LIVES AT RISK: SINGLE-PAYER NATIONAL HEALTH INSURANCE AROUND THE WORLD. BY JOHN C. GOODMAN, GERALD L. MUSGRAVE, DEVON M. HERRICK LANHAM. ROWMAN AND LITTLEFIELD, 2004.

Free-market advocates who thought that the drive for a single-payer health care system ended with the defeat of the Clinton-Magaziner plan on August 25, 1994 are in for a surprise.[1] The Associated Press reported (2005) that as of July 2005, due to a recent surge in health-care costs, the push for universal health insurance has been renewed at the state level with proposals now ready for debate in 18 state legislatures. On July 1, 2006, the state of Illinois will implement All Kids, a state health insurance program for children and teenagers up to age 18. Next door in Ohio, a group of activists including doctors, union officials, and clergymen believes that its single-payer referendum will win at the ballot box in November 2006 (Ibid.).

Lives at Risk, the second book by John C. Goodman and Gerald L. Musgrave on health care, directly confronts the issue of single-payer health systems. Goodman and Musgrave are probably best categorized as free-market conservatives due to their association with the National Center for Policy Analysis, even though their first book *Patient Power* was published by the Cato Institute, an ostensibly libertarian think tank.

The first unfortunate shortcoming of *Lives* is that much more is promised than delivered, beginning with the subtitle: "Single-Payer National Health Insurance Around the World." An examination of the workings of single-payer systems in many of the approximately 200 nations of the world would have been fascinating. Unfortunately in *Lives*, "Around the World" almost always means Canada and England. The authors state that they impose this comparative limit to preserve the validity of intercultural comparisons. One can wryly assume that it saved them considerable research resources as well.

Each of the first 20 chapters of *Lives* is devoted to refuting a particular myth about single-payer health systems. The reason the chapter titles might look eerily familiar to some informed readers is that they are nothing more than the 73 pages of chapter 17 in *Patient Power* expanded to 167 pages in *Lives*. The only differences are

[1]Actually this date marked the definitive defeat of any large-scale government-led health reform under Clinton.

that three myths have been changed to reflect the more recent emphasis on the issues of prescription drugs, technology, and managed care.[2]

Blatant recycling aside, much of the material has been updated with new studies only further weakening the case for national health insurance, bits and pieces of them quite devastating. The real problems come in terms of the superficiality of the authors' treatment; one problematic assumption is the validity of allopathy,[3] the regnant state-enforced medical paradigm in the U.S.[4]

Goodman, Musgrave, and Herrick (hereafter G,M,&H) provide an intriguing introduction in which they assert that most analyses ignore three "facts" (p. 1) of modern health care:

1. We can potentially spend our entire GDP on health care "in useful ways."
2. Whatever portion of income is spent on health care today, "we are likely to want to spend more in the future."
3. Normal market forces have been suppressed in dealing with the two "facts" directly above.

It is to beg the question to assert that propositions one and two are facts, not to mention strange statements. Few imaginable societies—certainly not the U.S.—could devote all output to the production of health services, usefulness aside (whatever that really means). The second "fact" is a definite implicit endorsement of allopathy, where most prescribed drugs and surgeries supposedly have benefits outweighing costs. Even before the current COX-2 inhibitors scandal, where as many as 60,000 patients died from the adverse effects of Vioxx during a five-year period (Ozols 2005) there was the December 2003 statement of Allen Roses, M.D., of GlaxoSmithKline that less than half the patients prescribed the most expensive drugs receive any benefit from them (Conner 2003).

The same can be said for many types of surgeries. Bypass, angioplasty, and atherectomy rarely make heart-disease patients better off over the long run than those who forgo the procedures (Whittaker 1995). Septoplasty is a mixed bag at best. Nissen fundoplication is likely dubious over the long term. Hysterectomy is often an unnecessary procedure. Arthroscopic knee surgery for the relief of joint pain is just about an outright fraud (Langreth 2003). If the most optimal drugs and surgery are

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[2]Specifically, myths 15, 17, and 18 in Patient Power were replaced by 5, 13, and 18 in *Lives*. While chapter 18 in *Patient Power* is "The Politics of Medicine," chapter 21 in *Lives* has the same title, is shortened, and slightly rewritten.

