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California Dreaming

The Fantasy of a Canadian-Style Health-Insurance Monopoly in the United States

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Executive summary

The purpose of this paper is to warn Americans about the dangerous ideas contained in the *Universal Health Insurance* bill (SB-840) that was recently passed by the Democratic Party majority in the California state legislature and Senate, but which was later vetoed by Governor Schwarzenegger. [1] The bill has now been resurrected and submitted again to the State legislature for another vote. Proponents of the bill want to impose a government-run, health-insurance monopoly in California similar to the one that Canada has. But, the Canadian experience shows that this is a seriously misguided proposal that will harm the quality and availability of medical care in the United States. Americans might be concerned about escalating costs and gaps in health-insurance coverage at home but, for different reasons, the Canadian system is in many ways much worse.

Despite the fact that Canadians spend less of their national income on health care than Americans, the evidence is clear that the Canadian health-insurance system is still among the most expensive in the world [2] and does not return good value for money spent. Health care appears to cost less in Canada than in the United States largely because Canadian public health insurance does not cover many advanced medical treatments and technologies that are commonly available to Americans. Canadian patients do not get the same quality or quantity of care as American patients. On a comparable basis, Canadians have fewer doctors, less high-tech equipment, older hospitals, and get fewer advanced medicines than Americans. If Canadians had access to the same quality and quantity of health-care resources that American patients enjoy, the Canadian health-insurance monopoly would cost a lot more than it currently does.

Experience also shows that the Canadian system is not financially sustainable in the long run. There is a growing consensus among government and private-sector researchers in Canada that, because public-health spending is persistently growing so much faster than public revenue, every one of Canada's 10 provinces are on a path to bankruptcy.

Canadian patients also wait much longer than Americans for access to medical care. In fact, Canadian patients wait much longer than what their own doctors say is clinically reasonable. Many Canadian patients wait so long for treatment that in practical terms, they are in many ways no better off than uninsured Americans: access to a waiting list is not the same thing as access to health care.

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[1] Previous research has warned Californians about bill SB-840 before it passed the state legislature—unfortunately to no avail. For an excellent treatment of this topic see John R. Graham, *Deadly Solution: SB-840 and the Government Takeover of California Health Care* (Pacific Research Institute, 2006).

[2] See Nadeem Esmail and Michael Walker, *How Good Is Canadian Health Care? 2005 Report: An International Comparison of Health Care Systems* (The Fraser Institute, 2006).

Even worse, Canadian patients are effectively prohibited from paying privately for health care services (above what they pay in taxes for the public system) to escape the delays in the public system. Canadian patients are in practical terms unable to buy quicker access or better care than what the public health-insurance program provides. Health care providers are not legally allowed to accept private payment for services that are eligible for public insurance coverage if they want to keep the right to bill patients served under the public insurance scheme. [3] Doctors are reluctant to give up their right to bill the public insurance program and so Canadian patients can only pay privately for health care if they leave the country. Therefore, the Canadian health-care system encourages under-served patients to spend their money in a foreign country—often the United States. The absurdity of such a policy is that, because patients are not allowed to spend their own money on medical care provided at home, the economic benefit of this spending is lost for Canada. Canadian patients end up spending money in foreign economies because they are not allowed to buy health care at home!

Finally, Canadian courts have seen the evidence and ruled that Canada's public health-insurance monopoly makes people wait too long to get medically necessary care. In a 2005 case challenging the province of Quebec's government-run health insurance monopoly, the Supreme Court of Canada struck down the single-payer system as a violation of patients' rights to preserve their own health. A similar case is currently underway in two other Canadian provinces where the plaintiffs are seeking to expand the Quebec precedent on the basis of nationally applicable constitutional rights.

Canada is currently witnessing the failure of its own public monopoly health insurance system. In the face of these circumstances, why would Americans want to adopt such a system for themselves? The fact is that the Canadian model is an example of what *not* to do in health care.

Highlights

- In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2006, that wait had nearly doubled to 17.8 weeks.

- Median wait times in Canada are almost double the wait that physicians consider clinically reasonable.

[3] There are nuances to this situation and some providers have found exceptions to this general rule in various provinces.

