

Icon and taboo: single-payer politics in Canada and the US

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ABSTRACT

In 1965 and 1966, the United States and Canada adopted single-payer models of government insurance for physician and hospital services – universal in Canada, but restricted to certain population groups in the US. At the time, the American and Canadian political economies of health care and landscapes of public opinion were remarkably similar, and the different policy designs must be understood as products of the distinctive macro-level politics of the day. Subsequently, however, the different scopes of single-payer coverage would drive the two systems in different directions. In Canada, the single-payer system became entrenched in popular support and in the nexus of interest it created between the medical profession and the state. In the US, Medicare became similarly entrenched in popular support, but did so as part of the larger multi-payer private insurance system. In the process universal single-payer coverage became politically iconic in Canada and taboo in the US.

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Those interested in the reciprocal relationship of politics and policy would do well to consider a remarkable natural experiment that occurred in American and Canadian health care policy in the 1960s, when different policy choices drove what were then two very similar health care systems along quite different future paths. Both countries adopted what came to be known as ‘single-payer’ systems. Only in Canada, however, was that system universal in coverage. That critical difference would drive profoundly different dynamics of subsequent change in each system. In Canada, the single-payer system became entrenched in popular support and established a powerful nexus of interest between the medical profession and the state. In the US, although a single-payer system restricted to covering the elderly and disabled became similarly entrenched in popular support, it did so in the context of the larger multi-payer private insurance system. In the process, the concept of universal single-payer coverage became iconic in Canada, while universalising the single-payer system in the US became politically taboo.

This history presents two essential puzzles. First, why did two such similar health care systems embark on such different paths, almost simultaneously in 1965 and 1966? Second, why did the model that lay at the heart of both sets of reforms – the single-payer system – become a symbol of national pride in Canada, while being abjured as a basis for universal coverage in successive reform episodes in the US?

We can understand this result as emanating from a two-phase process. In the initial phase, to simplify, politics shaped policy. Particular conjunctions of forces at the broad macropolitical level beyond the health care arena itself – the institutional resources, electoral mandates and partisan imperatives that bore on central political decision-makers, and the political calculations they made about their ability to overcome vetoes in the present and over time – drove divergent political strategies of scale and pace in policy change in the two nations. In both nations, reform was pursued at a fast *pace*, but in Canada the *scale* of reform was greater. In the next phase, policy shaped politics, as those differences of scale generated policy feedback that acted powerfully to constrain the menu of subsequent reform options.

These effects can be seen in even sharper relief if we consider a hypothetical counterfactual: what would have happened had Canada adopted a programme closer to the US model of coverage for the elderly and the poor, as was being advocated by the Canadian Medical Association and others at the time? If the above argument is correct, Canadian health-care politics would then have played out similarly to those in the US. In a coda to this paper we explore this question by considering briefly the experience with prescription drug coverage in Canada. Unlike physician and hospital services, prescription drugs outside hospital were not included in the original single-payer design. (In a sense, one can thus consider the physician and hospital services sector to represent the subjects of ‘treatment’ and the prescription drug sector to represent the ‘control.’) Provincial governments then moved over time to adopt varying programmes of coverage for the elderly and/or social assistance recipients. And indeed the subsequent politics of prescription drug coverage in Canada proved to be similar to the broader politics of health care in the US.

The Canadian and American health care arenas in the 1950s and 1960s: micropolitical similarities

To set the scene for our discussion of the founding of Canadian and American single-payer systems, we need to consider just how similar the health care arenas, economic conditions and landscapes of public opinion of the two countries were at the time. In general, medical services were provided by physicians in private fee-for-service practices; hospital services by non-profit institutions owned by voluntary societies, religious orders, municipalities and universities; and extended care in facilities owned by such non-profit groups or by private independent for-profit operators. In both countries in the mid-1950s, 80% or more of all community hospitals accounting for over 90% of community hospital beds were owned by not-for-profit organisations or public authorities (Tuohy, 1999, pp. 47–8).

The pattern of private health insurance in the two countries was also similar. Private, largely employer-based health insurance grew rapidly in both countries in the wartime and immediate postwar period, encouraged both indirectly and directly by public policies, and further fuelled by the very similar levels and patterns of unionisation in Canada and the US in the 1950s and 1960s (Tuohy, 1992, pp. 159–63). Wartime wage controls led employers to offer (unregulated) benefits to compete in the labour market, and the non-taxable status of those benefits was confirmed in legislation in Canada in 1948 and the US in 1954. Prior to the adoption of medical care insurance in Canada about 45% of the Canadian civilian population was covered by employer-based medical insurance – a proportion identical to that in the US at the same time.¹ In both countries, moreover, the private

market was divided fairly evenly between commercial and not-for-profit carriers. In both, the not-for-profit sector was dominated by provider-controlled organisations: Blue Cross, controlled by hospital associations, and a number of physician-sponsored medical insurance plans. Only in their relative degrees of concentration did the two markets significantly vary: In Canada, the largest 15 firms accounted for over three-quarters of gross premium income for medical insurance in 1961; in the US the largest 15 firms accounted for only 38% of the gross premium income for health insurance in 1958 (Tuohy, 1999, pp. 49–50).

The evolution of public opinion too was roughly similar in both countries: contrary to popular myth on both sides of the border, Canadian medicare did not emerge organically in response to ‘Canadian values’ or as a response to a groundswell of public demand. Poll data from 1940s indicate that roughly two-thirds of Canadian respondents who offered an opinion favoured a universal government plan – about the same proportion as in the UK and the US at the time (Canadian Medical Association, 1944, p. 33; Gallup/AIPO, 1945; Jacobs, 1993, p. 115).² But these responses were vulnerable to change depending on the wording of the question and to changes in the political context (Blendon & Benson, 2001; Canadian Medical Association Journal 1944, p. 33).