[3]Allopathy is the practice of using treatments that produce effects differing from those of the disease being treated. Homeopathy is the practice of using treatments in minute doses that, if used in high doses, would produce effects similar to those of the disease being treated. Modern allopathic practitioners tend to have a proclivity for more interventionist approaches including synthetic (drug) treatments and surgery. Homeopaths have a proclivity for natural treatments and less-interventionist approaches.

[4]This is certainly not to challenge all aspects of allopathy, but the approach has certainly not fully met the free-market test. What has been fascinating has been the new openness toward natural remedies and preventive medicine by allopathic doctors (M.D.s). including Julian Whitaker, and the authors of the new *You: The Owner's Manual*, Drs. Michael Roizen and Mehmet Oz.

no drugs and surgery wherever practical, and preventive medicine is the best medicine *where practical*, then it is clear that unless "health care" includes effective supplements, health-club services, and lower-carb, lower-fat diets, then it is not obvious that accurately informed health consumers are likely to want to spend greater portions of their future real incomes on costly treatments that are often unnecessary, and in terms of outcomes ineffective at best and lethal at worst.

Conceptual problems so early on do not destroy the value of *Lives*. As G,M,&H state at the end of their introduction, the goal of their book is "to dispel certain myths about health care as delivered in countries that have national health insurance" (p. 12). Chapters 1 to 20, where the authors dispel 20 myths, are all that is necessary in this volume to comport with their stated goal.

G,M,&H begin their puncturing of myths by refuting the idea that single-payer systems ensure a right to health care. The "right" only means obtaining health services for "free" (low marginal costs if any at the point of sale). If single-payer health care fails to deliver a particular service, there is no legal recourse. In Canada there is no right to the fiftieth heart-bypass surgery if a patient is seriously ill and holds the fiftieth place in line. This is due to politicians, their friends, members of their families, generous campaign donors, and even animals with political connections being allowed to jump to the front of the line. It would have been nice for the authors to include an exploration of the "right to health care" in light of rights theory. A right is a freedom, an activity with which the state cannot interfere. Does it make sense to equate freedoms to scarce goods or services, as in the statement "health care is a right?"

The authors are very effective in debunking the myth that class equality is advanced by single-payer systems. In this regard, the British and Canadian systems resemble the U.S. public-education system: higher quality in wealthy communities, lower quality in poor communities. The authors cite some very damning statistics undoubtedly heard by few Americans. A Rowntree study found that nonelderly Britons living in areas served by the worst hospitals were 42 percent more likely to die than average. Over time the system has gotten worse; if the British system were returned to its 1983 condition, each year about 7,500 more people under age 65 would be alive.

One obvious weakness of single-payer systems is technology. The authors don't simply offer the threadbare comparison of the number of per capita CAT scanners in the U.S. to those in Canada and Britain. They make the great point that as government interferes more and more in medical markets, the government's technophobia grows. The relatively few patients who are severely ill and in need of costly technology are outnumbered by the relatively many who are healthier and who primarily want perks (comfortable pillows, cable TV) during their relatively short hospital stays. Vote-maximizing politicians and bureaucrats who allocate scarce health resources naturally coddle the latter group.

One important point that the authors emphasize in a chapter on quality is the failure of life expectancy to reflect both better care and the level of spending on care. While the citizens of some single-payer systems have higher life expectancy than those in the U.S., this is due to the U.S. average being a composite of different ethic groups, each with sometimes significantly varying life expectancies. In 1999, Asian-American men had the highest life expectancy at 80.9 years while African-American males had

the lowest at 68.4 years. This places the U.S. life-expectancy rate across all ethnic groups at 74.1 years. This is lower than Japan's average of 78.6, yet G,M,&H report that the Japanese-American average in the U.S. is the same as it is in Japan. Thus differences in access and the level of spending have had no statistically significant effect on the health of diasporas.