- The Canadian government does not publish the number of patients who wait and are not able to get necessary medical treatment within each year. But in 2005, a Statistics Canada survey showed that, of the patients who finally did get access to health-care services within the year, 11% waited longer than three months to see a specialist; 17% waited longer than three months to get necessary non-emergency surgery; and 12% waited longer than three months to get necessary diagnostic tests.

- In 2004, Canada had 2.1 practicing physicians per 1000 population, compared to 2.4 in the United States—equivalent to 300 fewer doctors per 1 million residents.

- In 2003, 45 in-patient surgical procedures per 1000 population were performed in Canada, compared to 88 in the United States.

- In 2004, 25.5 MRI exams per 1000 population were performed in Canada, compared to 83.2 in the United States.

- In 2004, 87.3 CT exams per 1000 population were performed in Canada, compared to 172.5 in the United States.

- In 2003, the average hospital in Ontario (Canada's largest province) was 40 years old; the average hospital in the United States was 9 years old.

- The single-payer system in Canada does not cover out-patient drug expenses on a universal basis. Only about one-third of the population is eligible for various government-financed drug programs in Canada. The rest of the population has private insurance coverage or pays cash for out-patient drugs. And in Canada, governments often refuse to cover many new drugs at all. When new drugs are covered, patients have to wait between two and three years to get access to them.

- Between the fiscal years 2001/02 and 2005/06, on average across all 10 Canadian provinces, government spending on health care grew at a rate of 7.3% annually, compared to 3.9% for total provincial revenue, 2.3% for general inflation and 4.9% for economic growth. This means that in Canada government spending on health care is growing faster than the ability of the government to pay for it.

- It is estimated that in 6 out of the 10 Canadian provinces public health spending is on pace to consume more than half of total revenue from all sources by the year 2020, two-thirds by the year 2035, and all of provincial revenue by 2050. These estimates do not take into account the added pressures from an aging population.

- As of 2003, the unfunded liabilities of future government funding obligations for health care in Canada reached CDN$555 billion or 46% of the country's 2003 total economic output (GDP) of CDN$1.2 trillion—growing 29% since 1999.

- In June of 2005, the Supreme Court of Canada struck down the province of Quebec's public health-insurance monopoly, ruling that long waiting times violate individuals' right to preserve their own health. In two other provinces, patients are challenging Canada's government monopoly on health insurance in court on constitutional grounds.

- After adjusting for the purchasing power of the currencies, Canadian physicians earn only 42% as much as American physicians. Canadian nurses earn only two thirds as much as American nurses. Canada's public monopoly exploits the services of medical labour by holding down wage rates below what they would be in the market. After adjusting for inflation, average income for all physicians in Ontario is presently three quarters of its peak 1972 level. Since 1972, physicians' pay has dropped by half compared to average Ontario incomes.

- The negative incentives from below-market income opportunities are creating shortages in some physician practice areas. Figures from the year 2003 indicate that more than 1.2 million Canadians were unable to find a regular family physician.

- Thousands of Canadian-trained and previously active physicians have already left Canada for better opportunities and working conditions in the United States. American doctors are not moving to Canada for better opportunities or working conditions.

Background: Universal Health Insurance bill SB-840

California SB-840, the *Universal Health Insurance* bill brought forth by Sen. Sheila Kuehl (D-Santa Monica), proposed eliminating private health-insurance plans and replacing them with a statewide universal health insurance system similar to the one in Canada. Private health insurance would effectively be banned and replaced with a health-insurance monopoly owned and run by government. The state Assembly passed, and the state Senate, approved the bill but Governor Schwarzenegger eventually vetoed it. Senator Kuehl has recently reintroduced the bill in an attempt to override the Governor's veto.

The health insurance proposal intended to provide universal public coverage for all medical costs, dental care, prescription drugs, hospitalization, and mental health. For the record, this makes the program far more generous than coverage under the US Medicare program. Bill SB-840 is also more generous than government health insurance programs in Canada, which do not universally cover the costs of out-patient drugs, dental care, vision care, or long-term care.

