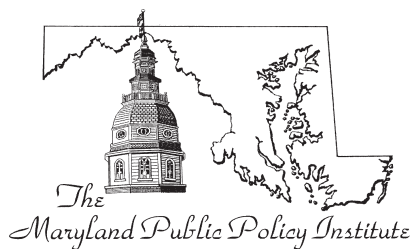
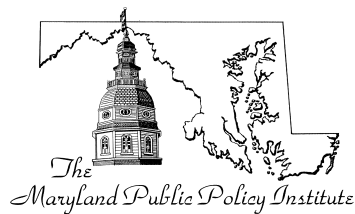


SINGLE-PAYER HEALTH CARE
FOR MARYLAND

TWO ANALYSES



SINGLE-PAYER HEALTH CARE FOR MARYLAND: TWO ANALYSES



Published by
The Maryland Public Policy Institute
1 Research Court
Suite 450
Rockville, Maryland 20850
(240) 686-3510
mdpolicy.org

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PROPOSALS FOR UNIVERSAL CARE IN MARYLAND

Marc Kilmer

As in previous sessions, the 2008 Maryland General Assembly considered a proposal to create a statewide universal health care plan. The 2008 proposal, authored by Del. Karen S. Montgomery (D–Montgomery), would have established a “single payer” system in which the state would have paid for all Marylanders’ health care and no Marylander would be permitted to not participate in the system. A Board of Governors would have been created for the Maryland Universal Health Care Plan (MUHCP), and that board would have established different plans that would be available to Marylanders. No private organization could offer duplicative services. The MUHCP also would have set rates for payment to doctors and hospitals. The sponsor of the legislation envisioned it be funded within current federal, state, and local budgets for health care services. (Medicare funds are excluded, however.)

As with previous attempts at universal health care, the General Assembly did not adopt the Montgomery proposal. However, special interest pressure remains strong in Annapolis for government-financing of Marylanders’ health care. This report offers two analyses.

OTHER AREAS OF SUPPORT IN MARYLAND

Advocates

One of the main groups pushing for single-payer care in Maryland is the Maryland Universal Health Care Action Network (MD UHCAN). On its webpage, MD UHCAN has a “Frequently Asked Questions” (FAQ) on a single-payer system. Some of its reasons for supporting single-payer are revealing.

Take, for instance, MD UHCAN’s description of the current health care system:

The health care insurance industry’s sole reason for existence is to make a profit for its owners, its stockholders. The best way to maximize profits is to provide as little actual health care as possible. Sell a product (health care) but deliver as little of it as possible. Insure only healthy people. Drop those who have chronic illnesses or develop catastrophic health problems. Use these profits for obscene executive salaries. Advertising. Administration. Lawyers. Clerks. Accountants. Denial experts. Stock dividends. Lobbyists. Campaign contributions. They call these expenses overhead.¹

Of course, what this analysis overlooks is that the largest health insurance provider in the state, CareFirst Blue Cross Blue Shield, is a nonprofit. It also fundamentally misstates the nature of profit in business. True, one way to maximize profits is to sell a product but deliver as little of it as possible. Another way, however, is to build a customer base by supplying a quality product at a good price. Furthermore, profits are an important way to motivate behavior. Businesses deliver goods and services that people want in order to make a profit. Yes, the businesses benefit but so do consumers.

1. See http://www.mdsinglepayer.org/what_is_single_payer.htm for the entire FAQ.

Regardless of the fundamental misunderstanding of economics present in MD UHCAN's analysis, there is also the issue that MD UHCAN misunderstands the nature of the current health care system. By focusing on health insurance it neglects to discuss the variety of other factors at play in our health care system. For instance, government plays a large role in our health care system. In terms of financing, it plays a larger role than insurance companies. If the current system is flawed—and it certainly is—then it makes sense to examine what role the largest player in the system plays.

Also significant, MD UHCAN states, “Insurance companies currently intrude as a barrier between the patient and the doctor.” What this viewpoint fails to acknowledge is that unless the patient pays for care directly, there will always be a “barrier between the patient and the doctor.” As will be seen from the discussion below on the Canadian system, in a single-payer system the government is a barrier between the patient and doctor.