By the 1960s, the landscape of opinion had shifted in both Canada and the US, as much of the population had become accustomed to coverage under rapidly-developing private plans. In the US, the debate about options had narrowed to focus on governmental health insurance for the elderly, which enjoyed majority support in public opinion on the order of 62–65% in 1964 and 1965 (Blendon & Benson, 2001). (Again, however, this support dropped to 46% approval when governmental insurance was pitted against a private option, which attracted 36% [Harris, 1965].) In Canada, support for tax-supported universal health insurance had dropped below 60% by 1960 (Naylor, 1986, p. 191). In the bitter contest that ushered in universal medical insurance on Saskatchewan, media commentary within the province and across Canada was sharply divided (Marchidon & Schrijvers, 2011, p. 218; Taylor, 1979, pp. 307–14). As the political debate continued across the country in the wake of that dispute, Canadians actually favoured a voluntary plan over a government plan in a 55/41 split in a 1965 poll (*ibid.*: 236; Taylor, 1979, p. 367).

One significant difference between the two countries in this period was the adoption of various programmes of governmental hospital insurance at the provincial and ultimately federal level. By the early 1950s, programmes of varying design had been adopted in four provinces representing about a third of the Canadian population, and within a few years the critical mass of an intergovernmental coalition for a national programme formed when the government of the largest province, Ontario, warmed to the prospect for a mix of pragmatic and partisan reasons (Maioni, 1998, p. 104). A federal Liberal government facing eroding public support and increasing opposition pressure as they neared a general election in 1957, agreed to a cost-shared federal-provincial programme of universal hospital insurance as enshrined in the Hospital Insurance and Diagnostic Services Act of 1957. Although a significant milestone along the road to universal health insurance, it represented only limited progress. In the 1950s and 1960s, hospitals in Canada, as in the United States, functioned essentially as ‘physicians’ workshops’ or ‘physicians’ cooperatives’ under the *de facto* control of their medical staffs (Pauly & Redisch, 1973). Governmental hospital insurance covered services provided by hospitals as institutions, but not

the services of their independent medical staffs. And indeed medical opinion about universal hospital insurance ranged from strong support to some trepidation. Organized medicine was cautious and muted in its response, while taking care to draw a bright line between ‘hospital care’ (as covered by the government plan) and ‘medical services’ (Naylor, 1986, pp. 165–6). Accordingly, as Taylor put it, compared to the adoption of physician services insurance in the 1960s, the hospital insurance episode would look like a ‘contest between farm teams’ (1979, p. 333).

When it came to physician services insurance, however, medical politics in Canada mirrored those in the US. The ditched opposition of organised medicine in the US to universal health insurance in the post-war period has been extensively documented and analyzed.³ In Canada, an immediate post-war consensus in favour of national health insurance (heavily influenced by contemporary developments in Britain) had unravelled. Organized medicine had, as in other many other advanced nations, adopted a stance of ‘medical liberalism’ strongly supportive of the autonomy of the individual physician (Marchidon & Schrijvers, 2011). Provincial medical associations and the umbrella Canadian Medical Association (CMA), like the AMA in the US, had come to favour government subsidisation of voluntary private plans and to oppose a universal public plan as tantamount to ‘constriction’ of physicians. The battle over the introduction of universal medical insurance in Saskatchewan in 1962, indeed, played out in microcosm the vitriolic politics that attended the US Medicare debate under the Kennedy administration at the time.

The Saskatchewan episode was a towering contest, typifying the clash of peak associations and left-right parties that classically characterise the redistributive politics of welfare-state establishment (Lowi, 1972). After an election bitterly fought on the issue in 1960, the CCF government passed legislation in November 1961 establishing a universal plan for government coverage of physician services. The fierce opposition of the Saskatchewan Medical Association (SMA) culminated in a 23-day strike when the legislation came into effect in July 1962, one of the most prolonged and bitter of the wave of physician strikes against the introduction of universal health insurance cross-nationally in the 1960s (Marchidon & Schrijvers, 2011, p. 204). It drew national and cross-national attention from interests who saw the Saskatchewan protagonists as their proxies in a broader policy battle. The SMA was supported financially and in-kind not only by other provincial medical associations and the umbrella Canadian Medical Association, but also by the American Medical Association. Other interests were similarly aligned, with insurance and business lobbies from across Canada supporting the SMA, and the social democratic parties at the national level and in other provinces, as well as the labour movement, supporting the Saskatchewan government (Marchidon and Schrijvers (2011, p. 208, 212). The adoption of Saskatchewan ‘medicare’ was thus a dramatic development that was to have an important demonstration effect. But it would have been limited to Saskatchewan had not macropolitical forces opened a window of opportunity at the federal level.

The scale and pace of the founding of US and Canadian medicare: macropolitics

Windows of opportunity for major policy change, in health care and other policy areas of high political salience and risk, occur when a government has the institutional and electoral resources necessary to build a winning coalition of support, and sees partisan

advantage in doing so as part of a broader agenda (Tuohy, 2018, p. 6). In both Canada and the US, such factors converged in the 1960s, an era of buoyant economic conditions and fiscal expansion in both countries.⁴ In the US, the landslide 1964 election gave the Democrats control of the Presidency and both houses of Congress with a nominal supermajority of 67% in the Senate. Lyndon Johnson's contest with his arch-conservative Republican challenger Barry Goldwater had 'posed a distinct choice between pursuing change or returning to the period before the 1930s and the New Deal' (Jacobs, 1993, p. 191), and the electoral outcome could therefore be seen as a resounding endorsement of the Democrats' progressive social policy agenda, and as a spur to consolidate their partisan advantage by enacting that agenda.