The illusion of cheap Canadian health insurance

Some people mistakenly assume that Canada achieves lower levels of spending and that Canadians get the same quality and quantity of health-care goods and services as Americans. These assumptions could not be further from the truth. Canadian public health insurance costs less than American health insurance partly because the Canadian government restricts the supply of health professionals and medical technologies, neglects the modernization of its hospitals, and holds the wages of health professionals as well as the prices for other medical goods and services below market prices. The result is lower costs but fewer medical resources and less access to health care compared to the United States.

Wait times

The most obvious problem with Canadian health care is wait times for medical services. In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2006, that wait had nearly doubled to 17.8 weeks. And, wait times in Canada are almost double the wait that physicians consider clinically reasonable [Esmail and Walker, 2006b].

Canadian governments do not publish the number of patients who are seeking health care but cannot get it. However, Statistics Canada surveys those patients who do finally get access to necessary medical treatment within each year. In 2005, of those patients surveyed who finally did get access to health-care services within the year, 11% waited longer than three months to see a specialist; 17% waited longer than three months to get necessary non-emergency surgery; and 12% waited longer than three months to get necessary diagnostic tests [Statistics Canada, 2006a].

A 2005 survey compared the wait times experienced by health patients in six countries including Canada and the United States. When asked how long they had waited to be seen in ER, 24% of Canadian respondents answered "4 hours or more," compared to 12% of American respondents. The difference between wait times to obtain a specialist appointment was even greater: 57% of Canadian respondents claimed that they had to wait more than four weeks for an appointment with a specialist compared to 23% of their American counterparts [Schoen et al., 2005].

Canadians also have fewer health-care resources than Americans. For example, in 2004 Canada had on average 2.1 practicing physicians per 1000 inhabitants, compared to 2.4 in the United States [OECD, 2006]. [1] Thus in 2004, there were 300 fewer physicians available per million people in Canada than in the United States. Similarly, Americans have better access to surgical procedures than Canadians. In 2003, total in-patient surgical procedures per 1000 inhabitants were 45 in Canada and 88 in the United States [OECD, 2006]. In addition, patient access to diagnostics in the United States is far better than in Canada. In 2004, Canada averaged 25.5 MRI examinations per 1000 inhabitants, compared to 83.2 in the United States. Likewise, Canada averaged 87.3 CT examinations per 1000 inhabitants in 2004, compared to 172.5 in the United States [CIHI, 2006a].

Overall, rationing of medical services by government has reduced the number of hospitals and medical facilities in Canada and has permitted the capital deterioration of existing facilities. Research has shown that in 2003 the average age of a hospital in Ontario (Canada's largest province) was 40 years, which nearly matches the length of time that Canadian public health insurance has been in place. By comparison, the same research found that the average age of an American hospital in 2003 was only 9 years [OHA, 2003]. The Canadian health-insurance system is not designed with appropriate incentives to modernize and recapitalize the nation's health-care infrastructure. In Canada, it takes central planners and bureaucrats years to realize that shortages exist, let alone make timely decisions to modernize the health-care infrastructure. By contrast, consumer choice and private-sector competition within American health care forces hospitals constantly to modernize and invest in new technologies.

[1] Internationally, relative to comparable countries of the OECD, Canada ranks twenty-fourth out of 27 countries when the number of "doctors per 1000 people" is compared on an age-adjusted basis [Esmail and Walker, 2006a].

Access to the most advanced medicines is also limited under Canada's government-run health-insurance monopoly. First, the single-payer system in Canada does not cover out-patient drug expenses on a universal basis. Only about one-third of the population is eligible for various government-financed drug programs in Canada. The rest of the population has private insurance coverage or pays cash for out-patient drugs. And in Canada, governments often refuse to cover many new drugs at all [Skinner, 2005a]. When new drugs are covered, patients often have to wait between two and three years to get access to them [Skinner et al., 2007].