Quality in the U.S. has been ambiguous to say the least. While the rate of technological development has been impressive, what makes the U.S. health system the most dangerous industry to U.S. consumers is the number of annual preventable deaths and injuries due to medical error. The authors cite a 1999 Institute of Medicine study which estimates annual deaths at between 44,000 and 98,000. However, a still-recent July 2004 *HealthGrades* report puts the annual level of deaths up to 195,000. The latter figure is roughly more than 534 deaths per day, or the equivalent of more than two jet aircraft crashing each day with no survivors.

While most physicians are either at a loss to explain these staggering numbers, or assert that they are a fact of medicine, G,M,&H emphasize that U.S. hospitals lack even the rudimentary type of quality controls found in the average supermarket, such as centralized digital information and bar-code scanning. They note that the U.S. government is pushing U.S. hospitals to adopt private-sector quality control. They do not mention that the effort is being jump started with a minimum of $125 million in taxpayer funds per year, an amount too paltry to form effective quality controls anytime soon (*Business Week* 2005).

The claims of single-payer advocates that single-payer systems control costs better than the U.S. system are all-too familiar. Besides the fact that, on average, Canada's cost increases have been at a rate second only to that of the U.S., Canadian costs do not include the capital costs of buildings and equipment, as the latter are classified as government spending. These two aforementioned points were emphasized in the U.S. debates of the early 1990s during the Clinton administration. To these G,M,&H add that throughout the 1990s, the Canadian government reduced the level of services to control costs. Fifty hospitals were closed in Saskatchewan alone, and the number of beds across Canada went from 6.6 per thousand in 1987 to 4.1 in 1995 (p. 80).

With respect to whether the U.S. system hinders the U.S.'s ability to compete internationally, the authors' arguments are intriguing. First, they make the rather eyebrow-raising claim that there is "no evidence that the cost of private health insurance adds anything to the price of goods and services sold in the marketplace" (p. 143). (Their evidence to support this assertion is a self citation to an earlier work.) Their argument runs thus: Health insurance is just one component of an employee's compensation, a tax-free benefit in place of money wages. Japanese workers spend a greater portion of their incomes on food than Americans, and Canadian workers spend a larger portion of their incomes on education than Americans, but this does not mean that these consumption patterns add to the price of Japanese automobiles or Canadian lumber, respectively. This argument is bolstered by a citation to a Uwe Reinhardt article, but no explicit empirical evidence is provided.

Given that the U.S. system's costs and changes in costs are much more explicit, then it follows that their effects on U.S. markets obviously are as well and the end result is a reduction in market supply and some degree of upward pressure on nominal prices, *ceteris paribus*. The analogies to Japanese automobiles and Canadian lumber fail because large Japanese and Canadian industries do not pay respective food and education "insurance" premiums for their employees. Regardless, Detroit

automakers and their suppliers (both management and unions)[5] are definitely convinced that high health-care costs have played a role in putting them at a competitive disadvantage[6] in world markets against rivals such as Toyota.

Although it falls outside their goal of puncturing myths about single-payer health care systems, probably the most valuable chapter of this book is about the politics of medicine. Why does the average consumer in a single-payer system have much less incentive to become treatment-conscious than the average American? The authors' answer: marginal knowledge is less valuable. In cases where very new and costly treatments would be beneficial, they would be unavailable in an extensively socialist system. The most time-consuming political activism would not likely change this artificial scarcity anytime soon, so why even learn about cutting-edge treatments?

