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Socialized Medicine

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Introduction: Past and Present

The basic problem of health care is the typical economic problem of virtually infinite wants chasing scarce resources. What are the best social institutions to deal with this problem? Is socialized medicine or the free market more efficient? In this paper, I will review the often overlooked problems of socialized medicine.

From ancient Greece to the contemporary world

Socialized medicine existed in antiquity, but not in the freest societies of the time. In ancient Greece, medicine was generally a free market activity.¹ Egypt, by contrast, had a regime of socialized medicine. Not surprisingly, as historian Jacques Jouanna notes, “[g]entleness in treatment was taken to be one of the characteristics of Greek medicine that distinguished it from Egyptian medicine.”² Jouanna tells the story of Darius, the Persian king, who dislocated an ankle and called on his Egyptian physicians: “But these doctors, as Herodotus reports, twisted the foot too sharply and worsened his suffering: for seven successive nights, the king could not sleep. It was thus upon learning of the presence of a Greek physician among his prisoners – Democedes of Croton – that Darius summoned him and obliged him to treat his injury.” Jouanna continues by quoting Herodotus: “Democedes, using Greek remedies and gen-

tle rather than forcible means ... succeeded in getting Darius his share of sleep and, in a while, healed him completely.”³

Socialized medicine as we know it today appeared in Germany in 1883, when Chancellor Otto von Bismark introduced a host of social measures that included compulsory public health insurance for factory and mine workers. By 1911, the original act had been extended to nearly all employees. Similar health insurance legislation was soon introduced in other countries, including Austria in 1888, Hungary in 1891, Luxembourg in 1901, Norway in 1909, Serbia in 1910, Great Britain in 1911, Russia in 1912, and Romania in 1913.⁴ Before the creation of public health insurance, workers in England, America, France – and, I suppose, in other countries – relied on voluntary mutual aid societies to help with expenses related to illnesses, accidents, and death. The first public health insurance programs for workers crowded out the mutual aid societies, and prevented the development of other private means for coping with catastrophic events. Some Welfare State justified more Welfare State.

In 1942, Sir (later Lord) William Beveridge proposed to unify all British social insurance programs (unemployment, family assistance, health, disability and old-age pensions, etc.) into a single system. His famous report, often called the “Beveridge Report,” prepared with a committee of civil servants, proposed free

¹ See Ludwig Edelstein, *Ancient Medicine* (Baltimore and London: John Hopkins University Press, 1967); and Jacques Jouanna, *Hippocrates* (Baltimore and London: John Hopkins University Press, 1999).

² Jouanna, *op. cit.*, p. 78.

³ *Ibid.*, p. 21.

⁴ Ron Hamowy, “The Genesis and Development of Medicare,” in Roger D. Feldman (Ed.), *American Health Care: Government, Market Processes, and the Public Interest* (Oakland: The Independent Institute, 2001).

medical care for the whole population, and led to the creation the National Health Service in 1948.⁵

Socialized medicine did not progress at the same speed in all countries, but the trajectories were generally parallel, albeit with some lags. In France, the majority of the population was covered by the mid-60s, but it was only at the turn of the millennium that compulsory public health insurance became really universal.⁶

The development of public health insurance in the United States was slower and, to this day, has still not produced a universal health insurance system. However, many elements have been put in place. The 1960 Kerr-Mills bill provided medical assistance to the “medically indigent” among the old, and was adopted by a vote of 91 to 2 in the Senate. The Social Security Amendments of 1965 extended public health insurance (called Medicare) to all Americans over 65 years of age, and created a similar program for social welfare recipients (called Medicaid).

Socialized medicine today

The result is that, today, all developed countries have socialized medicine to some – generally high – degree. This can be seen in the importance of public health care expenditures in OECD countries (see Chart 1): the proportion of public expenditures in total health care expenditures is 73% on average in OECD countries, with little variability among countries.

With rare exceptions like Germany (where people over a certain level of income can opt-out of the public regime) and the Netherlands (where people over a certain level of income are excluded), the population covered by pub-

lic health insurance is virtually 100%.⁷ The other exception is the U.S., where private health insurance is, for most people, the primary form of health care financing. The Canadian system is probably the most socialized of the OECD: publicly insured services are supplied free of any charge, private insurance covering them (as, in general, out-of-pocket payments) is illegal, only supplementary private insurance exists, and all hospitals are de facto public institutions.⁸

Even if relatively less socialized, the American health care system contains a large public sector which, relative to the economy (6.6% of GDP), is basically the same as in Canada (6.7%) and above the OECD average (median of 6.4%). Moreover, the American private health care sector, including insurance, is tightly regulated.⁹

⁷ *OECD Health Data 2004*, CD ROM (Paris: OECD, 2004).