Canada's public health-insurance monopoly is headed for bankruptcy

Not only does Canada's government-run health-insurance monopoly produce low value for money, the evidence is that the system is not even financially sustainable. Canada's health-insurance system is run by the provinces. Each of the 10 provinces maintains a government-run health-insurance monopoly under which every resident is eligible for the coverage of hospital and physician services. The provinces also have separate programs to pay for outpatient drugs but only for a minority of the population. Between the fiscal years 2001/02 and 2005/06, on average across all 10 Canadian provinces, government health spending grew at a rate of 7.3% annually, compared to 3.9% for total provincial revenue, 2.3% for general inflation, and 4.9% for economic growth [Statistics Canada, 2006b; calculations by authors]. This means that in Canada, government spending on health care is growing faster than the ability of the government to pay for it. In fact, in every Canadian province the experience is the same: government spending for health care is consistently growing faster on average than total revenues from all sources. This has resulted in health care taking up an increasing share of provincial revenue over time [Skinner and Rovere, 2006]. Whether one looks at the most recent five years of data—or at over 30 years of data—the trends are all the same [Skinner, 2007].

Based on the most recent five-year trends, it is estimated that in 6 out of 10 Canadian provinces public-health spending is on pace to consume more than half of total revenue from all sources by the year 2020, two thirds by the year 2035, and all of provincial revenue by 2050. These projections do not even take into account the added pressures from an aging population that will further accelerate the growth of provincial health spending as a percentage of total revenue and cause these dates to occur much earlier. If provincial governments continue to cling stubbornly to the single-payer approach to funding health care, the costs will soon exceed their capacity to pay [Skinner and Rovere, 2006].

Using Statistics Canada's own micro-simulation model and detailed data from Statistics Canada and the Canadian Institute for Health Information, researchers have also generated estimates of the unfunded liability of Canada's single-payer health-insurance system [Palacios and Veldhuis, 2006]. As of 2003, Canadian governments faced future funding obligations for health care that exceeded expected future revenues by CDN$555 billion or 46% of Canada's 2003 total economic output (GDP) of just over CDN$1.2 trillion [Statistics Canada, 2007]. Most worrisome is that this unfunded liability grew by 28.5% between 1999 and 2003, from CDN$432.2 billion to CDN$555.3 billion.

Runaway costs of public health insurance will put pressure on the wages of health-care professionals

Health professionals in the United States should beware that whenever Canadian health care has been able to achieve savings, it has usually come from restricting access to publicly insured medical goods and services, from not paying the full costs of innovation in medicines [2] and technology, from not investing in new hospitals and equipment, *and* from holding down the wages paid to health professionals. For example, on average Canadian physicians earn only 42% as much as American physicians [table 1]. [3] Other research indicates that Canadian nurses earn only two thirds as much as American nurses [Skinner, 2002]. American health professionals earn more on average than their Canadian counterparts because Canada's public monopoly exploits the services of medical labour by keeping wage rates below what they would be in the market. In fact, after adjusting for inflation, average income for all physicians in Ontario (Canada's most populated province) has declined over the 30 years between 1974 and 2004 and is presently three quarters of its peak 1972 level. Since then, physicians' pay has dropped by half compared to average Ontario incomes [Mullins, 2004].

The result of the government holding medical wage rates below market prices is that fewer medical students are entering the lower-paid physician practice areas in Canada like family medicine [CARMS, 2006]. The negative incentives from below-market income opportunities are creating shortages in these specialties. In fact, figures from

[2] The Canadian federal government imposes price controls on patented medicines. The policy has been a failure [Skinner, 2005b].

[3] This figure is computed by dividing the total spending on physicians in the United States and Canada in 2004 by the active total physician populations in each country in the same year and adjusting for the purchasing power parity of the currencies in 2004 [CIHI, 2007b; US NCHS, 2006].

Table 1: Average American and Canadian expenditure on physicians, 2004

	2004 Data	Sources
United States		
Total national health expenditure on physicians	$399,900,000,000	US NCHS, 2006a
Number of professionally active physicians	744,143	US NCHS, 2006b
Average expenditure on physicians	$537,396.71	Authors' calculations
Canada		
Total national health expenditure on physicians	$17,167,900,000	CIHI, 2007a
Number of professionally active physicians	60,436	CIHI, 2006b
Average expenditure on physicians	$284,067.44	Authors' calculations
Average expenditure on physicians @ 2004 US PPP	$227,253.95	Authors' calculations
Canada : United States PPP	1.25	OECD, 2007
Average Canadian expenditure on physicians @ 2004 US PPP / average American expenditure on physicians	42%	Authors' calculations

the year 2003 indicate that more than 1.2 million Canadians (about 4% of the population) were unable to find a regular family physician [Statistics Canada, 2004].

