Single-payer, universal health insurance: still sound after all these years

Steven Lewis

ß See related article page 603

Hardly a week goes by without yet another report or media release from a think tank, politician or commentator declaring that our health care system is unsustainable in its current form. The case is roughly this: Health care is choking off provincial governments' capacity to invest in other sectors. New drugs, fancier imaging machines and ever-growing public expectations create uncontrollable cost pressures. The system needs more money and personnel now, and a great deal more in the future. Financing medicare's core programs of physician and hospital care (let alone expanding pharmacare and home care) through general taxation is no longer a viable option. The solution: introduce or raise premiums, pursue public–private partnerships or add a means-tested surtax on individuals in proportion to their use of services.

Certainly our health care system needs fixing, but the critics have attacked it in the one area where we actually have it mostly right. A single-payer, state-run, tax-financed universal health insurance program is public policy at its finest. Let us recount its virtues, all but forgotten in the current environment.

First, it is that rare form of achievement: social justice combined with administrative efficiency. Although somewhat imperfectly (which is inevitable), it allocates service on the basis of need, not ability to pay. It reduces paperwork, lowers transaction costs, and frees personnel and programs to concentrate on delivering care, not fretting over coverage or itemizing the costs of the tissue paper and syringe.

Second, it signals that health care is a public good, not a market-driven commodity. One crucial element of a public good is the duty to use it prudently, manage it effectively and preserve its accessibility to everyone. To be sure, some aspects of health care have become commodified: heavily marketed drugs, ultrasound "movies" for the prenatal scrapbook, prestige once-overs including whole-body scans. This trend is precisely the problem. More is taken to mean better; utilization mistaken for effectiveness. Keeping health care public is the only way to challenge the more-is-better fallacy that is the real enemy of sustainability.

Third, it creates a community of interest in, and collective judgements about, access and quality. It places all Canadians in the same health care boat, irrespective of their wealth or station. If the well-off want a better system, it must be better for all. If it requires more tax dollars, governments have a warrant to raise taxes. In a world of hundreds of television channels and isolating technologies, medicare demands a solidarity that transcends class and region.

Fourth, it liberates businesses and individuals from the wearying, costly and fractious burdens of securing and fine-tuning private health insurance and supplemental programs. It is not simply that the cost of health insurance is higher than the cost of the steel in a US-made car. It is freedom from having to decide where to seek work or whether to stay in a job on the basis of health care coverage, and from spending valuable time worrying about it. It is a wonderful paradox that a state-run, universal health care system lubricates the private economy.

Fifth, it has the (not fully realized) potential to keep prices down. Drugs are a classic example. A single purchaser has clout with sellers. It could also signal to manufacturers that the state will pay in relation to therapeutic value, not an arbitrarily set price or a multiple of the costs of production. In fragmented, third-party insurance systems, the buck often stops nowhere, while in a single-payer system, accountability is clear. This disciplines both decisions and behaviour.

Sixth, it is ethically coherent. The system cares for people irrespective of the vagaries of genetics and circumstance, and even the consequences of their own behaviours. Many alternative schemes, notably those proposing to tax the sick, assume that individuals alone choose their health states. This is patently false in many cases — science has not yet uncovered the process for choosing multiple sclerosis or Parkinson's disease or leukemia — and even where behaviour matters, the vast literature on the determinants of health has put paid to the notion that we make our choices on a level playing field.

Given these virtues, the solution is not to contract the scope of publicly insured services but, rather, to expand it, just as both the National Forum on Health and the Romanow Commission recommended after a combined 4 years of careful research, consultation, analysis and deliberation. Yet critics continue to retail oft-refuted myths — for example, our growing elderly population must drive costs through the roof — and dismiss the potential to improve quality and contain costs by remodelling primary health care and creating true health care teams that optimize the division of labour. The system remains rife with perverse financial incentives that reward volume at the expense of spending time with patients and that encourage the padding of wait lists to secure more time in the operating room.

DOI:10.1503/cmaj.1041286

Some of the doom and gloom comes from the usual suspects: the small but well-funded minority who challenge medicare's egalitarian and redistributive ethos; the suppliers and providers who see money in further privatization; the neoconservative politicians and their allies in the business community who value lower taxes over tax-funded health care. But the current defeatism suggests a more ominous and widespread ennui. For 3 decades we have been told that government is inherently wasteful and incompetent, a dead hand on the economy, better when smaller. Citizens look on government less as the expression of their collective interests and higher aspirations than as an alien force unto itself. Even some governments apparently subscribe to this view. It is notable that the most pessimistic rhetoric about the sustainability of medicare has come from the 3 richest provinces: British Columbia, Alberta and Ontario.

Consequently, the public sector seems to have forgotten that, since the beginning of universal health insurance, the system has required adjustments, modifications, additions and subtractions of services: a continual process of navigation and renewal. Politicians and health boards cave in to lobbies and narrow interests. For too many of them, medicare is no longer an inspiring metaphor — the social policy equivalent of the Canadian Pacific Railway — but, rather, an unmanageable inheritance with a huge appetite and a will of its own. As for the public, let them eat cake — as much as they want — but levy a premium, and institute a co-payment.

Neither premiums, nor co-payments, nor surtaxes based on use, nor offloading programs will fix health care. They will merely increase citizens' and businesses' costs and erode equity. There is nothing wrong with the concept of single-payer, universal health insurance. It fails only when memory of why we fought for it fades, and the will to sustain it breaks down.

Steven Lewis is President of Access Consulting Ltd., Saskatoon, Sask., and Adjunct Professor at the Centre for Health and Policy Studies, University of Calgary, Calgary, Alta.

Competing interests: None declared.

Correspondence to: *Steven Lewis, Access Consulting Ltd., 211–4th Ave. S, Saskatoon SK S7K 1N1; fax 306 343-1071; steven.lewis@shaw.ca*