In Canada, any national framework for health insurance would necessarily involve intergovernmental negotiation, given that the provinces had constitutional responsibility for most dimensions of health care delivery. In the 1960s, the development of an agenda of province-building and the emergence of a new generation of leaders at federal and provincial levels created a climate of 'cooperative federalism' in which jurisdictional jealousies could be subordinated to the interest of securing federal funding for the building of provincial capacity. At the federal level itself, the pursuit of an aggressive social policy agenda was intrinsic to Liberal party rebuilding after the chastening of successive electoral defeats. In opposition from 1957 to 1963, the Liberals underwent a wrenching internal party conflict (Bryden, 2009). 'Social' Liberals wielded an ambitious social policy agenda as essential to renewal – pointing to the negative electoral consequences of the perceived arrogance of the 'business' wing of the party and the niggardliness of its social programmes. Returning to power in the 1963 election as a minority government, the Liberals were able to convert the inherent weakness of that position into strength by forging a de facto coalition with the social-democratic New Democratic Party (NDP). Close personal networks connected the two parties (Kent, 2009) – indeed, in 1965, secret negotiations were held regarding a possible merger (Coutts, 2003, p. 17). Arguably the Liberal reformers had greater leverage within their own party in a minority government context than they would have in a majority. The Liberal leader, Pearson, however, aligned himself with neither the social nor the business factions of the party – as he had come from the successful foreign policy side of government, a large part of his appeal was that he was 'not tarnished by the old Liberal regime's image of domestic policy fatigue' (Coutts, 2003, p. 14). But he was an institution-builder, who came to support social policy reform, a central pillar of which was health care, when he saw it as central to rebuilding the party (*ibid.*, 15).

The opening of a window of opportunity, however, does not determine what happens next. In particular it does not determine the scale and pace of change, which are matters of strategic political calculation as leaders assess their ability to overcome vetoes not only in the present but over time (Tuohy, 2018). Where leaders assess that their current positions of advantage are vulnerable to change in the near future, they have the incentive to act quickly to secure their gains. Both the American Democrats and the Canadian Liberals were in such a position. Democratic President Lyndon Johnson's 1964 landslide, with an electoral majority in the popular vote (61.3%) that surpassed that of any president since 1820, could be attributed to two extraordinary factors: the election occurred in the wake of a presidential assassination and Johnson's opponent, Barry Goldwater, was a (then) outlier on the opposite end of the political spectrum. A sense that his political

capital would rapidly erode added to Johnson's natural propensity to move quickly before opponents could mobilise (Blumenthal & Morone, 2010, p. 190). Canadian prime minister Lester Pearson was acutely aware that his Liberal minority government could fall at any time, especially after they failed to secure a majority in two successive elections in 1963 and 1965. Both leaders, and their advisers, had strong incentives to act quickly.

If both governments were similar in the pace of change they would adopt, they differed fatefully in the scale of change to be attempted. This in turn was driven by political calculation. Making fast-paced change at a large scale means mobilising support for a comprehensive 'big-bang' model to be enacted all at once. In turn that means securing agreement without on the one hand having to negotiate multiple particular bargains which would dilute the overall coherence and scale of the scheme or on the other hand having to delay parts of the package to be fleshed out and enacted later. Typically, this in turn requires a disciplined coalition, such as exists under a majority government in a unitary Westminster system, but these conditions can arise in other institutional contexts as well. Conversely, where political leaders must negotiate change rapidly with other actors with independent power bases, they are likely to pursue a 'mosaic' strategy of multiple ad hoc bargains, which aggregate to an amalgam of many simultaneous small-scale changes to established arrangements rather than a comprehensive transformation.⁵

Despite what a quick reading of their institutional and electoral resources would suggest, Johnson was in 'mosaic' territory, while Pearson could pursue a big-bang. Even with his strong majority in the popular vote, the fact that his party controlled both houses of Congress with supermajorities, and his own legendary legislative and persuasive skills, Johnson could count on levels of party unity of only about 75% and 78% in the Senate and House, respectively. In reality Johnson faced myriad actors with independent power bases, even within his own party, whose consent would be necessary to enact a major piece of health care legislation. Particularly problematic for his health care agenda was the presence of a bloc of conservative democratic senators from southern states, whose segregationist concerns were sharpened by the intersection between a government programme of health insurance and another major item on the Democratic agenda: civil rights legislation. For the southern Democrats, the passage of the Civil Rights Act in 1964 not only represented a major loss; it also 'raised the stakes' of other reforms by requiring that no programme receiving federal funding could discriminate on grounds of race, colour, or national origin (Blumenthal & Morone, 2010, pp. 195–6).

The Pearson Liberals were in a stronger position. With a minority federal government, they lacked the classic institutional conditions for a big bang of large-scale change. But they had the functional equivalents: a de facto coalition with the social-democratic New Democratic Party at the federal level and a set of provincial governments strongly motivated to agree to a common platform. Though constitutionally independent, the provinces had compelling incentives to reach agreement on a framework that would provide substantial federal funding at a time in which they were building their own capacity to provide social programmes.

In these different macropolitical contexts, a different strategy of change was pursued in each country. In the US, the result of intense negotiations between the Johnson administration and the congressional Democratic leadership was a set of smaller-scale additions to the prevailing employer-based system. Chastened by failures of previous administrations to institute universal health insurance, Johnson and the health policy reformers in his

administration initially moved quickly to propose a framework that built on existing institutions and programmes. They focused on a programme of hospital insurance for the elderly – a group enjoying broad public respect and sympathy – as an addition to the Social Security programme of contributory public pensions for the elderly and their dependents, established three decades earlier in the wake of the Great Depression and now well-established and broadly popular. Legislation to this effect had been unsuccessfully introduced in the House in the months prior to the 1964 election. Even in the changed post-election legislative context, negotiators had to cover off potential vetoes in Congress and to temper the opposition of the AMA. They were therefore drawn by the inexorable logic of negotiation into expanding the scope of the negotiation in order to avoid coming to an impasse over a single item. The Democratic leadership, centred on the relationship between President Johnson and Wilbur Mills, the southern Democrat chair of the powerful Ways and Means Committee in the House, wrapped contending proposals into a compromise package. The result was something no-one had intended at the outset, touching on more aspects of the health care arena and more segments of the population than had the administration's initial hospital insurance plan. It comprised a tripartite set of amendments to the Social Security Act: a compulsory hospital insurance plan for the elderly ('Medicare Part A,'); a government-subsidized voluntary plan to cover medical services to the elderly similar to proposals advocated by Republicans and the AMA ('Medicare Part B'); and a programme of expanded federal assistance to the states to provide medical and hospital care to the indigent, defined according to federal criteria ('Medicaid'), also favoured by some Republicans and by the AMA.