Many Canadian physicians have also already left Canada for better opportunities in the United States. Importantly, the reverse is not true: American doctors are not moving to Canada. Based on data covering the 10 years from 1996 to 2005, it has been estimated that one in 12 Canadian-born and educated physicians practiced in the United States. Collectively, this is equivalent to having two, average-sized, Canadian medical schools dedicated solely to producing physicians for the United States. In fact, Canada is the second largest source of immigrant physicians to the United States, second only to India. Coincidentally, the number of Canadian emigrant physicians to the United States is approximately equal to the current physician shortage in all Canadian provinces [Skinner, 2002; Phillips et al., 2007].

Canada's Supreme Court has ruled that the public health-insurance monopoly violates individual rights

Proponents of a universal public health-insurance monopoly in California should also know that such a system would not likely withstand constitutional challenges in US courts [Graham, 2006a]. Recently, in June of 2005, the Supreme Court of Canada struck down the province of Quebec's public health-insurance monopoly. [4] The Court ruled that long waiting times violate an individual's right to preserve his own health. Policy makers are now scrambling to deal with the realization that Canada's public health-insurance monopoly is in legal jeopardy. In the province of Alberta, another patient is challenging Canada's government monopoly on health insurance in court on the basis of constitutional rights [Cameron and Evans, 2006]. The Alberta case could expand the 2005 ruling to apply in all 10 Canadian provinces. Most recently, another case has been launched in Ontario that is challenging the province's single-payer health-insurance monopoly as a violation of constitutionally protected rights [CCF, 2007]. Based on this legal precedent, it is very doubtful that the California bill would survive similar legal challenges in the United States, where there is supposedly a stronger individual-rights tradition. However, if bill SB-840 is passed despite the probability of constitutional challenges, it would do incalculable damage to the health-care system and cost taxpayers dearly in the meantime.

A better solution for covering the uninsured

In a private market, there will inevitably be a few people who lack the income to purchase health insurance and there will also be some who are unwilling to make the purchase of health insurance a priority, even when their income is sufficient to do so. This becomes a problem when universal health-insurance coverage is considered to be a social and political necessity. But making everyone eligible for medical benefits that are publicly subsidized 100%, as in Canada and the dangerous California proposal, is not the best way to achieve universal health-insurance coverage.

First, the problem of the uninsured in America is overstated. According to the US Census Bureau's Current Population Survey (CPS), 45.8 million Americans lacked health insurance in 2004 [US Census Bureau, 2005]. However, estimating the number of

[4] *Chaoulli v. Quebec (Attorney General)*, 2005. Supreme Court of Canada (SCC 35).

people without health insurance in the United States is the subject of much debate because of the way that the US Census Bureau collects data on the issue; the government's survey questionnaires cannot be relied upon to reflect reality accurately.

Table 2 illustrates the problems with the CPS: it shows the numbers for the estimated US population in each of the survey categories for health insurance coverage. Note that the total number of people with private health insurance, government health insurance, and no health insurance exceeds the Census Bureau's estimate for the entire population of the United States—an obvious impossibility. The number of responses to the CPS questionnaire is inaccurate by a margin of at least 32 million people! An accurate estimate must take account of the particular characteristics of the survey population, including:

- those who are uninsured only for a short period because they are between jobs and have temporarily lost employer-based health insurance; or who are students transitioning between family, school and work coverage;
- those who are eligible for public health-insurance programs like Medicaid and SCHIP programs for children but who are reluctant to enroll until the moment they require health care services'
- those who have sufficient income to buy health insurance but choose not to;
- those who are uninsured for long periods of time because they lack employer-based insurance or the income to buy health insurance themselves [BCBS, 2005].

Table 2: Inaccuracies in the US Current Population Survey questionnaire on health-insurance coverage among Americans

Survey response	Estimated population
Had private health insurance	198,262,000
Had government health insurance	79,086,000
No insurance coverage during the year	45,820,000
Total of above	323,168,000
Total CPS US Population	291,155,000

Source: US Census Bureau, 2005.

Researchers who have looked at the inaccuracies in the CPS survey have estimated that the actual number of uninsured is about half of the figure reported by the US Census Bureau and that being uninsured is usually only a temporary condition [Herrick, 2006; Graham, 2006b].

