Lessons for the United States From Single-Payer Systems

US political debates often refer to the experience of "single-payer" systems such as those of Canada and the United Kingdom. We argue that single payer is not a very useful category in comparative health policy analysis but that the experiences of countries such as Canada, the United Kingdom, Spain, Sweden, and Australia provide useful lessons. In creating universal tax-financed systems, they teach the importance of strong, unified governments at critical junctures—most notably democratization. The United States seems politically hospitable to creating such a system.

The process of creation, however, highlights the malleability of interests in the health care system, the opportunities for creative coalition building, and the problems caused by linking health care finance and reform. In maintaining these systems, keeping the middle class supportive is crucial to avoiding universal health care that is essentially a program for the poor.

For a technical term from the 1970s, "single-payer health care" has proved to have remarkable political power and persistence. We argue it is not a very useful term but the lessons from such systems can be valuable for those contemplating movement toward universal health coverage in the United States. (*Am J Public Health*. 2019;109:1493–1496. doi:10.2105/AJPH.2019.305312)

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See also Donnelly et al., p. 1482.

Although discourse on health care reform in the United States often uses the term "single payer," there is some debate on how analytically useful the term is and some confusion over what is and what is not a single-payer system. Single payer is an Americanism, a technical term developed in the 1970s to distinguish a specific kind of health financing that has also become a slogan for people in the United States who support universal, egalitarian, health care.

In practice, the terms "single payer" and "multipayer" can be misleading.[1] There are so-called multipayer systems in which one of the social insurance funds covers a large majority of the population, such as that of France. There are also single-payer systems with extensive complementary and substitutive private insurance, such as those in Ireland and Australia.

Instead of counting payers, as the terms single- and multipayer suggest, it is a better base for comparison to pay attention to which organizations in the system are buying health care, the extent to which they behave in similar ways, and whether they pay the same prices. If their behavior is highly similar or highly coordinated and they pay the same prices, a de facto monopsony—a market in which there is effectively only one payer—exists. All universal health care systems, including those of Scotland, Japan, Austria, and Taiwan, combine some form of de facto monopsony with price controls, such as a single price scheme.[2] As a result, the politics of systems labeled "single payer" and those labeled "multipayer" will often look quite similar because they share key features, such as universality, government accountability, monopsony, and price controls.

Although their similarities will often be more important than will their differences, there are a subset of health systems in which de facto monopsony and price controls involve government financing of essentially all health care with central taxation rather than using a multipayer model of tightly regulated social insurance funds. In other words, it means the national health service systems (e.g., the United Kingdom, New Zealand, Canadian, Nordic, Iberian, Italian, and Taiwanese systems) in which the government finances most care with direct taxation. The category includes countries with large health care programs financed with taxation but very large private insurance sectors for the better off as well (Ireland, Australia). We exclude the systems, such as Germany's, that are formally social health insurance models with multiple funds, because they clearly are not what is meant by single payer in US discussions.

Even in this group, there is considerable variation. There are systems in which the national health service (NHS) is not universal, such as those of Ireland, Cyprus, and Australia; in these countries the system formally and informally shifts a large part of the population into private health insurance. There is a great deal of variation in ownership, from direct public ownership to a preference for contracting with nonprofits. There is also variation in the basket of services covered. Canadian pharmaceutical insurance, for example, is a provincial responsibility. As a result, pharmaceutical coverage is more fragmented and less effective at insuring people against risk than are its federal–provincial health care arrangements. As the Canadian example shows, there is also important variation in the governments that operate health care systems. It is, for another example, hard to characterize "the" Spanish system because its 17 regional governments operate increasingly different systems with different priorities and management.

The United States is clearly capable of operating health care

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systems in ways that resemble other countries, as with the Veterans Health Administration (effectively a British-style national health service model) and Medicare, which resembles the Canadian model of public finance for services provided privately. What it has not done, and what these other countries have done, is create a universal overall system, single payer or otherwise.