By using Social Security as the vehicle, these reforms established the federal government as a 'single payer' for insured services to certain population groups, while leaving the vast swathe of the health care arena essentially untouched. Only about half of the elderly (age sixty-five-plus) population had private insurance in the early 1960s, representing about 7% of the private insurance market.⁶ The target population for the Medicaid programme either had no coverage or relied on state plans, which varied widely. Hence the 1965 reforms had little impact on the private insurance market, and even Medicare itself modelled itself on a not-for-profit template and essentially 'adopted the norms of the private insurance industry' (Oberlander, 2003, p. 31).

In Canada, adopting a federal framework for medical insurance would require the building of coalitions at the federal-provincial negotiating table as well as in the federal parliament. The first process was facilitated by the emergence of a cohort of reform-minded premiers between 1958 and 1960 (Coutts, 2003). Especially significant was the election in Quebec in 1960 of the Liberals under Jean Lesage to replace the long-time Duplessis government. That election encapsulated and advanced Quebec's Quiet Revolution – the shedding of an insular, clerically dominated conservative regime to embrace a modernising agenda of state-building.

The table had been set by events in the early 1960s, when the conflict between the Saskatchewan government and the provincial medical association led the Canadian Medical Association (CMA) to appeal to the federal Progressive Conservative (PC) government to appoint a commission of inquiry to consider a federal approach. The Royal Commission on Health Services, established in 1961, would play a definitive role in the design of the Canadian system. Chaired by Justice Emmett Hall of Saskatchewan, the composition also comprised four healthcare professionals, a Progressive Conservative businessman,

and an academic economist (Taylor, 1979, p. 342) – hardly presaging a radical report. But the Commission was strongly led by Hall himself, who formed his views on the basis of the expert advice of his staff and through public consultations, not through negotiations with the major interest groups. Through a mix of principle and pragmatism he came to support a single comprehensive universal programme of physician and hospital services insurance. Pragmatically, he saw a single-payer plan as both more administratively efficient than a means-tested programme, and a comprehensive model integrating physician and hospital services as allowing for economies of scale (Canada, 1964, pp. 743–4). The recommendations themselves however were conceived as a set of principles, in the form of a ‘Health Charter for Canadians,’ that ultimately would inform the elegant simplicity of the subsequent legislation.

The Hall Commission report, in 1964, was radical as to the means of financing of health services, but not as to the organisation of their delivery. It announced its opposition to ‘state medicine,’ included a commitment to ‘free and self-governing professions’ in the Health Charter, and essentially recommended the underwriting by government of the costs of the existing system. In the propitious economic climate, such a model appeared both feasible and desirable (Coutts, 2003), especially given that it had been pioneered by Saskatchewan.

With the Saskatchewan example and the Hall Commission report before it, the pressure of the opposition NDP at its back, and the neutralisation of the PCs, whose own government, after all, had appointed the Hall Commission, the support of the Liberal cabinet for a universal model began to gel (Maioni, 1998, p. 134; Taylor, 1979, p. 353). Divisions nonetheless remained in cabinet, which constrained the scale of change somewhat. Importantly (and presaging an ongoing debate), concerns of fiscal conservatives about the uncertain trajectory of prescription drug costs meant that universal drug coverage, recommended by Hall, was not included. Equally important were the negotiations with the provinces. At first, at a federal-provincial conference in July 1965, discussion was low-key and opposition muted (Taylor, 1979, pp. 354–66). As the federal programme took shape over the ensuing months, and especially after the 1965 election, provincial opposition mounted, and misgivings within the federal Liberal cabinet increased. A number of provinces, most notably Quebec and Ontario, resisted having the ‘Saskatchewan model’ adopted nationwide. Quebec was accommodated with a provision allowing it to ‘opt out’ of federal cost-sharing arrangements, receiving a different form of compensation to offer a plan on terms similar to the federal conditions. More generally, provincial resistance to complying with federally prescribed conditions was assuaged by designing a framework allowing broad provincial discretion. Rather than signing detailed province-by-province agreements as was the norm for programmes of federal cost-sharing, including hospital insurance, the federal legislation would simply specify certain conditions under which it would share the costs of provincial programmes. Any provincial programme meeting those conditions would then be eligible for federal funds, without the need for separately signed agreements (Bryden, 2009, p. 326). Other concerns related to the manner of financing the programme, through a 2% ‘social development’ federal income surtax, raising the concerns not only of fiscal conservatives such as Finance Minister Mitchell Sharp, but of several provincial premiers who contended that they were effectively being coerced into supporting a programme for which their residents were being taxed (Taylor, 1979, p. 375). In the end, the only compromise was to delay the

effective date of implementation to 1 July 1968. Provinces would of course have the autonomy as to whether and when to enact their own legislation establishing compliant plans. The Medical Care Act passed in the federal parliament December 1966 with all-party support and only two dissenting votes. Over the period from 1968 to 1971, all provinces entered the plan by establishing medical care insurance plans that met the federal criteria.

Compared to the founding legislation of health care states in other nations, the Medical Care Act was simplicity itself: its key provisions, setting out the conditions for federal transfers, comprised two pages of text. Plans were to cover, for at least 95% of the residents of a province (with no more than a three-month waiting period), all 'medically required' physician services (not further defined) on 'uniform terms and conditions' that could not 'impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons.' Plans were to be administered on a non-profit basis by a public authority, and had to be portable across provinces. The full legislative package comprising Canadian medicare included the relevant provincial legislation. But in comparative context, this federal footprint appears remarkably light.

