

Chapter 4.17

Current Practices in Select Healthcare Systems

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ABSTRACT

In this chapter, current practices of healthcare delivery in three economically advanced countries will be reviewed. Is healthcare delivery commensurate with economic prosperity? Countries with technological and economic advantages may be better poised to deliver healthcare efficiently. However, this is not the case in fact. The following review will show that medico-legal and technological prowess may not translate into a healthier life and better healthcare delivery. It will be argued that poor allocation of ample resources is tantamount to resource insufficiency. The chapter will cite anonymous but true cases of patients to illustrate the salient points.

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INTRODUCTION

In this chapter, current practices of healthcare delivery in three G8 countries will be reviewed. Does economic prosperity lead to a better quality of delivered healthcare? Countries with technological and economic advantages may seem to be better poised to deliver healthcare efficiently. However, this may not be the case in fact. The following review will show that medico-legal and technological prowess may not translate into a healthier life and better healthcare delivery. Distribution of wealth does not necessarily correlate with the distribution of health. It will be argued that poor allocation of ample resources is tantamount to resource insufficiency.

In the attempt to provide improved healthcare for its citizens, many of the G8 countries have tried everything in the spectrum from a publicly funded healthcare system to a fully private system. Common to all these are the intimidating waiting lists for doctors' appointments or surgeries. Some may argue that a waiting list is an inevitable by-product of an economically efficient healthcare system. Patients who are deemed to be surgical candidates are obviously quite ill and possibly in pain. If you ask such a patient if a waiting list is acceptable, the answer would be a resounding rejection of such a concept.

The issue at hand is more than an argument about what constitutes a welfare system. The concept of economic efficiency in healthcare is a red herring. To be efficient from an economic standpoint may not be the same as efficiency in the distribution of healthcare. One may argue that a competitive market resulting in economic efficiency may result in a distribution of wealth with people holding extremes of wealth or poverty. Inequities in health distribution may be a similar outcome of an economically efficient system. The United States of America is an example of this disparity in healthcare. There can be no such tradeoffs in healthcare. In an efficient healthcare system, one cannot accept a dichotomy with some people having ready access to healthcare and some having none. The existence of such a state of society is, admittedly, a failure of the healthcare system. Society must see to it that the last person who needs healthcare receives it.

Some may be quick to interpret this as an advocacy of socialism. In truth however, there is no such thing as socialism in healthcare. Socialism is an economic concept. Wealth distribution is an economic concept. But an equitable distribution of healthcare is as much a necessity as the distribution of oxygen. Everyone ages and every aging person is a potential healthcare consumer. Healthcare is a prime example of market failure. Therefore the allocation of healthcare by free markets is inherently inefficient. The reason a market

for healthcare fails is due to (a) the existence of externalities discussed below and (b) the existence of transaction costs and asymmetric information. President Barrack Obama and Secretary of State Hillary Clinton have both strongly emphasized the philosophy that "every American has the right to affordable healthcare" during their 2008 presidential campaigns. Yet a waiting list is a denial of that essential service of healthcare.

In such a context what is a surgical or patient care waiting list? One may have a society where all its citizens have access to healthcare but are placed in a waiting list to see their doctor or to receive appropriate surgical intervention. How does this differ from a society where some have immediate treatment of their illnesses and some do not? The emergence and establishment of surgical waiting lists must therefore be considered a cost to society due to pain and suffering of those waiting patients. The impact on the patients' quality of life and society's productivity is obvious. In the written words of the Supreme Court of Canada Chief justice Beverly McLachlin in the 2005 *Chaoulli v. Quebec (Attorney General)* case, "Access to a waiting list is not access to healthcare."

Consider, for example, patient D.L. from Canada who has a brain tumor compressing on her optic nerve. She was virtually blind in one eye and was losing vision in the other. She was placed on a waiting list and it took several months for the surgery to decompress the tumor. On the day of the scheduled surgery, she was "bumped" and the surgery was cancelled due to unavailability of beds. One month later, her vision now worse, she was taken to surgery emergently. As another example, in the specialty of ophthalmology, the mean waiting time for cataract surgery in Canada was 17 weeks in 2005 (Conner-Spady, B.L., Sanmugasunderam, S., et al., 2005). Patients in the U.K. have had to endure long waiting lists for surgery, some as long as six to nine months (Martin, R., Sterne, J.A.C., Gunnell, D., et al., 2003). Even in the U.S. with a mostly private healthcare

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