⁸ Insurance schemes in OECD countries are described in many OECD reports, including OECD Health Project, *Towards High-Performing Health Systems* (Paris: OECD, 2004); Eddy Van Doorslaer et al., *Income-Related Inequality in the Use of Medical Care in 21 OECD Countries*, OECD Health Working Papers No. 14 (Paris: OECD, May 11, 2004),

<http://www.oecd.org/dataoecd/14/0/31743034.pdf>; Insurance Committee Secretariat, *Insurance and Private Pensions Compendium for Emerging Economies*, Book 1, Part 2:4: *Private Health Insurance in OECD Countries: Compilation of National Reports* (Paris: OECD, 2001),

<http://www.oecd.org/dataoecd/49/46/1815562.pdf>; and

Francesco Columbo and Nicole Tapay, *Private Health Insurance in OECD countries: The Benefits and Costs for Individuals and Health Systems*, OECD Health Working Papers No. 15 (Paris: OECD, September 2, 2004),

<http://www.oecd.org/dataoecd/34/56/33698043.pdf>.
⁹ Elizabeth Docteur, Hannes Suppanz, and Jaejoon Woo, *The US Health System: An Assessment and Prospective Directions for Reform*, OECD Working Papers, No. 350 (February 27, 2003),

⁵ William Beveridge, *Social Insurance and Allied Services*, American edition reproduced photographically from the English edition and published by arrangement with His Majesty's Stationery Office (New York: Macmillan, 1942).

⁶ Jean Magniadas, *Histoire de la Sécurité Sociale*, speech at the Institut CGT d'Histoire Sociale, October 9, 2003, www.ihs.cgt.fr/Texte-telecharger/Securite-sociale-Jean-Magniadas.pdf.

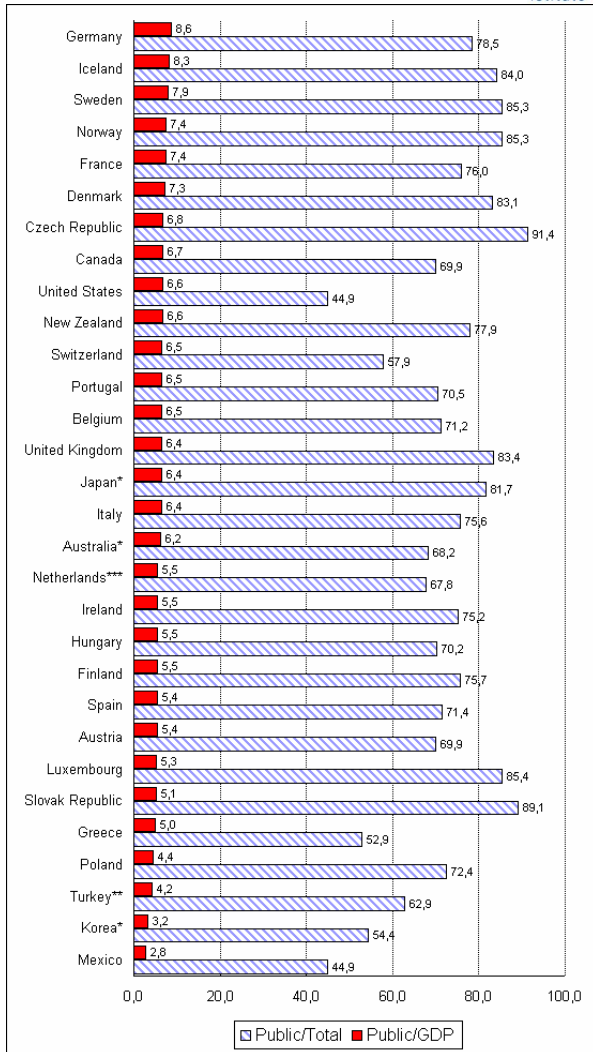


Chart 1. Public health care expenditures as a percentage of GDP and of total health expenditures in OECD countries, 2002.

