn more than their colleagues who prefer to practice in attractive urban settings.” Id.
187. Id.
188. Id. “It matters little that there is no price barrier if there is no doctor.” Id.
189. See supra notes 166-68 and accompanying text.
190. See C. Lindsay, supra note 1, at 76-79.
191. See Evans, supra note 130, at 27.
but meaningless.

In sum, the centralized framework of the Canadian health network, although still relatively young, has created an environment in which medical care has stagnated. The system is engrossed in bureaucracy, where decisions are based on the pursuit of budgetary goals and votes, while consumer demand goes unmet. Once again, as evidenced by the British experience, the ideology of centralized medicine, although admirable in theory, fails upon practical application. Although Canada intended to open access to medical care to all citizens, both the rich as well as the poor, it has instead created a vast misallocation of resources and has shifted the majority of the financial burden onto the public. Based on the difficulties this system has already encountered, and the trends that are presently evolving, Canada appears to face a future where its valiant objective to provide health care to everyone is buried beneath the bureaucracy and inflexibility of its monolithic structure.

V. Analysis

The preceding analysis of the current health care systems employed by Great Britain and Canada emulate the underlying deficiencies of a centralized form of medicine. Both nations' utilization of this "need" based system has failed to improve the allocation of health resources while the quality of care has suffered as those patients who wait are rushed through their visits. In an attempt to cut medical costs, these government medical systems concentrate support on the short-term needs of its users. Critical long-term investments in medical research, new techniques and new devices are neglected; in effect, medical innovation is paralyzed. In addition, as the government decreases its contribution to rising medical costs in order to meet budgetary goals, much of the cost burden is filtered down to the consumer. These socialized systems produce structures that ration resources by queuing, resist change, and leave decision-making to political bureaucracies.

Alternatively, the market system — which remains at the root of the American health care system, despite increased government intervention in recent years — is based on the theory that supply expands to meet demand. The market philosophy envisions a scenario of "competing delivery systems, each priced according to its

192. C. Lindsay, supra note 1, at 83.
193. See supra notes 178-80, 185-87 and accompanying text.
194. See supra notes 166-68 and accompanying text.
195. C. Lindsay, supra note 1, at 73.
197. J. Vaizey, supra note 38, at 102.
costs and chosen by consumers on the basis of quality, cost, and other factors.\textsuperscript{198} Although the market theory falls well short of absolute perfection, the same is true of government medicine,\textsuperscript{199} as evidenced by the chaos in Britain and Canada. These socialized systems have removed the price rationing device without replacing it with an adequate substitute.\textsuperscript{200} It was hoped that “need” would provide the new criterion;\textsuperscript{201} but instead, health care has been effectively rationed through queuing in Britain,\textsuperscript{202} and queuing and added costs to consumers in Canada.\textsuperscript{203} Moreover, this banishment of price from the health care market has not produced the additional resources to accommodate those unable or unwilling to pay for them.\textsuperscript{204}

In addition, the centralized system lacks the ability to adapt to the ever-changing medical field, as evidenced by the British system. “The bureaucratic system is necessarily sluggish — slow to close down what has become redundant and slow to expand when demand is expanding . . . [s]uch a system is inherently badly adapted to a period of rapid change.”\textsuperscript{205} The market system, on the other hand, is able to adjust to these changes as consumers demand them.

Similarly, the socialized system removes the profit motive from the supply side, in effect creating a misallocation of resources\textsuperscript{206} and a suppression of medical innovation.\textsuperscript{207} Physicians have no incentive to practice in less attractive areas, nor to devote a career toward innovative research since no reward awaits them.\textsuperscript{208} “Attempts to control priorities and to limit profit, therefore, are certain to be shortsighted and to slow down medical progress.”\textsuperscript{209}

Furthermore, the socialized system seemingly fails to fit into the social framework of this nation. Both Canada and Britain are more regimented and homogeneous\textsuperscript{210} as a people than the United States, and therefore, the imposition of such a system is easier. There seems to be a greater degree of passivity on the part of its people in these nations as well,\textsuperscript{211} as opposed to the innate instinct of Americans to go out and get what they want.\textsuperscript{212} Also, the United States’ popula-

\textsuperscript{198} Havighurst, Competition in Health Services: Overview; Issues and Answers, 34 Vand. L. Rev. 1117, 1118 (1981) [hereinafter Havighurst].
\textsuperscript{199} National Health Issues, supra note 11, at 4.
\textsuperscript{200} Id. at 2.
\textsuperscript{201} Id.
\textsuperscript{202} Id.
\textsuperscript{203} See supra notes 168, 181-84 and accompanying text.
\textsuperscript{204} National Health Issues, supra note 11, at 4.
\textsuperscript{205} J. Vaizey, supra note 38, at 103.
\textsuperscript{206} National Health Issues, supra note 11, at 4.
\textsuperscript{207} J. Vaizey, supra note 38, at 90.
\textsuperscript{208} See supra note 113 and accompanying text.
\textsuperscript{209} J. Vaizey, supra note 38, at 90.
\textsuperscript{210} See C. Lindsay, supra note 1, at 53-54.
\textsuperscript{211} J. Vaizey, supra note 38, at 102; see also Weller & Manga, supra note 159.
\textsuperscript{212} J. Vaizey, supra note 38, at 102.
tion is substantially greater than that of either Britain or Canada, and the advent of such a socialized system would present a difficult structural and administrative task. The complex structures which exist in the British and Canadian systems accentuate the difficulty which would be involved in designing a system for a nation as large as the United States.

The socialized systems have proven to be ineffective in creating its intended health care utopia. The United States, in addressing its health problems, should reform its market system from within. Some suggested reforms are: to increase competition within the market by fully embracing the health maintenance organizations (HMOs), with the theory here being that the larger the percentage of the market participating in HMOs, the greater the market-forcing effect of reducing overall costs — as a result, lower HMO costs will reduce costs in the fee-for-service system as well; allow Medicare and Medicaid recipients to enroll in a competitively priced basic health package provided by HMOs; increase the role of employers by increasing their employees' selection of health insurance plans; and by initiating health education and management plans. This reform will be difficult and will require time to take effect; but it makes more sense than initiating a costly and complex change to a system foreign to the framework of this nation.

VI. Conclusion

The effect of introducing a socialized system of medicine gives the power of decision-making and resource-allocation to a political mechanism buried in bureaucratic red tape. In the rapidly changing field of medicine, one that presents unique and perplexing challenges each day, this sluggish system stagnates the much-needed area of innovation citizens depend on to survive. The control of health care should never be placed into the hands of a political operation which cares more about reducing costs and winning votes; life is entirely too precious.

John J. Moran

213. C. Lindsay, supra note 1, at 73.
215. Havighurst, supra note 198, at 1150-51. In effect, the costs associated with these basic plans could be reduced through market competition. The government could still play an essential role in monitoring these costs to protect their citizens' welfare.
216. Id. at 1149. This idea suggests that competing health plans will reduce costs while expanding their insured services to attract subscribing employees.
217. Merrill & McLaughlin, supra note 214, at 148. "Their objective is to promote employees' health, thereby reducing absenteeism, increasing productivity, and slowing the growth of health care costs." Id.