Additionally, lacking health insurance is not the same thing as a lacking access to health care. The uninsured in the United States are not prohibited from obtaining health care through direct payment and it is illegal for hospitals to refuse urgent life-saving care. So, the lack of health-insurance coverage is not an absolute barrier to getting necessary medical care.

Nevertheless, there are probably significant numbers of people who need, but cannot afford, health insurance coverage in the United States. And, the demand for universal coverage has unrelenting political appeal—as evidenced by the resurrection of Bill SB-840. So, the question is how the United States can achieve universal health-insurance coverage without suffering the enormous costs and failures associated with a public health-insurance monopoly like that in Canada. The point is that achieving universal health-insurance coverage does not require a public health-insurance monopoly. In fact, a public health-insurance monopoly is the worst way to achieve universal coverage. But, if American policy-makers do not address the demands for universal coverage soon, the United States could end up making the same mistakes Canada made.

The Canadian experience is instructive of the fact that universal, tax-funded, health insurance is not even necessary. Research in 2002 using Canadian data on the individual-level distribution of illness and income in the population indicates that:

- only about 4% of the population has health expenses that can be considered catastrophic (even when generously defined) compared to other kinds of expenses;

- and less than 1% of the population has catastrophic health expenses (even when generously defined) *and* also lacks the income to pay directly or buy private insurance for their health care needs if it were available [Skinner, 2005b].

Despite the fact that so few people actually need public financial assistance in paying their medical expenses, the Canadian system publicly subsidizes all medical expenses for everyone. The politicization of eligibility and coverage decisions under a tax-funded universal, public health-insurance monopoly creates pressures upon policy makers to agree to first-dollar coverage for everything. But, taxpayers should not be paying the cost of affordable medical care for the nearly 99% of the population who do not need a public subsidy. A more rational approach would be to provide public financial assistance only for those few people who are truly in need, by supplementing their incomes on the basis of an income and assets means test so they can afford to buy private health insurance.

If universal health-insurance coverage is considered politically unavoidable, then the population could be required to privately purchase mandatory, basic, health insurance in a regulated, competitive market. [5] After all, if the proponents of universal medicare suggest that it is fine to force each of us to pay for our neighbours' health insurance, why would it be wrong to force our neighbors to prioritize their own income toward the purchase of their own health insurance?

This is similar to the way health insurance works in Switzerland, where individuals are required by law to purchase private health-insurance policies for which the premiums are "community rated," that is, the same for each person in a particular region or municipality taking out insurance with a particular company or non-profit organization, regardless of individual risk rating. People are guaranteed a free choice of insurance provider and can change their compulsory health-insurance provider up to twice a year. Insurance providers are not allowed to refuse an individual's application for a compulsory health-insurance policy and high-risk insureds are cross-subsidized by the entire insurance sector acting as a single cooperative risk pool through a government-controlled mechanism. The insurance providers compete based on the level of the premium, and price competition works. To reduce the social impact of premium costs on low-income people, tax-payers partially subsidize compulsory health-insurance premiums through a means-tested subsidy that varies according to the income and assets of the insured person [European Observatory on Health Care Systems, 2000].

Additionally, according to Graham [2007] there are some notable advantages to Swiss health policy that could already be adopted in the United States without even changing the current basic system of health insurance.

1. The Swiss tax code does not punish people for buying health insurance directly as individuals. By contrast, in the United States health insurance is taxable if purchased directly but not if received as part of employment benefits. The Swiss each have personal ownership of their health insurance and therefore do not lose coverage if they switch jobs. [6]

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[5] This is not a radical departure from other types of insurance regulation in the United States and Canada. In most states and provinces, motorists are already familiar with legislated, compulsory purchase of auto insurance. Scandlen [2006] and Graham [2007] have both rejected health-insurance mandates, arguing that a percentage of drivers ignore such mandates for auto insurance. However, health-insurance mandates could be enforced through the income-tax return system on a means-tested basis, something not done with auto insurance mandates. There could also be exemptions from the mandate for those who can demonstrate financial capacity instead of insurance—similar to auto insurance in many states. Finally, the important practical point is that, once a person refuses to obey the mandate, they have revealed their preference and have thus surrendered any moral claim on the state to provide them with health insurance. Therefore, even if a mandate did not actually achieve universal coverage, it would eliminate the real need for it. The mandate would also de-legitimize any political demands for a single-payer system.

