VIEWPOINT

Canada as Single-Payer Exemplar for Universal Health Care in the United States
A Borderline Option

C. David Naylor, MD, DPhil
Department of Medicine, Dalla Lana School of Public Health, and Institute for Health Policy, Management, and Evaluation, University of Toronto, Toronto, Ontario, Canada.

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The late great Uwe Reinhardt still called himself a Canadian decades after moving to the United States, but steadfastly rejected the idea that Canada's health care system was suitable for transplantation to the United States,[1] even as he celebrated its comparative strengths and championed its principles of universality, cost containment, and equitable access to care.[2] Reinhardt instead recommended European models and highly regulated multipayer arrangements as an alternative means to those worthy ends.[1]

Perhaps because of Canada's adjacency and close relationship with the United States, many policy makers and health care advocates in both nations still seem preoccupied with each other's systems. Canadians of all political persuasions affirm the superiority of their health care systems by drawing comparisons with the costs and inequities of the US health care system. US opponents of single-payer reforms often demonize Canadian health care, even as US proponents extol their northern neighbor's approach. This Viewpoint argues that the constant overemphasis on Canada is unhelpful to advancing the cause of universal and equitable access to health care for US citizens.

Different Nations, Different Values

Widely referred to as Medicare, publicly administered health care in Canada operates with local variations through 13 provincial and territorial plans, all supported by conditional per-capita block grants from the federal government.

Canada's first universal single-payer programs were introduced for hospital services (1947) and medical services (1962) in the province of Saskatchewan. In 1957 and 1968, respectively, the federal government followed suit for each sector, enacting conditions for cost-sharing on a 50-50 basis that galvanized all provinces and territories to institute coverage on "uniform terms and conditions" for every citizen.

Although the pioneering steps were taken by a social democratic provincial government, the programs composing Canada's strong social safety net, including single-payer health care, have been built by governments spanning the political spectrum. That consensus reflects a deep difference in political values between the United States and Canada. As one illustration, Canada's major conservative party governed the nation from 2006 to 2015 and made no substantive changes to universal health care.

Health care, in particular, is a realm in which egalitarianism is given priority in Canada. For example, the consolidated federal health care legislation for cost-sharing (Canada Health Act 1984) outlaws private insurance for any publicly insured service and penalizes provinces and territories that levy user fees or allow additional charges by physicians beyond the negotiated "Medicare" fee schedules. These restrictions clearly conflict with the libertarian ethos of the United States.

Different Governance, Different Times

Unlike the US system of checks and balances, parliamentary democracy in Canada gives substantial power to the prime minister as well as the premiers of the 10 provinces and 3 northern territories. Parliamentary procedures also reduce the influence of lobbyists and interest groups on the voting patterns of individual Canadian legislators. This situation contrasts sharply with the greater independence of US lawmakers and influence of special interest groups.

Canada's foundational health care legislation was also enacted in a different and simpler time. It is no accident that the 2 cornerstone Canadian laws cover 14 pages, contrasted with the more than 900 pages of the Affordable Care Act. When universal hospital insurance was enacted in 1957, all Canadian hospitals were nonprofit or public entities. Insurance cover was uneven, charity care was commonplace, and the federal legislation was supported unanimously across party lines.

By 1965, as the federal government considered a national medical plan, matters were slightly more complex. About 120 private insurers covered 25% of the Canadian population, while plans sponsored or formally approved by organized medicine insured another 29%. Organized medicine and the insurance industry lobbied for extending coverage to all through means tests and subsidies. However, with 45% of the population uninsured or covered on limited "medical welfare" plans, and the physicians' own nonprofit plans providing an obvious template, the logic of a single-payer system for medical services was compelling. There were only 2 nays out of 179 votes cast in the final parliamentary vote.[3,4]

The Canada of 5 or 6 decades ago bears limited resemblance to the United States today. On the one hand, financial barriers persist for tens of millions of US citizens with limited coverage, and polls of the general public and physicians are moving in favor of greater government intervention in health care financing. On the other hand, the absence of a political consensus on these issues is obvious; and a large number of powerful entities have a major financial stake in the status quo. As Reinhardt often cautioned, these heavily entrenched groups can exert a powerful influence on US lawmakers.

Imposing Canadian-style "uniform terms and conditions" through federal cost-sharing also seems challenging. If all US citizens initially achieve equal or better coverage, as occurred in Canada, then costs are likely to increase substantially unless prices can be reduced and low-value

Corresponding Author: C. David Naylor, MD, DPhil, 4 Shorncliffe Ave, Toronto, ON M4V 1T1, Canada (david.naylor@utoronto.ca).

intermediaries eliminated. Moreover, given the current state-level variation in commitment to Medicaid, it seems unlikely that a national consensus could be achieved on a more expansive plan.

Clear Goals, Fuzzy Logic

Canadian Medicare remains admirable in many ways. The skills of those who work in Canadian health care are world class. Although seldom scaled, pockets of remarkable health care innovation can be found across the nation. Canada also boasts long-term success in cost containment, modest administrative expenses, good health care outcomes, and mitigation of the socioeconomic gradients in access that existed before universal coverage of medical and hospital services.