Probably the best analysis in the book is G,M,&H's explanation of why single-payer health systems continue to exist. The British and Canadian systems are becoming steadily more unpopular, yet Britons and Canadians have no desire to transform their systems in the direction of free markets. The authors list three reasons for this. First, the wealthy and politically connected can manipulate the system to jump waiting lines and acquire special accommodations such that they never incur the most damaging costs inflicted by their system. Thus those in positions of power who could reform the systems have no incentive, especially personal, to do so. If British CEOs, Queen Elizabeth, and Tony Blair were all forced to use only the British NHS and they received the same standard of care as the average Briton, the NHS "would not last a week" (p. 197).

Second, those at the end of long single-payer cues are ignorant of treatment alternatives that would be available in a freer market and suppliers have no incentive to alert them to these unavailable treatments. Third, in this information vacuum, single-payer patients undergo "serfification:" they become grateful to be on the receiving end of even the rudest, unpunctual, and poorest-quality care. The authors quote one physician who stated,

> The British people . . . verge on the stoical as compared with the American patient, and, of course *this fact makes them, purely from a physician's point of view, the most pleasant patients*. The resulting service [British socialized medicine] has evolved over the years into a service that would in my opinion be all but totally unacceptable to any American not depending on welfare for medical services. (pp. 197–98 emphasis added)

Lives is a concise and in parts very effective refutation of misconceptions about British and Canadian health care. Anyone with a desire for a quickly navigable repository of ammunition against single-payer myths will be satisfied. While the authors' goal was to refute myths, they seem diffident. They clearly want to suggest avenues for reform of the American system in three separate chapters that criticize

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[5]For a union perspective see, (*Contra Costa Times* 2005) "I won't . . . call the legacy and health-care problems Detroit is facing a red herring. For sure, health care, especially, is a serious issue not only for Detroit automakers, but also for the entire country."

[6]Health costs for GM are approximately $1,525 per vehicle. See Benton (2005). The A.T. Kearney consulting firm estimates that active and retiree health costs are about $1,300 per vehicle for U.S. automakers while for German automakers it is $430. For Honda and Toyota, retiree coverage per vehicle is about $124. See Mayne (2005).

managed competition (chapter 22), outline a plan for designing an ideal health care system (chapter 23), and outline a plan for designing ideal health insurance (chapter 24).

Unfortunately this is where conservative, free-market Republican, and supply-side analyses founder. Free institutions do not have to be ideally delineated. They arise from spontaneous order in the absence of or in the vacuum of the retreating state. The authors demonstrate well that the British and Canadian systems serve the interests of the rent-seeking medical classes first and foremost, but of course this is true of the U.S. as well.

The return of true free-market health care institutions will never be through the incrementalism of small tax changes and medical-savings accounts that the authors and conservatives/Republicans believe they will somehow sneak past statist gatekeepers. Good intentions at defending free markets aside, international comparisons between different degrees or types of statism are ultimately of little lasting and practical value in advancing free medical institutions.

Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer. By Sally C. Pipes. San Francisco: Pacific Research Institute, 2004.

Sally C. Pipes is president and CEO of the Pacific Research Institute. As an economist and Canadian residing in the U.S., she has insights into the nature and problems of both the U.S. and Canadian health care systems. The purpose of her book, Miracle Cure, is to "provide the general reader with an easy-to-understand guide to the issue [of health care]–an overview of the problems and clear solutions" (pp. xiii-xiv). While she has arrived at a somewhat accurate view of the problems of both systems, unfortunately she ends up peddling the standard "free-market" conservative/Republican nostrums that are anything but clear solutions to the problems of U.S. and Canadian health care.

Pipes remembers the "halcyon days" of American medicine when an avuncular man with a large black bag appeared at patients' homes to give long and thorough examinations to family members. Why does health care cost increasingly more and deliver increasingly less? Medicine completely missed the customer-service and information-technology revolutions of the 1990s that transformed almost all other industries. Patient information in physician offices and hospitals still resides preponderantly in crude and bulky paper files and folders.