Political Support

Besides MD UHCAN, a variety of Maryland politicians have supported a single-payer system. In Congress, Maryland Representatives Elijah Cummings and Albert Wynn are cosponsors of H.R. 676, which would essentially expand the Medicare program to cover everyone in the U.S. When former Baltimore Congressman Kweisi Mfume ran for the Democratic nomination for the U.S. Senate in 2006, his support of a single-payer system was at the heart of his campaign.²

FLAWS OF UNIVERSAL COVERAGE PROPOSALS

What these single-payer advocates fail to understand is that there are many flaws in a single-payer system as proposed by Delegate Montgomery. If enacted in Maryland, it would require a huge increase in state taxes to finance it. A single-payer system would also inevitably lead to rationing of health care by government bureaucrats.

Cost

The legislative plan for a single-payer system proposed to pay for medical services by gathering all federal, state, and local health care dollars in a trust fund and using that money to pay health care providers. However, this plan would not pay for all the health care consumed by Marylanders. In 2006, total health care spending in the state was \$32.7 billion.³ In its fiscal analysis of Delegate Montgomery's single-payer bill, the Department of Legislative Services noted that private insurance pays for 40 percent of health care services in the state and individuals pay for 16 percent.⁴ That means government funds (the type that will go into the proposed single-payer trust fund) paid for 44 percent of health care spending in the state.

In real numbers, this means insurance companies paid \$13.1 billion and individuals paid \$5.2 billion for health care services in Maryland in 2006. Since under a single-payer system health care would be “free” to the user, where would the money come from to pay these expenses? The bill is silent on this detail, although single-payer advocates claim that with the government paying there

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2. “Md Senatorial Candidate Mfume Touts Single-Payer Health Care System,” Kaiser Daily Health Policy Report, August 31, 2006, http://www.kaisernet.org/Daily_reports/print_report.cfm?DR_ID=39567&dr_cat=3, accessed on September 19, 2007.
 3. Department of Legislative Services, Fiscal and Policy Note of HB 1125, p. 3, http://mlis.state.md.us/2008rs/fnotes/bil_0005/hb1125.pdf, accessed on March 14, 2008.
 4. *Ibid.*

will be lower overhead. The money saved by reducing overhead would then be used to pay for health care services. The Maryland Universal Health Care Action Network estimates that overhead expenses amount to 30 percent of the health care spending in this nation, compared to 1 to 2 percent for Medicare. These advocates then go on to say:

Recapturing the overhead lost in the current “non-system” and making it available for actual health care would mean that we can afford comprehensive care for everyone. Drugs, dental, mental, doctors, hospitals, vision, long-term care, medical equipment, medical devices, etc.⁵

These numbers just do not add up. With private insurance and individuals paying 56 percent of the health care expenses in Maryland, even if we assume that government overhead costs could be kept low (in the 1 percent to 2 percent range claimed by single-payer advocates), there is no way the state government could cover the total amount of health care spending.

Of course, there is no reason to assume that these advocates’ numbers are correct. As Merrill Matthews, Ph.D. of the Council for Affordable Health Insurance points out:

It is very difficult to do a real apples-to-apples comparison of Medicare’s true costs with those of the insurance industry. The primary problem is that private sector insurers must track and divulge their administrative costs, while most of Medicare’s administrative costs are hidden or completely ignored by the complex and bureaucratic reporting and tracking systems used by the government.⁶

Dr. Matthews concludes that a more accurate figure for Medicare’s administrative cost is 5.2 percent and for private insurance administrative cost is 8.9 percent. While the cost of private overhead is still higher than the cost to administer Medicare under this analysis, Dr. Matthews also points out that Medicare’s administrative expenses do not cover a variety of things covered by the private sector.⁷

Dr. Matthews’s more accurate numbers make clear that any savings from lower administrative costs would be negligible. These savings certainly would not pay for the amount of health care currently covered by private insurers and out of the pockets of individual consumers. That means taxes would need to be raised to close the gap.

How much would the state of Maryland need to collect to provide “free” health care? Using 2006 dollars and adjusting for the difference between private sector overhead and Medicare overhead, the state would only see a savings of \$1.17 billion if it switched to a single-payer system. That means it would still need to cover a \$17.13 billion shortfall between total medical spending in the state and government spending on medical care.⁸ In Fiscal Year 2006, the state collected \$11.5 billion in General Fund revenue.⁹ Over \$5.5 billion more in taxes would have to be col-

5. See http://www.mdsinglepayer.org/what_is_single_payer.htm

6. Merrill Matthews, “Medicare’s Hidden Administrative Costs,” The Council for Affordable Health Insurance, January 10, 2006, p. 2, http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf, accessed on October 2, 2007.