Programme design: micropolitical similarities and differences

By the mid-1960s, the politics of the health care arena in both countries were broadly similar with some emerging differences. The fierce resistance of the medical profession and the private insurance industry to the introduction of Medicare and Medicaid in the US in the 1960s has been fully and extensively documented (See for example Marmor, 2000, pp. 17–21, 38–44, 60–61; Oberlander, 2003, pp. 21–31). In Canada, notwithstanding the bitterness of the Saskatchewan episode, the temper of political debate had substantially moderated by the time the issue came to a head at the national level. Organized medicine still favoured subsidisation of voluntary plans, but it was no longer prepared to go to the barricades. The Saskatchewan profession had wrested key concessions from the government in the strike settlement. The Hall Commission, even while recommending a universal plan, had also endorsed the medical liberalism underpinning the Saskatchewan settlement by recommending as well that a universal plan must recognise the principle of 'free and self-governing professions.' And pragmatically, the Saskatchewan regime had another demonstration effect: medical incomes, no longer subject to bad debts, rose in tandem with those across Canada.

Why, however, did the Canadian private insurance industry not mount the sort of vigorous opposition to the national plan that it did in the US? After all, many of the commercial insurers were the same firms. The answer lies principally in the differences in the scale of the two arenas. As noted above, commercial insurance at the time accounted for about half of the health insurance market at the time in both countries. Since most of these firms were US-based, Canadian enrolment represented only a small proportion of their total business income, and most simply exited the market (Boychuk, 1999, p. 113). As for not-for-profit insurers, their opposition was muted through accommodation as discussed below.

Indeed specific programme design in the two countries was shaped through accommodation with key interests. In both cases, physicians were remunerated largely on their own terms. In Canada, the final settlement of the Saskatchewan strike had set the parameters of

a single-payer system. Physicians continued in private practice and had the option of receiving payment at negotiated rates within the plan or staying outside to maintain discretion over their fees and have their patients reimbursed at the government rate. In the US, Medicare administrators also adopted an accommodating stance, and participation in the programme was richly rewarded (Marmor, 2000, pp. 96–9). Hospitals and physicians were to be reimbursed by Medicare not according to a negotiated schedule but for ‘reasonable costs.’ Physicians could choose whether or not to ‘participate’ in Medicare and were allowed to bill patients above the amount reimbursed by the plan.

As for insurers, a model initially adopted in Saskatchewan, allowing private insurers to act as carriers of the public plan, was also replicated in both national programmes. In Canada, a similar model was adopted in other provinces as they came into compliance with the federal legislation. In Ontario, which accounted for about 40% of the Canadian health care sector, the bulk of the not-for-profit Blue Cross Blue Shield (BCBS) operation – an arm of the Ontario Hospital Association – morphed into a new Ontario Hospital Services Commission, while the remaining entity continued as a non-profit insurer covering amenities not covered by the government plan (*ibid.*: 111). In the US, hospitals could nominate ‘fiscal intermediaries’ for the administration of their participation in Part A of Medicare; and most chose Blue Cross plans. Similarly, private insurers were appointed by the Secretary of Health, Education and Welfare as ‘carriers’ of Medicare Part B coverage; and in most cases the appointment went to Blue Shield (the not-for-profit counterpart to Blue Cross for the coverage of medical services) (Starr, 1982, p. 375).

In Canada, though not in the US, various dimensions of the settlements with physicians and insurers would prove transitory. Private insurers ceased to be intermediaries for provincial plans in the 1970s. In 1984 federal legislation, the Canada Health Act, consolidated the statutes providing for hospital and medical services insurance respectively, clarified the conditions for federal cost-sharing and in so doing provided for dollar-for-dollar penalties for any province allowing physicians to ‘extra-bill’ or for hospitals to impose ‘user charges’ above the public benefit. In a month-long and largely symbolic protest, some Ontario physicians withdrew some services in protest when Ontario adopted legislation in compliance with the Canada Health Act in 1986.

Policy feedback: the entrenchment of medicare, Canadian- and American-style

It has long been recognised that policies shape politics, as well as vice versa (Lowi, 1972). The effects of policies feed back into the political system to create conditions that variously foster or constrain further policy change. Negative feedback occurs when unexpected effects of policies emerge and/or when those who are disadvantaged by the policy mobilise in protest and opposition (Jacobs & Weaver, 2015). Positive feedback from those who invest in and/or benefit from the policy framework, in contrast, raises the costs of departing from the established path (Pierson, 2000). In some cases a mix of positive and negative feedback buffets policy makers and drives a process of cycling among options within the established policy repertoire (Tuohy, 2018, pp. 60–5).

All of these forces can be seen to have been at work in the period following the adoption of Canadian medicare and American Medicare and Medicaid. The dominant force was that of positive feedback, which served to entrench both systems as the new model shaped the structure of interests in which health politics would subsequently be

conducted. Negative feedback, as costs increased and providers chafed against government constraints, created pressures for change. But the dominance of positive feedback kept those changes within the parameters of the established system, driving cycles of tighter and looser regulation in the US, centralisation and decentralisation of provincial health care delivery systems in Canada, and government austerity and largess in both countries.

In Canada, the single-payer model (in which 98% of physician income and more than 90% of hospital revenue are publicly financed) effectively established a bilateral monopoly between the state and the medical profession, and welded the two protagonists into an accommodation in which all significant changes to the system had to be negotiated at a central table. This founding bargain arguably elevated the medical profession to a position of influence which is stronger in Canada than in most other advanced nations. The profession-state axis in each province was shaped by the different governing styles that emerged from the economic, political, and cultural context, and the terms of each provincial-level profession-state accommodation varied accordingly. But this variation has primarily been about levels and modes of remuneration and the organisation of health care delivery rather than about the scope of coverage or the financing model.