Contrary to popular misconception, healthcare is not that directly expensive to consumers: Americans pay only 14 cents out of pocket for every health-care dollar spent while the remaining 86 cents are paid by third parties. Pipes faults the U.S. tax code's subsidization of employer-based health insurance for this, but the other culprit is the perverse cost structure of Blues-dominated health insurance which initiated the absurd coverage of routine and small services (e.g., flu vaccine).[7] Working in tandem,

these two perverse, state-enforced policies transformed true insurance into prepaid consumption which in turn has caused costs to perennially skyrocket.

Pipes blames the employer-based system for the large number of uninsured Americans, but again, the Blues part of the story is missing. In terms of solutions, she's not too enthusiastic about focusing on the adverse effects of the state: it's unproductive and delusional. Only "practical and achievable changes" (p. xxii), toward the objectives of "affordability, access, and quality" (Ibid.) need be considered. She believes that "incremental and relatively painless reform can be achieved" (Ibid.) Talk about delusional.

One Misesian theme Pipes touches on is that state intervention creates problems which inevitably lead to more state intervention to correct those problems. The intervention in turn leads to additional problems which policymakers use as a rationale for further intervention. One example is the Hill-Burton Act of 1946 which directed $4.6 billion into building nonprofit hospitals. The string attached to the $4.6 billion federal subsidy was an obligation that these hospitals provide free care to the poor. This became an expensive boondoggle, such that by 1974 the National Health Planning and Resources Development Act sought to rein in costs by putting restrictions on the number of new hospitals and enlargements of existing hospitals inspired by Hill-Burton.

Pipes favors extending the tax break for employer-based insurance to both individuals and the association health plans (AHPs) endorsed by George W. Bush. AHPs would allow nonemployers such as trade groups, lodges, and religious groups to purchase group health plans. Small employers could also unite into large groups to purchase insurance at lower premiums. Stuart Butler, who brought the enterprise zones idea to America, favors transforming the corporate tax break into a tax credit to be used by individuals to purchase the insurance plan of their choice. About this Pipes writes

> [B]y providing limited subsidy, the tax credit would also have the effect of making people more prudent shoppers of health insurance. There would no longer be an incentive to purchase prepaid medicine, which would reduce costs by reducing unnecessary, overuse of health care. (p. 36)

This supposed demise of pre-paid medicine is a bit premature. While such new mass purchases of health insurance would certainly reduce the number of uninsured, future cost increases would hardly be controlled if the perverse Blues structure of insurance coupled with the traditional tax subsidy remained in place. Indeed, the incentive for such greater numbers to purchase prepaid medicine would likely increase costs, as a version of the tragedy of the commons unfolded whereby maximum short-term consumption would be encouraged before future premium increases could be implemented by insurers.

As for prescription drugs for seniors, Pipes's solutions get worse. She favors putting more seniors into government programs, and proudly trumpets that

> seniors who are retired on incomes of less than 100% of the poverty level and who have amassed few assets on which to live are eligible for both

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[7]Medicare.gov notes that "[m]any private health insurance plans also cover flu vaccine."

> Medicare by virtue of their age, and Medicaid by virtue of their economic status. It is these seniors, roughly one in six, for whom paying for prescription drugs is the greatest burden. Thanks to a taxpayer-supported program, they are largely relieved of this burden. (p. 54)

Matthew "Come Get Some Free Government Money" Lesko could not have said it any better. On the issue of prescription drugs *per se*, Pipes is every bit as bad as Goodman *et al.* in terms of her uncritical bias toward allopathy. One embarrassing claim (as part of her *apologia* for increasing drug prices) is that Vioxx and Celebrex along with several other drugs "greatly enhance the quality of life" (p. 69, inset box). Vioxx, Bextra, and Celebrex (COX-2 inhibitors) were estimated by an FDA official to have prematurely killed between 89,000 and 139,000 consumers between 1999 and 2004 (Sardi 2005). Most of the rest of her material is the standard conservative-mainstream libertarian dogma of only discussing the purported benefits of prescription drugs while ignoring important implicit costs. (Citing the now-familiar Frank Lichtenberg study claiming that $1 of increased drug spending reduces other health-care expenditures by $7.17 is an almost obligatory sacrament in the Church of Pharmaceuticalism.)