HOW SINGLE-PAYER SYSTEMS ARE ESTABLISHED

There are broadly 2 conditions under which single-payer systems have been established. One is institutional: countries with strong and unified central governments, such as the United Kingdom, New Zealand, and Sweden, have single-payer systems. Canada does as well, although its strong and unified central government is balanced by federalism. Consequently, the creation of Medicare in Canada was a very Canadian story of powerful executives acting and the federal system then compensating for the structural instability of subnational government finances[3] by generalizing the financing across the country.[4] These strong and unified governments can pass NHS models because in such systems there are fewer opportunities for incumbent interests to block legislation, and government can make broader trade-offs in sustainability, coverage, and organization.

The other, sometimes overlapping, condition is historical. Single-payer systems are also established in critical political junctures when a country is democratizing and has no universal health care system.[5] Thus, for example, Spanish democratization in the late 1970s and early 1980s brought in parties elected in part on the promise of expanding the welfare state, and the Spanish single-payer system emerged from their debates on how best to do that (the socialist party, which was attracted by the model of Sweden, defeated the right-wing party, which was interested in social insurance). The pattern continues, with, for example, democratization creating the opportunity for Taiwan to create a single-payer system.[6] A new democracy with a relatively blank slate is a prime location for the creation of a simple, egalitarian, and encompassing program like single-payer health care.

From this perspective, the United States seems like a very hostile environment in which to establish a national single-payer health care system. By contrast with the United Kingdom, New Zealand, and Sweden, the United States does not have a strong, unified central government. In fact, the United States has an unusually large number of political players who can block legislation.[7] Power is divided vertically, with autonomous states whose independent actions produce policy divergence, and horizontally, with governments subdivided into multiple legislative chambers, powerful courts, and independent and powerful executives. The result is that it is relatively easy for narrow interests or opponents of a policy to find a place from which to exercise a veto, for example in the US Supreme Court ruling Medicaid expansion in the Affordable Care Act optional and in US states then refusing Medicaid expansion.

Similarly, the creation of the US welfare state was divorced from democratization. In Spain, the conversations about the shape that the welfare state should take were an integral part of the democratization process, but in the United States conversations about health care excluded a large proportion of the population. The United States became a fully inclusive democracy only with the passage of the Voting Rights Act of 1965,[8] decades after the creation of Social Security and the employer-sponsored health insurance system set it on a track toward today's financing mix.[9] Even today, exclusion persists in different forms. Students of US politics disagree about the exact proportion of persons in the United States whose views have no identifiable influence on politics, but it appears to be at least the bottom half of the income distribution.[10–12] A national single-payer system that redistributes downward might be a hard sell in a system with such strong class bias.

Despite these obstacles, however, other countries do offer the United States a number of useful lessons. First, it is not inevitable that doctors and hospitals will oppose the establishment of a single-payer system. In large part this depends on how they were being paid before the single-payer system was established, but it also depends on whether they are well paid in the new system, whether the new system can credibly commit to continue to pay them well, and whether they will be subjected to organizational reforms that they oppose, such as payment system or provider system changes.

The last point is crucial: yoking organizational reforms to universal coverage endangers the universal coverage. Providers are more likely to understand and appreciate the benefits of a steady income and less paperwork than they are to applaud proposals for the top-down rationalization of their organization and work. The NHS of the United Kingdom, for example, simply removed all financial barriers in 1948. There was no administrative rationalization until 1974, long after the NHS had become part of life. Current Irish and Cypriot efforts to move to universal systems are both endangered, not because of opposition to universality but because of providers' opposition to changes in payment systems and health care organization. Those who focus on reorganizing medicine and health care delivery compete for attention and power with those whose main interest is in universal access.[13]