The American system is criticized for the non-coverage of 14% of the population.¹⁰ One fourth are covered by Medicare or Medicaid. The rest, that is more than 60%, are covered by private health insurance, generally from their employer. The plight of the uninsured is not as tragic as some try to paint it. It includes a (admittedly small) number of rich people who are able to pay for ordinary health care out-of-pocket.¹¹ Note also that 40% of the un-

¹⁰ *Ibid.*, p. 6,

[www.oecd.org/olis/2003doc.nsf/43bb6130e5e86e5fc12569fa005d004c/a17bfa31f942be2cc1256cdb00332d3c/\\$FILE/JT00140050.PDF](http://www.oecd.org/olis/2003doc.nsf/43bb6130e5e86e5fc12569fa005d004c/a17bfa31f942be2cc1256cdb00332d3c/$FILE/JT00140050.PDF).

¹¹ More than 14% of the non-insured are in households with income of \$75,000 or more; see *ibid.*, p. 6.

insured are not employed full-time, which suggests more an employment problem than a health insurance problem per se. Finally, those without formal health coverage do carry some informal health insurance through free access to county hospitals, the so-called safety net providers, and through private charity.¹²

Inefficient

One of the main features of socialized medicine is to break the link between price and service. In its extreme form, it makes health care accessible at a zero price.

The economics of queues

Demand for health care (or, more precisely, for specific health care services) is like demand for any other good and service: the higher the price, the lower the quantity demanded. Indeed, it is to increase quantity demanded that the proponents of socialized medicine want to impose price ceilings or give health care free. Price elasticity of health care demand is estimated at between -0.2 and -0.3 (a 10% price increase causes a 2%-3% decrease in quantity demanded)¹³, which means that demand is relatively inelastic. If the price decreases, it is not only the poor who will try and consume more, but everybody else too – although we can safely assume that the poor's elasticity of demand is higher. Supply presumably shows the normal positive relationship between price and quantity supplied: for more health care goods and services to be offered, prices have to be higher – in order to incite actual providers to increase their production, to bring new producers in the market, and eventually to bid resources away from other industries.

When the state imposes a price ceiling, a shortage develops, that is, quantity demanded is higher than quantity supplied at the con-

¹² *Ibid.*, pp. 7 and 13.

¹³ Elizabeth Docteur and Howard Oxley, *Health Care Systems: Lessons from the Reform Experience* (Paris: OECD, December 5, 2003), p. 29, www.oecd.org/dataoecd/5/53/22364122.pdf.

trolled price. This is true as long as the state does not subsidize producers (physicians, hospitals, and so forth) enough to supply all that is demanded at the controlled price.

A “real” shortage – that is, quantity supplied lower than quantity demanded at *market* prices – will only develop if a parallel private market is forbidden by law. Otherwise, the parallel private market will fill the unsatisfied demand from consumers who prefer to pay the market price rather than go without the service in short supply. Allowing a parallel private market thus increases welfare, compared with a Canadian-style prohibition of private arrangements.¹⁴

When a shortage develops, consumers will have to pay a non-pecuniary price in order to get what is short supply. This non-pecuniary price is in terms of what a consumer has to do to jump ahead of the queue: waiting in line, entertaining one’s doctor, making friends with doctors and hospital personnel, etc. It may be that, for certain categories of consumers like the poor, the non pecuniary price is lower than the free market price – for example, if it is mainly made of the opportunity cost of their time – and that consequently “free” health care operates a redistribution of health services from the rich to the poor. But, as we shall see later, this is not necessarily the case.

Queues in socialized systems

Just like waiting lines formed at grocery stores in the former communist countries, health queues will appear if the state does not satisfy all the quantity demanded at below equilibrium prices, and if private supply is regulated. Other things being equal, queues will be more important the lower the public health care expenditures are.

