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## No Canadian Cure for Our Health Care Malaise *by Richard A. Epstein*

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. Periods of stress often bring demands for overhaul. So at a time when unpopular managed care organizations offer an easy target for legions of reformers, it's easy to look north longingly to the Canadian single-payer universal health care system: access for all at prices that everyone can afford.

We have ample reasons for disquiet about our health care system. But the lion's share of blame does not belong on the heartless "market" that incurs the wrath of so many health care reformers. Rather, the true indictment of American health care starts with its Byzantine regulatory infrastructure. Relax the regulations and the access problem will be ameliorated as lower costs and greater innovation expand the scope of beneficial medical services.

Here is a quick primer of some of today's hot spots that cry out for correction.

- Our system of professional liability for physicians, hospitals and managed care organizations is in terrible disrepair. Those mandates have led to expensive litigation and restriction of services. We need private initiatives, not judicial mandates, to set standards of care and to define consequences of breach.

- Our system of state licensure prevents the movement of medical talent into the country and across state lines and blocks the use of low-cost nonphysician substitutes. These barriers need to be lowered, if not eliminated.
- We heavily subsidize heroic measures at the end of life. It costs a fortune to extend one frail life for a week; those dollars could be reallocated to keeping more individuals away from critical care to begin with. We need to curtail access in most terminal cases.
- Our extensive edifice of employer mandates requires companies to offer costly coverage (such as mental health and alcoholism) that employees don't want. The upshot is that workers prefer no coverage instead of the bloated coverage that regulators require. Scrap the mandates.
- Our Medicare system is popular with its recipients largely because about three-quarters of expenses are borne by payroll taxes and other levies from nonusers. The subsidies lead to massive overconsumption and create an indefensible two-tier system of health care based largely on political clout. We need to stop its expansion and begin cutting back its scope.

No one wants to swallow this bitter medicine, so many people seek relief in universal health care on the Canadian model. But they overlook some key differences. Canada runs its malpractice system at a fraction of the cost of ours, without any clear evidence in decline in levels of care: The liability system is so erratic that it has little if any deterrent value. Canada also powerfully constrains

the expensive treatments routinely allowed in the United States. For instance, it limits intensive care access and cuts back on kidney dialysis for the elderly. Additionally, Canada has the dubious advantage of using its monopsony power to purchase the drugs at a fraction of the cost that they charge in the United States. On the positive side, its drug approval processes are speedier than ours, leading to a steady stream of contraband traffic coming south of the border.

Given these differences, universal health care can't be easily transplanted from Canada — where the results are decidedly mixed. The basic stumbling block is quite simple: Americans are not prepared at present to give up their domestic set of patient prerogatives. We just can't afford to marry Canadian-style of coverage to the heftier American bundle of individual rights.

In truth, the problems with the Canadian system run far deeper. Single-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. But plugging one leak opens other holes. The Canadian system is not cheap to operate either, 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 unresponsive 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 staunched 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 employer, 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 thumping of the Romanow Commission offers strong evidence to Canada's determination to keep its health care system afloat, 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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