Avoiding reorganization is quite contrary to the US instinct to fill health care access policies with efforts to improve quality and contain costs. Part of the reason for this instinct is that the US health care sector is exceptionally expensive, which means that reducing its overall cost is a motivation for many reformers. The instinct to reform also arises for 2 other reasons, both stemming from the complexity of US political institutions: (1) legislation is so hard to pass that everybody wants to add their policy ideas to must-pass laws,[14] and (2) budgetary rules adopted in the 1970s and 1980s oblige programs to be costed in often spurious but politically important ways.[15] Disregarding these imperatives is difficult advice. Nevertheless, Blumenthal and Morone are onto something: to pass universal health care, "hush the economists," for they, and even more so budgeters, will likely be interested in the costs of something that is inevitably expensive.[16] In the longer run, we can hope that economists, and budgeters, can start to account better for the benefits of an equitable and efficient health care system.[17,18]

HOW SINGLE-PAYER SYSTEMS ARE MAINTAINED

Maintaining a single-payer system can seem hard. Its virtues, in terms of tight overall financial control, redistribution from rich to poor, and responsiveness to government, can also be demerits if the system is seen to be underresourced or mismanaged, whereas there are always business opportunities to be seen in changes that make it less universal and egalitarian.[19] As a result, in national single-payer systems there is a permanent worry about the risk that the middle classes will desert the system. Middle-class people in most systems have enough disposable income to buy private procedures or insurance. The risk to a public universal system is that they start voting with their feet by going private and voting with their votes by ceasing to support it politically. The United Kingdom, for example, has a lively ongoing debate about whether any given policies are leading to the death of the NHS, with critics pointing out that the death of the NHS has been confidently predicted almost every year for decades.[20,21] The underlying intuition that fuels this discussion is a good one, namely that the systems are popular but always vulnerable to undermining by those who would underfund it or divert their resources into less efficient private businesses (as we also see in discussions of the US Veterans Health Administration, the closest thing the United States has to a national health service system).[19,22]

Nonetheless, there is no really clear case of a single-payer system in a rich country backsliding, even if there are policies introduced that damage efficiency or redistributive characteristics on the margins. A major reason is that it solves important problems for many others. Universal health care contains health care costs (only the United States has health care costs as a percentage of gross domestic product that increase regardless of government policy). It creates accountability for health care outcomes. It solves problems for people who need not worry about the cost and availability of their health care. Finally, it solves problems for businesses by freeing them of a recruitment and retention strategy (offering health care) that binds them to an expensive, inflationary sector that is much harder to control than are most suppliers. US businesses have understood this last point in the past.[23] They might understand it again if they are offered a coherent and financially acceptable way to leave behind their existing commitments to employee benefits and the associated human resources expenditure and strategies, because payroll taxes are far cheaper to administer and more predictable than are health benefits. In firms, the human resources department is a constituency that can be expected to fight for its role and survival, although it is usually not a very strong one.[24]

The risk, instead, is of middle-class exit. Broadly, programs that serve the middle classes and poor are much more likely to survive and thrive than are programs that serve the poor.[25] Every system, with the partial historical exception of the Canadian, has let the rich buy out in one way or another, going private for such things as office visits and low-risk births that the private sector can profitably insure and supply. But the middle classes are crucial. If they view the public system as desirable, they are a reservoir of support for the basic concept of the system and a large pool of engaged users who can fairly quickly tell when it is deteriorating and exert influence on the government of the day. A trap exists in which the public universal system underpins a middle-class preference for exit wherever possible. In such systems, which include those of Ireland, Australia, and Cyprus, the public system serves the poor and those with complex diseases, whereas whenever it is possible the middle classes opt out and pay via insurance or out of pocket. These countries all have higher-performing health care systems than does the United States, but few view them as efficient, fair, or stable across economic cycles. Both Ireland and Cyprus are currently trying to shift toward universal health care.[26,27]

The organization of hospitals is also crucial. In all the systems we discuss, the important and expensive hospitals are primarily financed in the public system. If all private payment buys is faster back surgery or nicer facilities for low-risk births, then it is naturally limited and will not exist at all in some parts of a country. High-risk births, long-term conditions, and complex procedures will gravitate back to public hospitals with the skills, equipment, and risk pooling needed to handle anything from breech births to diabetes. Teaching hospitals, in particular, are likely to end up in the public sector in such systems, in part because expensive patients can become assets in research and teaching contexts. They have a risk of partial privatization, as with private-pay beds in English elite hospitals, where patients pay out of pocket for a nicer and faster version of the same procedures carried out by the same staff they might have elsewhere in the building for free. The question is the extent to which the system effectively privatizes these public resources for the benefit of self-pay patients.