In the US, in contrast, the survival of private, employer-based insurance as the presumptive category of coverage for those in the workforce and their dependents preserved the economic and political power of the private insurance industry. From 1970 to 2000, roughly two-thirds of the population under 65 was covered by employer-based insurance, with only modest fluctuations around that figure. After 2000, coverage shrank somewhat to about 62% (Cohen, Makuc, Bernstein, Bilheimer, & Powell-Griner, 2009, p. 9). As a political force, the private insurance industry arguably surpassed the medical profession itself. In 1993–4, even as the American Medical Association announced its support of President Bill Clinton's health care reform initiative, the aggressive opposition of the insurance industry, as epitomised in an advertising campaign featuring the suburban couple 'Harry and Louise,' was correlated with a reversal of a trend of increasing support for the reforms (Goldstein, Goldstein, Swan, & Clemeña, 2001). Although the causality behind that reversal is open to dispute, industry opposition was credited in elite opinion (including reporters, legislators and their staffs, and administration officials) with strongly contributing to the demise of the Clinton plan (Jacobs & Shapiro, 2000, p. 184; West, Heith, & Goodwin, 1996). The solidification of the view that the industry would have to be accommodated in any reform initiative was apparent in the negotiations between White House and congressional leaders and insurance industry representatives in the design of the next major reform initiative under the Obama administration in 2009–10.

Positive feedback also operated through ideational channels.⁷ In both countries, 'medicare' – for the elderly in the US and the full population in Canada – became extraordinarily popular. But the understanding of those programmes, and their implications for the continuing agenda of health care reform, differed radically. Only in Canada did the programme become symbolically interwoven with Canadian citizenship itself. These different trajectories can be seen to derive in some part from the manner in which the programmes were presented and described in the first instance, but to a larger extent from the design of the programmes themselves, as discussed in the following section.

Narratives of single-payer politics: icon and taboo

In Canada public opinion, ‘medicare’ became, like the NHS in Britain, a national icon and a defining feature of Canadian identity. In the debate over Canada’s negotiation of a Free Trade Agreement with the US in 1988, for example, polls showed that the most effective way of turning soft support for the agreement into opposition was to invoke its potential to threaten medicare (Johnston & Blais, 1988). Over the next three decades, polls consistently showed Canada’s health care system to be an important – often the most important – symbol of Canadian identity and embodiment of ‘Canadian values’ (Mendelsohn, 2002, pp. 25–8; Nanos, 2009; Environics Institute, 2015).

The Canadian narrative had its heroes – notably Tommy Douglas, the Saskatchewan premier whose government had pioneered the single-payer system and who was voted the ‘Greatest Canadian’ in a 2004 contest run by the national broadcaster. It also contained a central metaphor⁸ – the presentation of health care as a ‘right.’ The first major rhetorical use of that frame was by Emmett Hall in presenting his 1964 recommendations as a ‘Health Charter for Canadians.’⁹ The Charter set out principles of universal and comprehensive coverage, but it also included a commitment to ‘free and self-governing professions.’ Crucially, it also emphasised that a right carries also an *obligation*: a responsibility of individuals not only to cooperate in their own health care but also to ‘allocate a reasonable share of [their] income (by way of taxes or premiums or both) for health purposes’ (Canada, 1964, p. 6, 12, 13). Subsequently, the universality of the single payer model – guaranteeing medical and hospital services insurance on ‘uniform terms and conditions’ (relating to payment) – gave the metaphor of health care as a citizenship right an experiential grounding. In a 1998 poll 69% agreed that ‘Medicare is a right of citizenship,’ and 74% approved of the adoption of a ‘Charter of Rights for health care’ (Mendelsohn, 2002, p. 28, 69).¹⁰ Support for universality routinely polls at about 85–90% (Mendelsohn, 2002, p. 25, 47; Nanos, 2009).

In the US, the truncated single-payer systems of Medicare and Medicaid were presented as part and parcel of the American insurance system. Arguing for his proposals for contribution-based health insurance coverage for the elderly in 1962, President John F. Kennedy invoked both the Social Security programme and the insurance principle to declare: ‘Nobody in this hall is asking for it for nothing. They are willing to contribute during their working years.’ (quoted in Hopper, 2017, p. 117). Kennedy’s effort failed, but his framing would be echoed by Lyndon Johnson at the signing of the Medicare/Medicaid legislation three years later, characterising it as ensuring that ‘every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.’ The complementarity of Medicare and private insurance was reinforced as private insurers continued to act as carriers of the programme and were offered progressively more active roles in offering alternative to standard Medicare coverage from the late 1990s onward.

Nonetheless, Medicare was understood and embraced as a popular government programme. Despite anecdotes that some participants in political town halls demanding that government ‘keep its hands off my Medicare,’ opinion polls from 1995 to 2003 showed that ninety percent saw Medicare as government programme. Only a small fraction ranging from two to seven percent confused it with private insurance (Blendon, Brodie, Benson, & Altman, 2011, p. 178). Medicare was second only to Social Security

among government programmes in popularity as measured in a 2015 poll (Norton, DiJulio, & Brodie, 2015). (Support for Medicaid was considerably less, and much more variable across party lines: it ranked not only behind Social Security and Medicare but also behind federal support for public schools, defense and military spending and student loans in the same poll.)

However, neither Medicare nor Medicaid evokes the kind of value-laden support we observe in Canada. The framing of health care as a 'right' of citizenship remains highly contested and sharply polarised by partisanship in the US (Gawande, 2017; Maruthappu, Ologunde, & Gunarajasingam, 2013; Mason Meier & Bhattacharya, 2012). Indeed, the intense partisan polarisation in attitudes toward health care policy in the US overall stands in stark contrast to the strong citizenship identification with universal health care in Canada (Nadeau, Bélanger, Pétry, Soroka, & Maioni, 2014). The proportion agreeing that government has a responsibility to ensure that *all* Americans have health care coverage fluctuated over the period 2000–2017 from about 60% at the beginning of that period to 42% in 2013 back to 60% in 2017. But that support was heavily concentrated among Democrats: 83% of Democrats, but only 30% of Republicans held that view (Kiley, 2017). And in comparative perspective, the view that the provision of healthcare for the sick 'definitely should' be a government responsibility is less popular in the US than in Canada. Proportions agreeing, as measured by the World Values Survey, rose from 39% in 1996 to 56% in 2006 in the US, and from 62% to 68% in Canada (International Social Survey Programme, n.d.).