These are important strengths. However, they are shared by health care systems in other Organisation for Economic Co-operation and Development (OECD) nations that have cost profiles similar to Canada, but have overall performance that is as good or better. The well-known 2014 and 2017 rankings by the Commonwealth Fund, for example, placed Canada 10th and then 9th out of 11 peer nations, slightly north of the United States, which has consistently come last. Those rankings reflect structural weaknesses in organization and finance that bedevil all the subnational Canadian plans, as reviewed extensively in a recent federal report.[5] Policy analysts have repeatedly cited limited integration as the key flaw in systems that have a payment architecture largely mired in the 1970s. However, integration is limited by the absence of intermediaries, such as US integrated delivery systems or accountable care organizations. Medical associations, in particular, have representation rights to bargain directly with provincial governments, and, despite arguments that alignment of incentives would be in mutual interest, resist consolidation of medical budgets with other health care services. So difficult has it been to modernize Canadian Medicare that a 2013 scholarly monograph focused solely on the causes of the "Paradigm Freeze" in health care policy.[6]

More importantly, given the near-chaotic pluralism of US health care, obsessive reference to Canada as exemplar conflates ends and means. Universal coverage has been achieved for different baskets of services in OECD countries with or without the use of multiple insurance carriers or intermediary administrative entities. Arguably, no country actually has a single-payer health care system for all services. Instead, there are varying mixes of public and private funding for specific services. Canada's public share (70%) is on the low end of the spectrum owing to the narrow scope of Canadian Medicare. Federal cost-sharing constrains provinces only to cover all necessary medical services and hospitalizations. Various other services are covered at provincial discretion, but the core coverage under US Medicaid is more generous than that available in any of Canada's 13 health care systems.

Canada's current challenges in extending universal coverage to prescription drugs are illustrative of a broader dilemma facing US reformers. In Canada, spending on drugs now exceeds the costs of physician services, and is shared almost equally across provincial plans, private insurance, and out-of-pocket sources. Very credible analysts[7,8] have argued that Canada could save billions through more effective procurement under a national pharmacare plan. But that rational step requires a shift from private to public financing—a difficult option when the federal government and several provinces face operating deficits and sizable debt burdens. There will be complex redistribution of gains and losses—not least between employees and employers, and intense federal-provincial jockeying as to who pays what share. Universal pharmacare should have been adopted in the 1960s or 1970s. Now, as with US health care, universal coverage is most likely to occur by a heavily regulated multipayer system with an overlay of consolidated procurement.

Conclusions

Health care reform discourse in Canada and the United States would be vastly improved if more commentators, advocates, and lawmakers could overcome the cross-border obsessions and misperceptions that distort contemporary debates. Canada does offer important lessons for reform in the United States, not least in its relentless commitment to equitable access for some key services, its administrative efficiency, and its success in cost-containment. However, Canada's health care arrangements are rooted in different values, facilitated by a different model of democratic governance, and reflect a different era, both in the conditions that fostered their creation and in an outmoded architecture that makes them a dubious exemplar for the United States. There is arguably much more for the United States to learn from the panoply of long-standing national experiments with universal coverage that can be found across the OECD. Reinhardt, for one, suggested that Germany, the Netherlands, and Switzerland merited particularly close examination.[1]

The good news is that if the United States were to move toward a fairer and more efficient health care system, it might promote wider adoption in Canada of the many positive innovations in health care delivery to be found south of the border. The better news is that the United States already spends so much so badly that it now has a chance to leapfrog every nation in the world as and when the United States devises and implements a home-grown solution to achieve equitable and universal health care coverage.

ARTICLE INFORMATION

Published Online: December 18, 2017. doi:10.1001/jama.2017.19668

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Additional Contributions: The author is indebted to Uwe Reinhardt for many discussions of health care policy extending well over 2 decades.

REFERENCES

1. Greenwald J. Reinhardt: repeal health care, make GOP cut costs. *Fiscal Times*. https://khn.org/news/fiscal-times-reinhardt/. Accessed November 17, 2017.

2. World Focus. How the US measures up to Canada's health care system. http://worldfocus.org/blog/2009/01/28/how-the-us-measures-up-to-canadas-health-care-system/3783/. Accessed November 18, 2017.

3. Taylor MG. *Health Insurance and Canadian Public Policy*. Montréal: McGill-Queen's University Press; 1978.

4. Naylor CD. *Private Practice, Public Payment*. Montréal: McGill-Queen's University Press; 1986.

5. Advisory Panel on Healthcare Innovation. Unleashing innovation—excellent healthcare for Canada. https://www.canada.ca/en/health-canada/services/publications/health-system-services/report-advisory-panel-healthcare-innovation.html. Accessed December 4, 2017.

6. Lazar H, Forest P-G, Lavis JN, Church J, eds. *Paradigm Freeze*. Montréal, Kingston: McGill-Queen's University Press; 2013.

7. Morgan SG, Martin D, Gagnon MA, Mintzes B, Daw JR, Lexchin J. Pharmacare 2020. http://www.pharmacare2020.ca. Accessed December 4, 2017.

8. Office of the Parliamentary Budget Officer. Federal cost of a national pharmacare program. http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare. Accessed December 6, 2017.