Submitter: Donna Torres

On Behalf Of:

Committee: Senate Committee On Rules

Measure: SB1089

Why must we try to implement proven "failed" systems to learn Universal Health Care does NOT work?
Top-down governance comes with tradeoffs. Bureaucrats can't foresee the problems that might arise from even minor errors in design. And once issues materialize, fixing them can take years. This has serious consequences for patients—and it leads to a work force that's so disgruntled it might just quit.

National Health Service (NHS) is collapsing around the world. Physicians and nurses are leaving the profession at an unprecedented rate, and students are entering other fields. Seven million Britons—more than one in 10—are waiting for treatment. And while COVID certainly accelerated the NHS' decay, it did not cause it. The system had been showing symptoms of an underlying problem for decades. NHS was destined to fail from its very inception.

Short of brute force, governments have limited options to deal with the inevitable mismatch between supply and demand. Beveridge-style systems can ration care, increase spending and taxation, or simply accept low-quality services. This is the dilemma facing Beveridge systems in the U.K., Sweden, and Canada today, all of which are struggling with some combination of shortages, delays, fiscal shortfalls, and quality-of-service issues that are undermining both the health of their citizens and the egalitarian ideals the systems were built on.

Countries built health care systems under the presumption that the laws of economics simply don't apply to health care—that physicians and nurses have nothing but their patients' well-being in mind and are not interested in making money, that patients aren't smart enough to be able to make choices about their health, and that systems that hide costs from patients won't result in resource-draining, unnecessary care. But reality has been catching up, and citizens of these countries are suffering and even dying as a result.

The NHS' problems are perhaps best illustrated by its ongoing "bed-blocking" crisis. As of July 2022, almost 13,000 hospital beds—about one in seven—were used by patients who were well enough to be discharged. Some had been there for nine months. Why? They had nowhere to go.

They're supposed to receive follow-up treatment at home, but there aren't enough personnel for that. That's no surprise considering there are about 165,000 open positions for adult social care in England. One in 10 positions is unfilled.

Consequently, other patients get stranded in ambulances waiting outside hospitals for beds to free up. An October 2022 analysis by the British Heart Foundation found that 230 heart disease patients a week were dying due to ambulance delays and bed blocking—30,000 excess deaths among such patients since the beginning of the pandemic. In August, calls had an average response time of 59 minutes. In one region, the average was 72 minutes, four times the 18-minute target set in the NHS' constitution. This has lethal consequences: Last summer, an estimated 500 British citizens died every week because of the extended wait time to receive emergency services.

Medical professionals already struggle with their workloads. Bed blocking means they receive more patients in dire condition due to the delays. Physicians and nurses are retiring en masse because they aren't able to take proper care of patients; they live in constant fear that they will make the wrong call when prioritizing patients and thus will precipitate a death. One crisis feeds another.

It's not just patients in ambulances who are waiting. Last June, more than 333,000 people were on cardiac waiting lists. That's 8,300 more than the previous month, and the number had been increasing for 24 consecutive months. More than 30 percent of those people had been waiting for over 18 weeks, the NHS' target for treatment.

I encourage everyone to read and learn: https://reason.com/2023/02/12/across-the-globe-government-health-care-systems-are-failing-us PLEASE VOTE NO!