In Canada, the only country where a private parallel sector is forbidden by law, queues have existed for a few decades, and have been lengthening with time (they are 90% longer

on average than in 1993). A survey of medical specialists realized by the Fraser Institute in all Canadian provinces concludes that the median waiting time from referral by a GP to actual treatment is 17.7 weeks across the country.¹⁵ A Montréal area physician, Dr. Jacques Chaoulli, has fought court battles for a decade, trying to force the state to allow the development of a parallel private system, including health insurance, for those who would be willing to pay for better or faster services.¹⁶ The final judgment from the Supreme Court is expected at any time now. A class action has recently been launched against Québec hospitals on behalf of 10,000 breast cancer patients who, since October 1997, have had to wait more than eight weeks for post-surgery radiation therapy.¹⁷

In fact, waiting lines are quite common in the OECD: of 20 countries analyzed by a major OECD study, 12 report waiting lines: Australia, Canada, Denmark, Finland, Ireland, Italy, the Netherlands, New Zealand, Norway, Spain, Sweden, and the U.K. A recent econometric study realized by two OECD economists¹⁸ suggests that, as expected, the lower the amount of resources devoted to the public health system and the lower the economic incentives to producers, the more likely waiting lines will develop, and the longer they will be.

¹⁴ Michael Hoel and Erik Magnus Saether, “Public Health Care with Waiting Time: The Role of Supplementary Private Health Care,” *Journal of Health Economics* 22 (2003), pp. 599-616.

¹⁵ Nadeem Esmail and Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute, 2004), www.fraserinstitute.ca/admin/books/chapterfiles/Complete%20Publication-wyt2003.pdf#.

¹⁶ Pierre Lemieux, “Monopoly on Trial,” *Financial Post*, 9 juin 2004, p. FP-19.

¹⁷ “Quebec Patients Sue Government over Long Waits for Cancer Care,” *Medical Post* 40, No. 13 (March 30, 2004), at www.medicalpost.com/mpcontent/article.jsp?content=20040329_200939_2784.

¹⁸ Luigi Siciliani and Jeremy Hurst, *Explaining Waiting Times Variations for Elective Surgery across OECD Countries*, OECD Health Working Papers, No. 7 (October 7, 2003), www.oecd.org/dataoecd/31/10/17256025.pdf.

Costly

But queues are only one manifestation of cost. More generally – and sometimes despite what appears to be the case – socialized medicine carries high economic costs.

Apparent and hidden costs

One measure of the economic cost of health care is its total cost compared to GDP (Chart 2), which can be said to approximate the value of the economic resources devoted to producing health care, and the value of the foregone production of other goods and services.

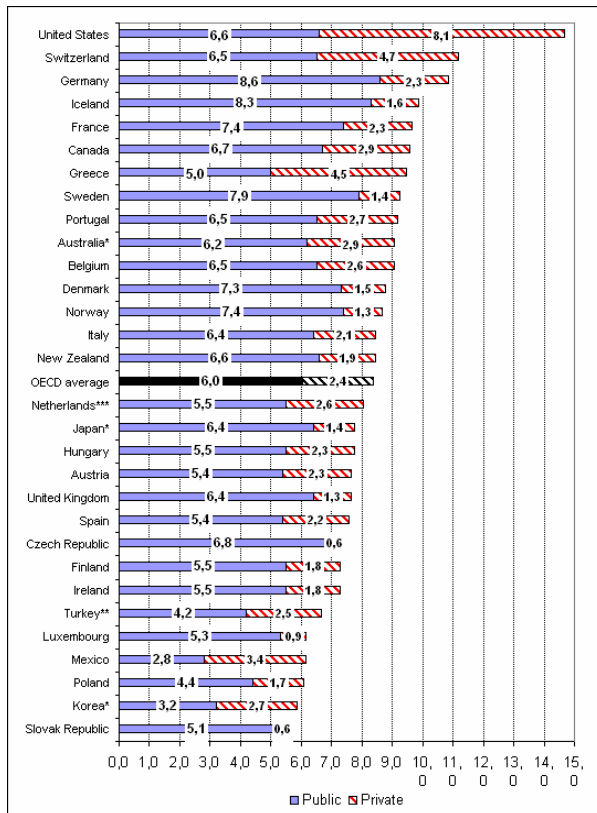


Chart 2. Public and private health care expenditures as a percentage of GDP in OECD countries, 2002.

The fact that total health care costs are higher in the U.S. (14.6%, after correction of the rounding error) than in any other OECD country, and much higher than the OECD average (8.4% – unweighted), is often taken as

proof that free-market medicine costs more than socialized medicine.

One problem with this claim is that the American system is not a private, free-market system, but merely a less socialized system. There are many other problems.