What really sends Ms. Pipes into a tizzy is the re-importation of drugs from Canada; she calls re-imported drugs "laundered" (p. 81). This is a curious designation, given that laundering is illegal, yet in the very paragraph she refers to "laundering" she mentions that the practice was authorized by the U.S. federal government. Part of the problem that Pipes has is that

> Foreign countries, including Canada, use government to demand a lower price, regardless of their citizens' demand for the product. This is how price discrimination works, and how some countries use the coercive power of the state, i.e., price controls, to make sure that they secure a rock-bottom price. (p. 83)

Of course what Pipes describes is nowhere close to "how price discrimination works." The issue of coercion is irrelevant anyway, since the U.S. industry isn't being coerced to sell to the Canadian market, never mind at an artificially low price. If the U.S. industry doesn't like the practice of re-importation, they will limit their exports. Canadian importers can either sell to Canadian distributors at artificially low prices or sell to U.S. customers for a much greater profit. The tendency will be in favor of the latter for higher profits; Pipes sees this as creating "shortages of drugs in Canada" (p. 85). Even if this were correct theory,[8] it would hardly be a bad occurrence for Americans to be receiving greater benefits from freer trade and for Canadians to be bearing more of the costs of their socialist system than they do now.

Pipes's treatment of the alleged role of lawsuits in driving up health-care costs is the usual run-of-the-mill conservative/Republican account. In its lowest and crudest form, it is the implication (*à la* Bush-Cheney Campaign 2004 and Fox News) if not explicit assertion that health-care costs are increasing solely or almost solely due to large awards given in runaway malpractice suits. Pipes points out that in 2002 malpractice costs amounted to $250 per U.S. household and that the average award increased from $700,000 in 1999 to $1 million by 2001.

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[8]All this of course depends on the real nature of supply and demand in Canada, to the extent they are fixed or not.

To her credit Pipes recognizes that much more is involved than just malpractice attorneys. About prospective malpractice plaintiffs and jurors, she writes, "Americans must recognize that mistakes happen in medicine, and rarely are they caused by malevolence" (p. 89). Malevolence is a red herring; the real point is the possibility of systemic negligence. For some strange reason, free-market economists are capable of acknowledging the artificial scarcity of physicians and hospitals created by the state, yet they are seldom able to connect the dots to the harmful effects that such artificial scarcity could create. One of those effects just might be a high incidence of malpractice. Neurosurgeon and attorney Harvey Wachsman, M.D., referring to the 100,000 to 200,000 annual deaths and possible millions of injuries in American hospitals due to medical error, writes that if anything, the "true crisis is an epidemic of medical malpractice" (Wachsman 2004).

At least Goodman *et al.* mention the absence of quality controls in American hospitals. Pipes, though, is clueless. She asserts that noneconomic damages

> must be reined in . . . [t]wenty-six states have passed legislation that limits non-economic compensation. It's no surprise that it works. In states with caps on non-economic damages, premium increases were roughly one third of those in states with no limits on what the lawyers can collect. This reform needs to go nationwide. (p. 90)

Pipes provides no sources for her statistic, but favorably cites a Congressional Budget Office (CBO) report that a Republican bill capping punitive damages could reduce premiums nationwide by an average of 25 to 30 percent. However, the CBO and Government Accounting Office (GAO) both failed to find evidence that limits on damages resulted in cost savings. Using the methodology of an earlier study and different data, CBO in January 2004 reported that "the evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency" (Factcheck 2004). The agency also "found no statistically significant difference in per capita health care spending between states with and without limits on malpractice torts" (Ibid.)

Finally, a recent Johns Hopkins study found that "higher costs associated with malpractice insurance have only a marginal effect on overall health spending" (Reuters 2005). While Americans certainly filed more lawsuits than their British, Australian, and Canadian counterparts, two-thirds of American lawsuits were "dropped, dismissed or found in favor of the defendant" (Ibid.). The average malpractice award to American plaintiffs–$265,000–was actually lower than the average award given to British and Canadian plaintiffs.