7. For example, the cost of management and boards of directors is included in private companies’ overhead. For Medicare, however, this is not the case. Congress is essentially Medicare’s ‘board of directors’ and the salaries and other expenses involved in running the Centers for Medicaid and Medicare Services (CMS) are not included in any calculation of Medicare’s overhead. The cost of raising capital is included in private companies’ overhead calculations; there is nothing comparable included in a discussion of Medicare. A much more detailed discussion can be found on pp. 3 and 4 of “Medicare’s Hidden Administrative Costs.”

8. This, of course, also assumes that the federal government would approve the state’s plan to use federal Medicaid dollars for a single-payer system. This is a dubious assumption, at best.

lected to fund only the single-payer health care system and the state would have to eliminate all other programs now financed through the General Fund.

In 2006, the state spent \$1.94 billion on Medicaid.¹⁰ That leaves \$9.56 billion for other state priorities, such as education, corrections, environmental maintenance, and other things. If the state had a single-payer system in 2006 that cost an additional \$17.13 billion, that means the state budget for 2006 would have been \$26.69 billion.¹¹ The state would have had to collect 132% more in taxes to fund the state budget under this scenario.

Rationing

Without raising taxes, the only way the government can pay for health care spending is to ration it. That is, it will deny certain services to certain people. Single-payer advocates do not like to acknowledge that this denial would have to be a key feature of any single-payer plan. In fact, these advocates go out of their way to assure people that there will be no rationing. As MD UHCAN says on its website, “You would be free to choose any doctor or hospital or other service that you need.” As the section of this paper dealing with Canada shows, that is not the case in that nation’s government health care plan.

Free choice is also not a component of the current government health care systems in the United States. Medicaid recipients, for instance, do not have a choice for any doctor or service they need. They must go to doctors that accept Medicaid dollars. Presumably this would not be the case under a single-payer system, since if a doctor wanted to operate in Maryland he or she would be forced to take payment from the government. Advocates attempt to claim this would not be the case under single-payer care. Again, MD UHCAN claims that doctors “could charge for their products and services and if they choose to remain outside of the system they would be free to do so.” However, Delegate Montgomery’s bill specifically prohibits any private organization from offering insurance coverage that duplicates the state coverage. Doctors would be highly unlikely to remain outside such a system (although many would likely choose to leave the state, further reducing patient choice).

In terms of services, however, the experience under a single-payer system will probably resemble that of Medicaid. Under Medicaid, recipients only receive the services that are allowed by the government. These services are often restricted or reduced during times of economic recession when state tax revenue declines. Presumably all necessary services would be covered by a single-payer system, but politicians will need to define what is necessary and assess the need for such procedures as fertility services, laser eye correction surgery, and even cosmetic surgery. Politicians (with the help of the affected industries’ lobbyists) will be tasked to determine this question.

Certainly some health care services being used today are not needed. Finding a way to reduce unnecessary care would reduce health care spending. Unfortunately, transitioning to a single-payer system would only increase this type of unnecessary care. An experiment by the RAND Corporation concludes that the more people paid for medical care, the less they used. The study also concludes that, outside of the poor, this increased usage of health care does not lead to better

9. Department of Legislative Services, “Fiscal Briefing,” January 22, 2007, p.8. http://mlis.state.md.us/2007rs/budget_docs/ALL/2007_Fiscal_Briefing.pdf, accessed on September 30, 2007.

10. Department of Legislative Services, “Analysis of the FY 2007 Maryland Executive Budget, 2006: Department of Health and Mental Hygiene, Medical Care Programs Administration,” p. 1, http://mlis.state.md.us/2006rs/budget_docs/All/Operating/M00Q_-_DHMH_Medical_Care_Programs_Administration.pdf, accessed on October 2, 2007.