Americans spend on public health care for less than half of the population a proportion of GDP that is higher than what the average country spends to cover 100%; and the Americans not covered by the public system choose to privately spend more than the residents of many other countries. There are many reasons for this high level of both public and private health expenditures. First, consumption of health care increases with prosperity: countries with lower GDP per capita show lower health expenditures per capita, while higher GDP per capita is associated with higher health expenditures per capita. Second, there is some evidence that health care prices are higher in the U.S. than in other OECD countries,¹⁹ partly because of uncontrolled drug prices and remuneration of medical personnel, and because of the litigation system and other restrictions on freedom of contract.²⁰ A third reason why prices are higher in the U.S. may be the more advanced medical technology.²¹ Finally, American patients probably pay more in order to get better quality: one indication of higher-quality, more personalized medical care in the U.S. is the number of hospital employees per bed, which is much higher than in other OECD countries (4 compared to less than 3 for most other countries).²²

In fact, socialized medicine systems transfer and hide real economic costs instead of reducing them. As competitive markets in general, multi-payer systems are more efficient than monopolistic, single-payer systems. The low-

¹⁹ Docteur et al., *The US Health System: An Assessment and Prospective Directions for Reform*, p. 23.

²⁰ Gerard F. Anderson et al., "It's The Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, No. 3 (2003), Exhibit 6, p. 98, content.healthaffairs.org/cgi/reprint/22/3/89.

²¹ *Ibid.*

²² Docteur et al., *The US Health System: An Assessment and Prospective Directions for Reform*, p. 22.

est possible prices consistent with real production costs are competitive prices. Single-payer systems can get better prices, but only if they hide costs, or if they produce less than the optimal quantity of health care.

Economic costs

The economic costs of socialized medicine are of three kinds: (1) the welfare loss from the production of too much or too little health care, compared to what individual consumers want; (2) the patients' costs of waiting; and (3) the economic cost of levying taxes. People who wait in queues for health care support many subjective costs, which are real economic costs. The cost of levying taxes is not mainly what government must spend to administer and enforce the tax system, but what is called the "excess burden" of taxes, that is, the lost value of production and consumption caused because people change their work, savings, and consumption patterns in order to minimize their tax burden. The excess burden of taxes has been estimated at between 17% and 50% of the marginal tax dollar.²³

Because of the problems in measuring the subjective benefits and hidden costs of socialized medicine, and because of deeper methodological problems,²⁴ it is impossible to provide a quantitative estimate of the "net social benefit" or "net social cost" of socialized medicine. However, I would argue that economic analysis strongly suggests that socialized medicine is not a good bargain. One indication is from revealed preference: individuals voting with their feet towards private health care reveal that, at least for them, the costs of socialized medicine are higher than its benefits.

²³ Patricia M. Danzon in "Hidden Overhead Costs: Is Canada's System Really Less Expensive?", *Health Affairs* 11-1 (Spring 1992), p. 37, <http://content.healthaffairs.org/cgi/reprint/11/1/21.pdf>.

²⁴ See Anthony de Jasay, *The State* (Indianapolis: Liberty Fund, 1998), pp. 111-112, www.econlib.org/library/LFBooks/Jasay/jsySttContents.html.

Inequitable

Equality is the main argument for socialized medicine. Indeed, the public has been brainwashed in thinking that this should be a goal of health care delivery. A survey of seven countries (Czech Republic, France, Germany, Italy, the Netherlands, Spain and Sweden) suggests that, at least in Europe, public opinion supports equality as the main goal of health care delivery, and opposes free-market based reforms. Some 80% of respondents believe that "[g]iving everyone equal access to the same standards of care" is more important than "[e]nsuring that you and your family have access to the best possible care", and this proportion does not vary much among countries.²⁵

This raises two questions: (1) Can socialized medicine be egalitarian? (2) Is equality a worthwhile goal?

Unequal access to socialized medicine

Do socialized medicine systems actually provide equal care to all their customers? Economic theory suggests a negative answer. Individuals for whom the non-pecuniary cost of jumping the queues is lower, or who can afford it, will get more. As for empirical studies, they have produced mixed evidence.²⁶ The major OECD study by Doorslaer et al. indicates that some countries with the most socialized health care system show evidence

²⁵ Helen Disney et al., *Impatient for Change: European Attitudes to Health Care Reform* (London: The Stockholm Network, 2004).