None of this comprises a categorical denial that malpractice suits are having a deleterious effect on the practice of medicine in the U.S., particularly in areas such as obstetrics and gynecology. However, it is also clear that the malpractice problem is not as cut and dried as the Republican establishment and its mainstream libertarian echo chamber would have us believe.

Pipes raises the question of whether market forces are beginning to radically transform the American health care system, but never definitively answers it. Health Reimbursement Arrangements (HRAs), Health Savings Accounts (HSAs), and other products will supposedly "make [consumers] conscious shoppers for health services" (p. 95). This transition to "consumer-driven policies will reduce costs, which in turn will allow health care providers to offer greater quality" (p. 96). Of course if these

arrangements were of any use, they would be radically transforming medical markets as we speak, and they are not. Putting aside the heavy regulations found in these plans, they have no power to alter quality deficiencies that are a function of restrictions in market supply.

Pipes's lack of understanding begins to really show when he she imputes to HSAs and HRAs[9] the establishment of a new system where consumers face the real prices of noncatastrophic medical services but in return get greater flexibility and choice. She never explains how this will happen if market supply remains as restricted as ever. What comes to the rescue is—surprise!—the state with its tax credits and vouchers that will supposedly enable individuals and families to buy health insurance and an HSA in one package. For seniors she recommends the Heritage Foundation approach and enthusiastically admits that it is "exactly the approach the federal government takes for its own employees" (p. 105). Seniors would get vouchers "to purchase private insurance from plans that were pre-approved by the federal government" (Ibid.). Even more appallingly, she writes that "this same voucher approach, which lies in the power of consumer choice, should be applied to Medicaid, the federal/state health program for low income Americans" (p. 106).

Pipes's overall analysis for her native Canada is not much better. Her insight is that in a free market, the marginal patient is a source of marginal revenue and therefore a good. This is why patients are treated so well and get a much higher quality of service in market systems. In Canada's single-payer system, the marginal patient is a marginal cost on a fixed global budget, and therefore a bad. This is why patients are treated so poorly and get such relatively poor service in single-payer systems.

Pipes's recommendations for Canada are a mixed bag at best. On the plus side, she wants to make provincial insurance plans and the taxes that fund them voluntary, open all government insurance to private competition, allow doctors to practice in whatever way they wish, and allow private firms to operate for-profit medical facilities offering any service they wish. Unfortunately, she also believes that "Canada would benefit from the flourishing of . . . Health Savings Accounts (HSAs)" (p. 204). Of course there would be no need for HSAs if she were to be consistent in advocating a free market approach. Unfortunately she does not seem to be close to understanding this. The irony escapes her when she notes that MSAs could easily be made compatible with Canada's pure socialist system. The state could provide the catastrophic insurance component while taxpayer funds could provide the money for the discretionary spending accounts. Government planners could allocate money to each savings account depending on "the age, sex, and health condition of the individual, with those more likely to need more care receiving more money" (p. 205). Pipes quotes economists Fred McMahon and Martin Zelder as stating, "MSAs are in fact both a health policy and an income redistribution policy, something that should appeal to left-wing thinkers" (p. 206). Why this should not set off alarm bells in the mind of an advocate of free markets is a real mystery.

In sum, Pipes certainly has no "miracle cure" for what ails American medicine. Goodman *et al.* and Pipes come to the table with hat in hand ready to bargain away

[9]HRAs come with the additional restriction of having to be funded directly by the employer, and not by employee salary deductions.

solutions that would truly deal with the real pathologies found in American and Canadian medical markets. They then hope to get gradual reform through repeatedly, mysteriously, and implausibly sneaking "free-market" legislation past the statist gatekeepers of both systems. Forget the underlying dishonesty of such an approach. If these are *laissez-faire's* champions, is it any wonder why the growth of Leviathan in both nations remains so unchecked?

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