11. This is counting merely state, not federal, revenue.

health outcomes.¹² That extra care is, therefore, unnecessary. Given that, on average, 84 percent of the cost of an individual's health care in Maryland is paid for by a third party, the performance of a large measure of unnecessary health care services can be expected in Maryland.

A logical implication of this study suggests that under a single-payer system, unnecessary health care services would increase. This conclusion is supported by a study of the elderly with osteoarthritis, which concluded that those who had generous drug coverage, not those who most needed the drug, were more likely to use COX-2 inhibitors to control pain.¹³

This type of unnecessary care (or even fraud and abuse) is also more likely under a single-payer system similar to Medicare because this type of system is not set up to catch this type of situation:

Medicare pays claims, millions and millions of them. The claims volume is so heavy that there is little time to do anything else—like scrutinize and review the providers' bills, check with providers if something looks amiss and withhold payment until discrepancies have been resolved. Rather, Medicare is set up to catch problems primarily in cases of massive fraud and abuse, and it does that through the Inspector General in the Department of Health and Human Services, not CMS. In other words, while insurers see claims oversight as responsible stewardship and a collaborative effort to ensure proper payment, HHS operates more as a policing effort.¹⁴

Since a single-payer system has little ability to determine what care is necessary and gives the patient no incentive to avoid unnecessary care, any attempt under such a system to ration care will likely be an indiscriminate rationing, not a rationing based on need. And this will certainly mean that some bureaucrat will “intrude as a barrier between the patient and the doctor” just as the single-payer advocates claim that insurance companies do today.

—*Marc Kilmer is a senior fellow at the Maryland Public Policy Institute.*

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12. Robert Brook and John Ware, Jr., William Rogers, Emmett Keeler, Allyson Davies, Cathy Sherbourne, George Goldberg, Kathleen Lohr, Patricia Camp, and Joseph Newhouse, “The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment,” p. 25, <http://www.rand.org/pubs/reports/2006/R3055.pdf>, accessed on October 4, 2007.
 13. Jalpa Doshi, Nicole Brandt, and Bruce Smart, “The Impact of Drug Coverage on COX-2 Inhibitor Use in Medicare,” *Health Affairs*, February 18, 2004, p. 1, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.94v1.pdf>, accessed on October 4, 2007.
 14. Matthews, p. 4.

A CANADIAN PERSPECTIVE ON MARYLAND HEALTH CARE PROPOSALS

Ian Munro

Canadians are always puzzled by the fact that the food labeled as “Canadian bacon” on American menus looks nothing like the meat that we eat with our eggs and toast on Sunday mornings north of the border. Similarly, the supposed nirvana of “Canadian style health care” in the eyes of many Americans is not what we actually tend to experience above the 49th parallel.

Current proposals before the Maryland legislature would impose a single-payer health care model in the state. One group supporting these initiatives states on its web site that “single-payer” is synonymous with “Canadian style health care.”¹⁵

Before setting the record straight on Canada’s health care system, though, it is important to note that virtually no Canadian wants to import “U.S. style health care” because it, like Canada’s, is currently far from a perfect system.

As well, research and analysis done by our Institute actually suggests that *certain aspects* of a single-payer system may be beneficial, but not of the type being touted for Maryland. We will return to this point after examining some of the myths that surround the Canadian health care system.

MYTHS ABOUT THE CANADIAN HEALTH CARE SYSTEM

Canada does not have the world’s best health care system to which the rest of the world aspires, despite the rhetoric of certain Canadian and American commentators. For example, a 2000 World Health Organization study that assessed “bang for the buck,” preventive measures, and access for vulnerable populations placed Canada in 30th spot (and the United States in 38th).¹⁶ As another example, United Nations statistics for 2005 show that Canada ranks behind much of Europe (as well as Australia, Japan, Singapore, and South Korea) in terms of infant and child mortality rates.¹⁷

Rather than a track record of consistently superior health outcomes and client satisfaction, the two sustainable constants in Canadian Medicare have been rapidly escalating costs and even more rapidly escalating cries for more money. Nonetheless, a 2006 article in the *New York Times* holds up Canada as an example for the United States to emulate because Americans spend even more for their health care than Canadians do, since Canada controls “the use of medical equipment and hospital resources, which statistics show has helped Canadians keep a lid on costs.”¹⁸ Instead, one must remember that this “lid” is relative—Canadian costs have risen, just not as much as in the United States; second, keeping a lid on costs comes with costs of its own.