²⁶ Samuel E.D. Shortt, "Equity in Canadian Health Care: Does Socioeconomic Status Affect Waiting Times for Elective Surgery?" *Canadian Medical Association Journal* 168, No. 4 (February 18, 2003), pp. 423-416; Barton H. Hamilton, Vivian H. Hamilton, and Nancy E. Mayo, "What Are the Costs of Queuing for Hip Fracture in Canada," *Journal of Health Economics* 15, No. 2 (1966), pp. 161-185; Eddy Van Doorslaer et al., *Income-Related Inequality in the Use of Medical Care in 21 OECD Countries*, OECD Health Working Papers No. 14 (Paris: OECD, May 11, 2004), <http://www.oecd.org/dataoecd/14/0/31743034.pdf>.

of pro-rich inequality: interesting cases include Finland, Sweden, and Canada.²⁷

I propose a hypothesis that I call “the nomenklatura hypothesis.” “Nomenklatura” is a Russian term that was used to describe the group of high-level communist apparatchiks, and came to designate the privileged class in communist societies – the ones who had access to foreign exchange, travel authorizations, special stores, better education and health care, etc. The level of inequality is lower in our own socialized medicine than it was in communist countries, and our nomenklatura is both larger and more open. Our own health care nomenklatura would be made of all those who are better able to afford the non-pecuniary prices for jumping the queues. These non-pecuniary prices include: friendly relations with doctors and managerial health personnel (perhaps as old classmates); the means to access doctors and managerial employees through membership in the same golf clubs, common children’s schools, or living in the same neighborhoods; the language, psychology and attitudes necessary to persuade or bully counter-type, entrance-level bureaucrats; and so on. The nomenklatura would include not only a large number of public bureaucrats, used to dealing with their colleagues, but also the rich, the famous, the well-educated, and probably a large part of the middle class. All these members of the nomenklatura would get privileged access to the public health care system.

Is equality equitable?

In other words, equality is impossible, and what we get when we try to reach it – a nomenklatura system – is, by many definitions, less equitable than the market. And there are good economic arguments to the effect that market systems are more efficient than nomenklatura systems to foster prosperity, and produce more of all goods, including health-care, for a larger number of people.

Assuming that poverty (as opposed to equality) is a problem, redistribution of income in

cash or subsidization of private health care insurance for the poor would be the efficient solutions.²⁸ The fact that these solutions are not the ones actually used suggests that the main practical goal of socialized medicine is not to provide health care to the poor.

Statist

Socialized medicine as redistribution to whom?

If not equity, then, what is the main practical goal of socialized medicine? It is certainly not a goal of economic efficiency, for there is no reason to think that health markets are different from other complex markets (say, education, life insurance, computers), and that consumers make choices differently with regard to their health than they do with regard to nutrition, risk, or other types of balancing costs and benefits in the normal course of their lives. To find the real motives, public choice theory suggests looking at who benefits from socialized medicine and has the power to implement it.²⁹

Analyzing this issue exhaustively would carry us far away – especially since there is, to my knowledge, no comprehensive public choice analysis of health care. From what we have seen, though, it is not obvious that the big gainers are the poor, since they are not part of the nomenklatura and are the ones who get the worst services. Even if the poor benefit from socialized medicine, we probably have to look elsewhere to find the heavy, concentrated interests that have the political muscle to run it. These special interest groups probably include unions of nurses and other non-medical health personnel, as well as government bureaucrats who gain from extending the public sector.

²⁸ A similar point is made by Patricia M. Danzon, *op.cit.*, p. 40,

<http://content.healthaffairs.org/cgi/reprint/11/1/21.pdf>

²⁹ On public choice theory, see Pierre Lemieux, “The Public Choice Revolution,” *Regulation* 27, No. 3 (Fall, 2004), at

<http://www.cato.org/pubs/regulation/about.html>.

²⁷ Doorslaer et al., *op. cit.*

State surveillance and power

More to the point, socialized medicine is in the interests of the state – that is, of those who individuals who man the state or benefit from it – because it leads to increased state surveillance and power.