American attitudes toward a single-payer plan are similarly polarised, but are also conflicted and malleable. In a July 2000 poll, for example, 58% of registered voters *opposed* 'a national health plan, financed by taxpayers, in which all Americans would get their insurance from a single government plan,' even as another poll the following month showed 54% of registered voters *supporting* 'national health insurance, financed by tax money, and paying for most forms of health care' (Blendon & Benson, 2001, p. 35). In the 2000s, support for a single-payer plan in polling by the Kaiser Family Foundation gradually rose from 40% on average from 1998–2000 to 53% in June 2017. Attitudes were nonetheless highly vulnerable to the presenting of supporting or opposing arguments, which could respectively raise support to 71% or opposition to 62% in the 2017 poll (Hamel, Wu, & Brodie, 2017). Other polling by the Pew Research Center found support for a single-payer plan to rise from 21% to 33% between March 2014 and July 2017, but attitudes were sharply divided along partisan lines: among Democrats, support rose from 33% to 52%, while only tiny fractions of Republicans (rising from 7% to 12%) held that view (Kiley, 2017).

Meanwhile, successive failures to introduce universal health insurance led to an article of faith among American political strategists that single-payer proposals would be 'dead on arrival.' Although a sub-set of Democratic politicians at both state and federal levels, as well as advocacy groups such as Physicians for a National Health Plan continued to promote a single-payer plan, they could not build the necessary coalition of support. For that sub-set, a single-payer plan remained an unobtainable grail, while in the broader political universe it continued to be taboo. Marmor and Hamburger (1993) depict the self-reinforcing conviction among politicians, the press and policy experts in the 1990s that deemed single-payer proposals as non-starters during the Clinton health reform initiative of 1993–94. During the legislative debates in 2009–10 that would

culminate in the passage of the Affordable Care Act under Barack Obama, single-payer advocates could not even bring their proposed amendments to a vote (McDonough, 2011, pp. 44–47). A ‘public option’ proposal which would have established a public programme to compete with private insurers in the market for individual and small-group policies could not gain sufficient traction, in large part because it was viewed by both supporters and opponents as a precursor to a single-payer plan. At the state level, legislation establishing a version of a single-payer plan was passed in 2011 in Vermont, but as the magnitude of the increase in taxation that it would have entailed became clear, its implementation was abandoned in 2014 (McDonough, 2015). Legislation in California met a similar fate in 2017. A referendum on single-payer system failed in Colorado in 2017.

This continued succession of failures may reinforce the taboo. Or it may encourage a more incremental approach, as proposals to progressively expand Medicare or Medicaid by, for example, opening them up on a voluntary basis to those in under-serviced insurance markets, or to those above a certain age without employer-based insurance, have begun to gain momentum (see for example Starr, 2018). Ironically given their aegis among single-payer sympathisers, however, most of these proposals would have the effect of moving the programmes away from their single-payer status by installing them as competitors in private insurance markets.

Nonetheless, there were some full-fledged single-payer plans in play at the federal level in 2018, most notably ‘Medicare for All’ proposal promoted by the long-time single-payer advocate Bernie Sanders. But if such a plan were to succeed, it would likely have to be as part of a ‘sea-change’ reform agenda in American politics akin to the Progressive era or the New Deal. As James Morone has put it, Medicare for All

‘is more than a health policy prescription. ... It is a policy proposal designed to improve health care delivery, an ambitious claim about equality and social justice, and an effort to usher in a more progressive era in American politics. Each is a long shot, but Medicare for All and its advocates stand in a venerable reform tradition that has rewritten U.S. politics many times in the past’. (Morone, 2017, p. 11)

Absent such a sea-change, the prospects for the success of single-payer proposals in the US can continue to be viewed with some skepticism, especially in the light of another intriguing feature of the natural experiment inaugurated by the adoption of Canada’s single-payer plan in the 1960s – the exclusion of prescription drug coverage from the single-payer system.

Coda: the politics of prescription drug coverage in Canada – the US in microcosm

As noted above, Emmett Hall recommended the inclusion of prescription drugs in his model of universal coverage, but that element of his report was not adopted in the face of opposition from fiscal conservatives in the Liberal cabinet. In the ensuing decades, the evolution of the politics of the drug sector in Canada mirrored in microcosm the evolution of the broad health care politics of the US. Private spending continued to be the norm, while provinces variously adopted public programmes of coverage for the elderly and social assistance recipients. By the early 2000s, private finance covered about 60% of drug expenditures (with private insurance accounting for roughly half of that amount). An estimated 60% of all workers and their families and 26% of retirees over

age 65 had employer-sponsored coverage for drugs, while only 1–5% of adults under age 65 had an individual drug plan. In 2005, private drug insurance financed about 29% of drug expenditures and accounted for 39% of premium revenue for insurers (Hurley & Guindon, 2008, p. 8, 10). This compares to the 62% of non-elderly Americans with employer-based health insurance and 7% with individual plans in 2004 (Fronstin, 2005, p. 4). Annual surveys by a major pharmaceutical firm monitoring the attitudes of members of employer health benefit plans suggest levels of satisfaction that, while not resounding, are strong enough to create political risks in moving to a single-payer system.¹¹

Proposals for universal ‘pharmacare’ on a variety of models, including an extension of the single-payer system, have emanated from various commissions of inquiry and political parties since the mid-1990s, including reports by a National Forum on Health, chaired by Liberal Prime Minister Jean Chretien in 1997, and the federal Commission on the Future of Health Care in Canada (the Romanow commission) in 2002. Most recently, the Standing Committee on Health of the federal House of Commons issued a report in April 2018, recommending a federal-provincial programme of single-payer coverage for prescription drugs under the Canada Health Act (although potentially allowing for modest co-payments). The Conservative members of the committee however issued a dissenting report expressing concerns about the costs of the proposal as well as its impact on existing private coverage and suggesting further review of other options (Canada, 2018).