[6] There may also be better cost recognition because consumers pay the whole bill themselves.

2 The Swiss government also does not order its people to give up private insurance and go into a government program at age 65 as the United States does with its Medicare policies.

3 Swiss insurers also have far more freedom to make individuals more responsible for the health care that they consume. They do this by introducing a price at the point of consumption through co-payments and deductibles. These strategies are very successful but American laws and regulations have historically inhibited such approaches to controlling the cost of health insurance.

In Canada, a similar approach to health-care policy would permit enormous reductions in the tax burden for Canadians and encourage the rationalization of health-care costs and benefits. Canadian policy makers are not serving either patients or taxpayers very well by stubbornly clinging to a public health-insurance monopoly when they could achieve the same policy goals with much greater benefit to their population by adopting a universal, compulsory, private health-insurance system.

For Americans, something like the Swiss health insurance model—tailored to the US setting—would solve contentious political demands for universal health-insurance coverage without requiring a harmful and wasteful public health-insurance monopoly. There are also some aspects of the Swiss system that might be an improvement when moving from the status quo in Canada that might not be optimal when moving from the status quo in the United States. For instance, the regulatory requirements for flat, community-rated, premiums under the Swiss system could raise the cost of insurance for healthy people in the United States [Herrick, 2006].

Conclusion

Canada's public health-insurance monopoly is failing. Canadian patients do not get the same timely availability of medical care as American patients. In Canada, public health insurance does not in practice cover the most advanced medical treatments and technologies. Millions of Canadian patients wait so long for treatment that in many ways, they are no better off than uninsured Americans. Access to a waiting list is not the same thing as access to health care. Even worse, Canadian patients are practically prohibited from paying privately (above what they pay in taxes for the public system) to escape the delays in the public system. Canadians are quite literally trapped in a failing system. This makes them even worse off than the uninsured in America, who can at least gain access to health care by paying cash (or credit) for it.

A Canadian-style, public health-insurance monopoly would cost American taxpayers dearly. The Canadian experience shows that such a system is not financially sustainable in the long run. There is a growing consensus among government- and private-sector researchers in Canada that, because public health spending constantly grows so much faster than public revenue, every one of Canada's 10 provinces are on a path to bankruptcy. The Supreme Court of Canada also recently struck down the public health-insurance monopoly in one province as a violation of patients' right to preserve their own health. The court has seen the evidence that Canada's public health-insurance monopoly delays or denies access to medical treatments and makes people wait too long to get medically necessary care. Canada is currently witnessing the failure of its own public, monopolistic, health-insurance system. Why would Americans want to adopt such a disastrous system for themselves?

The passing of a proposal for a public health-insurance monopoly through both the legislature and Senate in California, and its reintroduction following the Governor's veto should serve as an urgent warning. The problem of the uninsured needs to be solved before a tipping point is reached and Americans have a Canadian-style health-policy disaster foisted upon them by a group of people who are not disclosing the facts about health care in Canada. There are better alternatives that should be considered if universal health insurance coverage is deemed a political necessity. The Swiss health-insurance system is probably the best real-world model for how to achieve universal health-insurance coverage on a sustainable basis. Americans should consider adopting, and improving, the best parts of Swiss health policy.

In a private market, there will inevitably be a few people who lack the income to purchase health insurance and there will also be some who are unwilling to make the purchase of health insurance a priority, even when their income is sufficient to do so. Instead of an unnecessary, public health-insurance monopoly, Americans should simply demand that everyone be legally required to show individual proof of purchase for health insurance coverage or demonstrate the personal financial means to go without insurance coverage. Low-income people could be subsidized to help them buy private insurance. Such a system should replace existing public programs like Medicare and Medicaid. The evidence indicates that the best approach to achieving universal health-insurance coverage is to make people prioritize their own income toward the purchase of their own health insurance, not to make their neighbors buy health insurance for them through a redistributive, government health-insurance monopoly.

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