As socialized medicine gets more expensive and dissatisfaction (both from the consumer and the taxpayer) grows, the state will be under pressure to control costs. One way to do this is to intervene in lifestyle choices (smoking, obesity, alcohol...), especially if they pertain to minority lifestyles, in order to reduce the so-called “social costs” of risky behavior.³⁰ The fact that state provision of health care is naturally accompanied by an obligation of the recipient to accept the control of his health by others is illustrated by the “Proposed Health Covenant for Canadians,” recently recommended by a government commission. According to this so-called “covenant,” in return for free access to health care, individuals “have a responsibility to observe good health practices ... while respecting the judgment and expertise of health providers.”³¹ Another way to control health care costs is to carefully monitor individual consumption of health care services through health care cards and central databases of patients’ information. The French state is just introducing this means of control.³² The Canadian commission has similarly proposed to

“[e]nable the establishment of personal electronic health records for each Canadian.”³³

Is it not conceivable that the state likes socialized medicine *because* it increases its power – besides, or instead of, wanting more power because it needs them to run socialized medicine? There is a public-choice model of the state that supports a positive answer: the Leviathan model.³⁴ In the light of the Leviathan model, socialized medicine gives the state both more controllable and more grateful subjects. A quote attributed to Bismark, which figured in the “Motive” accompanying one of the 1883 law proposals, illustrates how the state uses welfare policies in general, and socialized medicine in particular, to bribe and tame the populace: “That the state should assist its needy citizens to a greater degree than before is not only a Christian and humanitarian duty, of which the state apparatus should be fully conscious: it is also a task to be undertaken for the preservation of the state itself. The goal of this task is to nurture among the unpropertied classes of the population, which are the most numerous as well as least informed, the view that the state is not only a necessary but also a beneficent institution.”³⁵ Two contemporary health specialists, Hussey and Anderson, repeat the same argument: “A single-payer insurance system can also foster citizens’ trust in the ability of the government to protect their welfare, enhancing the population’s view of the legitimacy of the government.”³⁶

³⁰ Pierre Lemieux, “Heil Health,” *The Independent Review* 4, No. 2 (Fall 1999), pp. 303-306, www.pierrelemieux.org/artproctor.pdf; and “The Public Health State,” *MD Canada*, May-June 2004, p. 72, reproduced at

www.pierrelemieux.org/artpublichealth.html.

³¹ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada, Final Report*, also called “Romanow Report” (Government of Canada, 2002), pp. 50-51, available at http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf.

³² *Le Monde*, July 30, 2004, www.lemonde.fr/web/imprimer_article/0,1-0@2-3224,36-374164,0.html.

³³ Romanow Report, pp. 75 and ff.

³⁴ On the state as Leviathan, see Geoffrey Brennan and James M. Buchanan, *The Power to Tax: Analytical Foundations of a Fiscal Constitution* (Cambridge, Cambridge University Press, 1980), www.econlib.org/library/Buchanan/buchCv9toc.html#The%20Power%20to%20Tax:%20Analytical%20Foundations%20of%20a%20Fiscal%20Constitution. See also de Jasay, *op.cit.* Leviathan is called “the Minotaur” in Bertrand de Jouvenel’s *On Power: The Natural History of its Growth* (Indianapolis: Liberty Fund, 1993); from the same author, see also *The Ethics of Redistribution* (Indianapolis: Liberty Fund, 1989).

³⁵ Quoted in Hamowy, p. 54.

³⁶ P. Hussey and G.F. Anderson, “A Comparison of Single- and Multi-payer Health Insurance Systems and Options for Reform,” *Health Policy* 66 (2003), p. 222.

Summary and conclusions

It is banal to say that no system is perfect, but it is still true. In fact, “perfect” cannot even be defined, except from a philosopher-king’s viewpoint, for the simple reason that individual preferences are different, and every individual has his own opinion about what would be a perfect health system. However, economic analysis strongly suggests that political and bureaucratic processes will not produce better outcomes than individual choices and free-market competition. The main failures of socialized medicine are fourfold: (1) it is an inefficient rationing system; (2) it is economi-

cally costly; (3) it is inequitable; and (4) it dangerously increases state power.

A fifth danger should be added. The more a country has moved towards socialized medicine, the more it becomes impossible to question it because it creates constituencies that will resist change (people who make a living out the system, and individuals who rely on the system because they have not purchased private insurances when they were younger or in good health), and because it changes people’s preferences towards state solutions. As Bismarck suggested, socialized medicine leads people to consider the state a benevolent big brother.



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