15. “What is Single Payer?” Maryland Universal Health Care Action Network, accessed at http://www.mdsingle-payer.org/what_is_single_payer.htm, February 6, 2008.

16. World Health Organization, accessed at http://www.who.int/whr/2000/en/whr00_en.pdf, February 6, 2008.

17. Millennium Development Goals Indicators, United Nations Statistics Division, accessed at <http://mdgs.un.org/unsd/mdg/SeriesDetail.aspx?srid=562> and <http://mdgs.un.org/unsd/mdg/Data.aspx>, February 6, 2008.

18. Maryland Universal Health Care Action Network, accessed at <http://www.mdsinglepayer.org/nyt12-31-06-.pdf>.

The extent to which cost pressures in Canada have been relieved has been through crumbling health infrastructure, loss of access to the latest medical innovations, declining numbers of medical professionals, and lengthening queues. Only three years ago our Institute published a commentary stating that “[b]y and large, people have access to ordinary, relatively low-cost services like general practitioner office visits, but find it increasingly difficult to get vital services such as sophisticated diagnostics, or many types of surgery and cancer care, where the waits can be measured in months, if not years.”¹⁹

Three years later, Canada’s hefty federal budget surpluses have provided for billions more in health care spending, but the problems are far from resolved. A recent article in a Halifax, Nova Scotia newspaper carried this headline: “MD: Health system is terribly clogged, doctors just as frustrated as patients.” The story goes on to quote a doctor as saying that in his 52 years of practice, he had never seen the health system so clogged, and he highlighted cardiac and cancer surgery cancellations and cases of “hallway medicine” in which patients are sent to TV lounges and hallways when beds are full.²⁰ Furthermore, in January 2008 the Canadian Medical Association released a report that estimates the economic cost of waiting for health care in Canada in 2007 at nearly \$15 billion.²¹

Recent research by another Canadian think tank highlights the many weaknesses of the Canadian health care system.²² Out of 28 countries²³ (Canada, Australia, Japan, New Zealand, South Korea and 23 European countries) surveyed, Canada ranks third in age-adjusted health spending, but also ranks only:

- 24th in doctors per 1000 people
- 13th in access to MRIs
- 17th in access to CT scanners
- 17th in disability-free life expectancy/life expectancy
- 22nd in infant mortality
- 15th in perinatal mortality

Furthermore, in a comparison of actual versus clinically reasonable waiting times between seeing a specialist and receiving treatment, “actual waiting time exceeded reasonable waiting time in 76 percent of the comparisons.”²⁴

19. “The Top Ten Things People Believe About Canadian Health Care, But Shouldn’t,” Brian Lee Crowley, *Heritage Lecture* No. 856, November 10, 2004, accessed at <http://www.heritage.org/Research/HealthCare/hl856.cfm>, February 6, 2008. We draw frequently on this paper in this section.

20. “MD: Health system is terribly clogged, Doctors just as frustrated as patients,” by David Jackson, *Halifax Chronicle Herald*, December 5, 2007.

21. *The Economic Cost of Wait Times in Canada*, report prepared for the Canadian Medical Association by The Centre for Spatial Economics, January 2008, and Canadian Medical Association, http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Media_Release/pdf/2008/EconomicReport.pdf.

22. “How Good is Canadian Health Care?” 2007 Report, Nadeem Esmail and Michael Walker, The Fraser Institute, November 2007, accessed at http://www.fraserinstitute.org/COMMERCE.WEB/product_files/HowGoodHC2007rev.pdf.

23. Not all 28 countries had data for some of the measures; hence the Canadian ranking may be out of, say, 22 or 25 in some cases.

24. *Waiting Your Turn – 17th Edition: Hospital Waiting Lists in Canada*, Nadeem Esmail and Michael Walker with Margaret Bank, The Fraser Institute, October 2007, http://www.fraserinstitute.org/COMMERCE.WEB/product_files/wyt2007rev2.pdf.

