Most Americans express satisfaction with their own health care, but many are uneasy about the overall state and direction of the American health care system. And for good reason. The next several years raise the specter of continued double-digit inflation in health care costs. Access and insurance coverage will shrink for vulnerable segments of the population who are already struggling in the present economic downturn. Pressure of stress often bring demands for overhaul. So at a time when unpopular managed care often bring demands for overhaul. So at a time when unpopular managed care organizations offer an easy target for renewal. The next problem will be ameliorated as lower costs, new payer has a nice ring to it, because an all-in system avoids game-playing that dogs any voluntary insurance system. Sick people don’t have to leap to buy insurance; healthy people cannot avoid participation. In truth, the problems with the Canadian system run far deeper. Single-payer has a system is not cheap to operate, and its run-up-in costs has roughly tracked our own in the last few years. In addition, the single-payer system creates a government monopolist that is unsponsive to long-term social needs. Innovation must be imported from outside the country, as with prescription drugs, which is an option that we quite simply don’t have. Needed capital expenditures are often held hostage to politics, so that right now Canada suffers from dilapidated plant and antiquated equipment. In November 2002, Canada’s Romanow Commission announced with great fanfare that Canada needed to inject $4 billion Canadian ($2.5 billion U.S.) into its health care system during the next three years to bring its facilities up to snuff. But why believe that this one-time fix will work when today’s underfunded Canadian system has increased in cost by 30 percent over the past five years — at a time when the overall economy grew by only 20 percent? Canada’s tax rates are already so high that fresh increases for the health sector could easily reduce productivity and crowd out needed investments elsewhere.

In addition, the want of competition has three further undesirable effects. First, since the Canadians will not ration by price, they must ration by queue. The New York Times reported in February that waiting times for nonemergency procedures have moved up sharply in the past 10 years. In response, Canada has grudgingly licensed some nongovernment units to perform, for example, MRIs. But these measures have not stemmed the flow to the United States for treatment of people who won’t wait until Canada sorts out its own management problems.

Second, a single provider is also a single employee, which means that doctors have to spar with the government in setting salary and terms of employment, with immigration their only way out if job actions and strikes fail. Our doctors who gripe about the monitoring from private managed care organizations will not be thrilled to work exclusively for Uncle Sam.

Last, placing everyone within a single insurance pool requires low-risk consumers to subsidize high-risk consumers. The universal coverage that benefits some will hurt others, creating political instability. Guaranteed coverage also leads to overconsumption by people who can’t be excluded from the system. Managing these manifold problems will be still greater in our huge system: 10 times the population, 20 times the grief.

Truth is, there is no easy way out. The moral churning of the Romanow Commission offers strong evidence to Canada’s determination to keep its health care system intact, but no considered argument as to how it will be accomplished. More sober souls temper that idealism with the recognition that in the end, any system of health care can at most minimize the imperfections of this complex service market. We have many problems of liability, quality and access within the American system. But we will only compound the misery if we pile a huge Canadian-style government monopoly on top of the current regulatory labyrinth.

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