In general proposals for universal prescription drug coverage have garnered only soft support in Canadian public opinion. In 2002, for example, in a survey conducted in the context of the Romanow commission, ‘Creating a new national pharmacare programme to help people pay for their prescription drugs’ ranked fifth in a list of seven potential priorities for more public spending on health care. Only 33% saw it as a top priority, as compared with 63% citing reducing waiting times for diagnostic imaging. In 2004, in the context of the negotiation of the federal-provincial ‘accord’ noted above, universal drug coverage ranked 12th of 13 potential priorities to ‘improve the quality of care’ (Soroka, 2007, p. 34, 38). Support for a single-payer plan of drug coverage is higher in Canada, arguably as a result of the halo effect of the single-payer model for physician and hospital services, than is single-payer support in the US as reviewed above. But in both countries support is soft, and vulnerable to concerns about costs. In a 2015 poll asking only about support for universal drug coverage without offering any competing priorities found overwhelming (87%) support for ‘adding prescription drugs to medicare’ (that is, extending the single-payer model). But majorities also opposed funding this expansion through premiums or increased sales or personal income taxes. Only ‘restoring the federal corporate tax rate to its 2010 level’ attracted majority support (Angus Reid 2015, p. 15). Compare this result to a US poll finding that support for a single-payer plan dropped from 55% to 40% once the prospect that ‘many Americans would pay more in taxes’ was raised (Norton et al., 2015).

Canadian politicians have proved wary of introducing single-payer plans for prescription drug coverage. Indeed the only comprehensive framework of drug coverage for the entire population at the provincial level, adopted in Quebec in 1997, is one of mandatory coverage combining regulated private employer-based insurance with a public plan. In the most recent foray at the federal level, the Liberal government in June 2018 established an Advisory Council on the Implementation of National Pharmacare, to advise on options for

a national plan. A single-payer plan may well be among those options, but the adoption of such a model would require, if not a macropolitical sea-change at the level necessary to bring about a broader single-payer model in the US, then at least a rare confluence of factors in which political leaders at federal and provincial levels would have both the institutional and electoral resources and the partisan incentives to undertake a major change in health policy. Even then, if history is a guide, the scale and pace of change adopted would depend on strategic calculations about the coherence of the coalition that could be built and the political urgency of action.

Conclusion

A remarkable natural experiment was set in place by the adoption of single-payer health insurance plans for physician and hospital services in the US in Canada almost simultaneously in 1965 and 1966. The universal reach of the Canadian programme, and the limitation of the American programmes to the elderly and social assistance recipients, took two health care arenas that had been almost identical and set them on fundamentally different courses. The founding myths of the two systems, reinforced by the two very different political economies that resulted, gave the single-payer model iconic and taboo status in the politics of health care in Canada and the US respectively. At the same time, however, the legacy of the exclusion of prescription drugs from Canada's single-payer model demonstrates how similar the evolution of the two systems might have been in their policies not diverged in the 1960s. Together these experiments provide a striking demonstration of the impacts of policy decisions taken at critical junctures.

Notes

1. Overall enrolment was similar in both countries, although the development of governmental hospital insurance plans in several provinces meant that enrolment in private plans in Canada was proportionately somewhat less than two-thirds that in the US: about 45% in Canada vs an estimated 72% in the US. As for medical care insurance, overall enrolment was proportionately somewhat higher in the US, and the scope of benefits somewhat broader in Canada (Tuohy, 1999, p. 49).
2. The British and American questions referred to a 'state-run medical service' and the Truman plan for national health insurance respectively. The Canadian question asked respondents whether they would support a government plan that was compulsory for their whole province or whether such a plan should be left to 'local option.'
3. For a concise summary, see Moran, 1999, pp. 41–8.
4. Real annual growth in Gross Domestic Product averaged about four percent in the US and about five percent in Canada over the decade. Total public expenditures as a proportion of GDP increased from 27% to 32% in the US and from 29% to 35% in Canada in the same period (calculated from OECD, 1993, Vol. II: 34–5, 40)
5. This analysis draws on the conceptual framework presented by Tuohy (2018). The framework also recognises slower-paced strategies – 'blueprints' or 'increments' – adopted where leaders judge respectively that they will be in a comparable or improved position after the next election.
6. About 70% of Americans, roughly 126 million people, were covered by private hospital insurance in the early 1960s, including about 9 million elderly. Coverage for primary and out-of-hospital care was much less prevalent among the elderly (Tuohy, 2018, p. 92).
7. For an excellent discussion of ideational forms of policy feedback, see Béland, 2010.

8. On the concept of a right to health care as a metaphor, see Lau & Schlesinger, 2005, p. 79. This presentation draws on the moral weight, though not the legal status, of a constitutional frame.
9. Douglas's framing was more modest and subordinate to more practical arguments about the inadequacies of private insurance. He posed his one reference to the concept of health care as a right in his landmark legislative speech defending the Saskatchewan legislation as a rhetorical question: 'Do we think that the best medical care which is available is something to which people are entitled, by virtue of belonging to a civilized community?' (Douglas, 1961).
10. Somewhat ironically, the concept of a constitutional right to health care has also been used in litigation to challenge a key feature of Canada's single-payer system: the legislative bulwarks against private alternatives (Flood, Roach, & Sossin, 2005).
11. The proportion of plan members rating their plan as excellent or very good declined fairly consistently 73% in 1999 to 48% in 2017, before rebounding to 58% in 2018. Only 6% however described their plan's quality as poor or very poor. Prescription drug benefits were most highly rated in quality and importance. Those with incomes of \$100,000 and above were more likely to be satisfied than those with incomes below \$30,000 (Sanofi Canada, 2016, p. 8; 2018, p. 4).

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