Another oft repeated myth about Canada's health care system is that it is fundamentally "fair" because no one gets better care than anyone else. However, this is not true in the following cases: you are on worker's compensation; you are in the Royal Canadian Mounted Police or the military; your company has its own salaried physicians; you use a private hospital like the Shouldice (which specializes in hernia surgery) in Toronto or one of the country's private abortion clinics; you are a member of the medical professions or know someone who is; or you are articulate and determined or famous and connected. Also, if you travel to the U.S. or any one of a number of other places, you can get better, faster, or more satisfactory care than a Medicare beneficiary.

Being accused of supporting "two (or more) tier health care" is the kiss of death in Canadian politics. Multi-tier medicine is a slippery concept, though. Some believe that a situation where some people can get a service by paying for it while others who cannot pay do not get access constitutes multiple tiers. On the other hand, there are people who oppose tiers in favor an ideology of egalitarianism. Thus, two people with similar conditions may both get treated—one more quickly through private payment and the other more slowly (but within appropriate norms for their condition) by Medicare.

This does not included people being denied care based on ability to pay, because anyone willing to wait will eventually get care (except for those who die while queuing for public health care). The complaint is rather that some receive care more quickly.

So this is the egalitarian objection: No one should be able to get faster treatment than in the public system, even where such faster access does not affect the quality or timeliness of the care obtained by people who continue to use the public system. This peculiar brand of egalitarianism suggests that people should not be denied service because of their own inability to pay but should be denied service because of their neighbor's inability or unwillingness to pay (through taxes) for the care an individual decides he or she needs.

Canada is almost alone in the Western world in outlawing private payment for services by the publicly insured. As a result, we cannot afford to publicly fund many services, such as drugs or home care.

Thus, by forbidding people who wish to do so the ability to pay, we satisfy our ideological craving for egalitarianism, but at the cost of an inability to make room in the public budget for a wider range of services that low-income people might truly need.

THE BASIS OF CANADA'S PROBLEMS

The fundamental problem with the Canadian health care system is not a lack of funding; the problems are structural.

Canada's single-payer system fuses the functions of universal insurer, provider, and evaluator of health care, and this naturally produces a conflict of interest: self-regulation will never entail the same level of transparency and scrutiny as would a system where the roles are separated and an external regulator reviews and reports on the work of the provider.

Poor performance tends to be associated with unregulated monopolies, which occur when a particular group captures a market, has no competitors, and is able to assess or judge its own performance without the need to comply with a set of external regulations.

Like their close cousins in the monopoly family, administrators of the Canadian health care system suffer no direct consequences as a result of poor customer service. They are not even answerable to a regulatory agency other than the federal government's vague powers to withhold funding

for violations of the equally vague principles of the Canada Health Act. Other than notoriously ineffective channels of complaints to politicians, letters to the editor, and calls to talk radio shows, dissatisfied consumers have little choice but to deal with the local health monopolist.

To inject the needed degree of competition while maintaining the valuable aspects of a single-payer health insurance scheme, it is essential to unbundle the functions of payment, administration, delivery, and evaluation.

Note that there *are* certain aspects of a single-payer health insurance scheme that can be valuable. If one starts from the premise that no citizen should go without necessary care due to his or her own inability to pay—a sentiment that is deeply and widely held throughout the Canadian population—the public sector should therefore pool everyone’s risk of sophisticated and expensive interventions (“catastrophic coverage”), while leaving ordinary interventions, whose cost can easily be borne by the average person, to individual consumer choice, supplemented by private insurance and subsidies for those on low incomes.

Note as well, though, that such a system, which would be far more rational than the Canadian status quo, still would require the acceptance of tradeoffs. Large pool risk sharing captures the advantages of catastrophic insurance protection at a lower cost per person, and public, single-payer provision of this aspect of health care avoids the adverse selection and risk selection problems that occur with unregulated insurance market competition. However, this approach still requires that “catastrophic” health problems and costs, and the treatments and services that will be provided, be defined, because the public purse always has limits. Through public debate and the political process, lines will have to be drawn to separate what will be covered, and what will not.

This is not to say that single-payer provision of catastrophic health insurance is the only appropriate route to follow. Another option is to have Medicare insurance itself be a competitive player within a private health insurance market. This would require that Medicare financing come not from general taxation, but from community premiums where everyone in the pool is charged the same premium to fund the pooled risk. If private insurers are also required to use only community-rated premiums and uniform deductibles and to accept every person who applies for coverage, then problems of moral hazard, risk selection, and cream skimming would be reduced. And if, like auto insurance, every person is required to purchase health insurance from either the publicly administered, not-for-profit system or from competing private insurers, then adverse selection problems would be greatly reduced.

