

Invited Commentary

HEALTH CARE REFORM

Drawing Lessons From Canada's Experience With Single-Payer Health Insurance

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In this issue of *JAMA Internal Medicine*, Ivers et al¹ discuss the course of Canada's "single-payer" (or "Medicare for all") health insurance system over the last 50 years. The article summarizes the reasons why the Canadian system can seem superior to the insurance system in the United States. Awareness of those differences is one reason why Canadians are especially wary of change; it takes little imagination for them to envision the universal coverage and other features that they could lose. The article also highlights the ways in which the Canadian system is by no means ideal—especially public concerns about constrained access to some medical care and the lack of universal coverage for pharmaceuticals. In the mid-1990s, worries about delayed access to care increased substantially in Canada and were accompanied by decreasing public satisfaction with the system.



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For US readers, 2 logical questions follow. First, would the United States have to have the problems of the Canadian system in order to have the benefits of the Canadian system? Second, is there something about the single-payer approach that creates the problems? By "single payer," I mean that government provides the main health insurance package and that the insurance is funded by taxes. In my view, the answer to the first question is "no," and the answer to the second question is "not particularly." We can see why by considering the health care systems in countries other than Canada.

Universal coverage of medically necessary physician and hospital services is the norm throughout rich democracies (and some not so rich or democratic countries). It is relatively rare, however, for governments to be the primary insurer. More commonly, the national government structures a system of private nonprofit insurance, or governments directly provide services.² In short, there are many routes, other than single payer, to the more equitable coverage and lower costs that characterize systems in countries that provide universal coverage, unlike the United States.

One problem in Canada, inadequate coverage of prescription drugs, surely is not necessary. Each province has its own special programs, normally covering seniors, people with low incomes, and some people with complex medical needs. Other Canadians are typically covered through employer-sponsored supplemental insurance, much like US workers' insurance, or not at all.³ Coverage thus is not worse than in the United States, but it stands out precisely because that is not a desirable comparison and other nations tend to have more extensive and universal drug coverage.⁴

Comparisons with other countries also show why it should not be inferred, from Canada, that universal coverage must cre-

ate "waiting lists" for care. Measurement of waiting times is extremely difficult.⁵ In the United States, people who are uninsured and are unable to see a physician for that reason are not recorded as "waiting" for care. As with pharmaceutical benefits, however, Ivers et al¹ argue that Canada is unusual with regard to waiting for care. For example, the surveys that show Canadians wait longer for care than people in the United States also show that people in France, Germany, Switzerland, and the Netherlands do not.⁵

The Canadian example gives no reason to settle for the high costs and poor health insurance coverage in the United States. But does Canada's experience show that a "Medicare for all," as promoted by US Sen Bernie Sanders (Independent, Vermont) and others, would be a mistake?

One possibility is that government insurance inherently leads to constraint due to budget worries. Such concerns did cause the squeeze on health care capacity in Canada during the 1990s. The subsequent period of spending increases in Canada through 2008 did not fully undo the cuts in the 1990s; public concerns in Canada were only modestly reduced.⁶ Owing in part to budget pressures since 2008, the supply in Canada for some services, such as specialist care, remains relatively limited.¹ Beliefs that it would "cost too much" also have been a major obstacle to the provision of additional pharmaceutical coverage.^{4,7}

Yet cost control is a concern with regard to health care everywhere. If constraint has been a bit stronger in Canada than in some other nations, that appears to be owing not to a single payer, per se, but to the combination of 3 other factors. First, Canadian governments generally do not have dedicated health care taxes. Classic "social insurance" systems have dedicated contributions, and it may be easier to raise funds on those terms, which is why some reformers in Canada have called for adding such revenues.⁸ Second, although federal-provincial conflicts are a factor in many countries, these conflicts seem especially important in Canada. Major change requires cooperation between the national and provincial levels of government. Such cooperation has been inhibited both by different parties often being in control of the national government and major provinces and by the fact that, for most of the past 50 years, Canada's national government has not been eager to give the provinces more money.^{4,7} The third factor is that the drug-coverage gap in Canada happened, for reasons that seemed plausible in the 1960s, when there was less attention to drug coverage and more attention to coverage for medical and surgical care. Subsequently, this gap has been hard to reverse for reasons that should seem familiar in the United States, not only the high costs but also the fact that most people have other drug coverage.

The other possibility, emphasized by Ivers et al,¹ is that Canada's funding arrangements make it difficult to pursue ef-

efficiency through changing the systems for the delivery of care or the incentives created by the payment mechanisms. Although there are reasons to believe that initiating such measures may be somewhat more difficult in Canada than elsewhere, comparisons with either the United States or other countries gives little reason to believe delivery and payment reforms would necessarily increase efficiency and thus allow the provision of more services with constrained funding.

For example, no nation has the kind of comprehensive electronic health record that Canada has been criticized for not creating. Even in Denmark and the Netherlands—2 countries frequently cited as leaders—there are substantial gaps between vision and reality, as I learned on recent research visits. Similarly, chronic care case management programs have a mixed record at best. The closest cases to success involve diabetes, and even in those cases, there tend to be selection issues (physicians with sicker patients refusing a bundled payment), and the programs generally do not save money. One review of the German experience provides a nice example of the pattern, which can be observed in other countries as well.⁹ The results of payment reform efforts in the United States have been similarly discouraging, although advocates for these policies try hard not to be discouraged.¹⁰

Therefore, there are 2 reasons not to blame Canada's single-payer financing for missing theoretical efficiencies from sys-

tem reform. First, many of the more “political” difficulties are not unique to Canada. For example, physicians in Denmark, France, and the Netherlands also have successfully resisted some initiatives. Second, and more importantly, many of the ideas require work that is very difficult. It is hard to measure performance fairly. Coordination across what in current parlance are called “silos” tends to take extra time, creates extra costs, and diverts people from doing what they already know how to do. The evidence required for more evidence-based medicine is rarely as strong as would be desirable. As a result, experience in the United States and elsewhere often does not support the health care reform theories.

The way Canada pays for most health care under its universal coverage system has advantages, particularly lower administrative and transaction costs, compared with the United States and other countries with multiple payers for insurance. The combination of features in Canada also appears to have some disadvantages. Canadians might gain especially from the example of dedicated financing for health care in other countries. For the United States, an important but perhaps overlooked lesson from Canada is that any decision about some version of “Medicare for all” cannot be separated from other decisions about health care financing and benefits, and the roles of the national and state governments. There are no panaceas in reforming health care.

ARTICLE INFORMATION

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