CONCLUSION

In terms of the health care services they receive, Canadians are very fortunate compared to many of the world’s peoples. However, the Canadian system has many flaws, most of which stem from ideological rigidity, rather than a lack of resources. These flaws have real consequences: when Canadians are denied timely access to appropriate medical care, they and their families suffer. The only people who would hold up Canadian health care as a model for the world to follow are those who have never had to use it.

In 2002 the Canadian public eagerly awaited the report of the Royal Commission on the Future of Health Care in Canada (known as the “Romanow Report,” because the Commission was headed by Roy Romanow, one-time premier of the province of Saskatchewan—the birthplace of socialized medicine in North America). Sadly, this report regurgitated tired, statist ideology, rather than advocate the profound systemic changes that are necessary to halt the deterioration of the Cana-

dian health care system. In response—in fact a few days before the release of the Romanow Report—our Institute published *Definitely Not the Romanow Report: Achieving Equity, Sustainability, Accountability and Consumer Empowerment in Canadian Health Care*.²⁵ This report contained a short section titled “What Works?” and this is what it contained:

- Regulated market competition offers more consumer choice, better quality and lower cost/benefit ratios
- Consumer co-payments reduce moral hazard, rationalize demand, lower unnecessary utilization, reduce waiting times and queues, and improve timeliness of access
- Targeted income subsidies are more efficient than universal subsidies at meeting social goals, reducing costs to public budgets, and making more funds available for low-income assistance as well as other programs or tax reductions
- Large pool risk sharing captures the advantages of catastrophic insurance protection at a lower cost per person

Eschewing these principles in favor of replicating the worst aspects of Canada’s single-payer system—a lack of competition, consumer focus, and accountability, along with irrational subsidization (in Canada, rich people pay nothing for visits to their family doctors while poor people may have little to no insurance coverage for necessary pharmaceuticals)—would be a tragedy. Marylanders who seek a Canadian-style, single-payer system should be careful with what they wish for.

—*Ian Munro is the Director of Research at Atlantic Institute for Market Studies*

25. Atlantic Institute for Market Studies, <http://www.aims.ca/library/notromanow.pdf> (Much of the discussion in this commentary has been drawn from this report.)

THE MARYLAND PUBLIC POLICY INSTITUTE

Founded in 2001, the Maryland Public Policy Institute is a nonpartisan public policy research and education organization that focuses on state policy issues. Our goal is to provide accurate and timely research analysis of Maryland policy issues and market these findings to key primary audiences.

The mission of the Maryland Public Policy Institute is to formulate and promote public policies at all levels of government based on the principles of free enterprise, limited government, and civil society. The Institute is a member of the State Policy Network. In order to maintain objectivity and independence, the Institute accepts no government funding and does not perform contract research. The Maryland Public Policy Institute is recognized as a 501 (C) (3) research and education organization under the Internal Revenue Code.

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The Atlantic Institute for Market Studies (AIMS) is an independent, non-partisan, social and economic policy think tank based in Halifax, Nova Scotia. The Institute was founded by a group of Atlantic Canadians to broaden the debate about the realistic options available to build our economy.

AIMS was incorporated as a non-profit corporation under Part II of the Canada Corporations Act and was granted charitable registration by Revenue Canada as of October 3, 1994; it has received US charitable recognition under 501(C) (3) effective the same date.

The Institute's chief objectives include:

- a) initiating and conducting research identifying current and emerging economic and public policy issues facing Atlantic Canadians and Canadians more generally, including research into the economic and social characteristics and potentials of Atlantic Canada and its four constituent provinces;
- b) investigating and analyzing the full range of options for public and private sector responses to the issues identified and acting as a catalyst for informed debate on those options, with a particular focus on strategies for overcoming Atlantic Canada's economic challenges in terms of regional disparities;
- c) communicating the conclusions of its research to a regional and national audience in a clear, nonpartisan way; and
- d) sponsoring or organizing conferences, meetings, seminars, lectures, training programs, and publications, using all media of communication (including, without restriction, the electronic media) for the purpose of achieving these objectives.