CONCLUSION: THE IMPORTANCE OF THE MIDDLE CLASS

US persons are justifiably debating ways to create a more universal, equitable, and efficient health care system and can build on successful and well-established programs, such as Medicare and Medicaid, that demonstrably weather political storms. In building out these programs, there are a number of lessons from other countries.

First, Medicare (or some other system) will not become the only US health care system. The political analysis of what it takes to establish a unified national single-payer system such as those in Canada, the United Kingdom, Spain, and Sweden suggests that the United States is not likely to create one. The institutions are too riddled with veto points, and even a critical juncture in US democratic history is unlikely to produce the kinds of clean slate reforms democratic transitions brought in Taiwan or Spain.

Second, there are a variety of lessons about the creation of a universal system nonetheless, notably that a credible commitment to give providers a decent and predictable income flow with no associated efforts to rationalize them can be an attractive offer. Likewise, it is noteworthy that combining administrative rationalization efforts with creating universal access is a formula for failure; providers who might not mind

the reduced bureaucracy and greater stability of a universal system are likely to object if it simultaneously involves their being rationalized and reformed from above.

Third, the biggest lesson about sustaining a national single-payer system is that the middle classes are crucial. Systems that the middle classes perceive as good value, whether Medicare, the NHS of the United Kingdom, or the social insurance systems across Europe, will have a political strength that systems targeted only at the poor generally lack. The political support for Medicaid that the past decade has shown might be attributable to its demonstrable value to middle-class families. The least redistributive single-payer systems are the ones that encourage a high level of middle-class exit through, for example, tax incentives or selective private access to public resources (including subsidized medical education for the doctors). In those systems, such as Ireland's and Australia's, middle-class support for the public system is less solid and the system is less efficient and equitable, but it is harder to make the case that the middle classes should use and vote for a better public system.

Policymakers in the United States, as they think through various universalist themes, should be careful to ensure that the system they create will be attractive to the middle classes, for it is there, and more than in industry interests or social justice, that political sustainability lies—even if creating such a program makes passage harder. Means-tested programs that target the poor and those of low income remain politically divisive and, as a result, often suffer from stigma and political instability. AJPH

CONTRIBUTORS

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REFERENCES

1. Glied S. Single payer as a financing mechanism. *J Health Polit Policy Law*. 2009;34(4):593–615.

2. White J. The 2010 US health care reform: approaching and avoiding how other countries finance health care. *Health Econ Policy Law*. 2013;8(3):289–315.

3. Greer SL, Elliott H, eds. *Federalism and Social Policy: Patterns of Redistribution in Eleven Democracies*. Ann Arbor, MI: University of Michigan Press; 2019.

4. Tuohy CH. *Remaking Policy: Scale, Pace, and Political Strategy in Health Care Reform*. Toronto, Canada: University of Toronto Press; 2018.

5. Toth F. Is there a Southern European healthcare model? *West Eur Polit*. 2010; 33(2):325–343.

6. Wong J. *Healthy Democracies: Welfare Politics in Taiwan and South Korea*. Ithaca, NY: Cornell University Press; 2004.

7. Stepan A, Linz JJ. Comparative perspectives on inequality and the quality of democracy in the United States. *Perspect Polit*. 2011;9(4):841–856.

8. Mickey R, Levitsky S, Way LA. Is America still safe for democracy? *Foreign Aff*. 2017;96(3):20–29.

9. Mayes R. *Universal Coverage: The Elusive Quest for National Health Insurance*. Ann Arbor, MI: University of Michigan Press; 2004.

10. Evans RG. Financing health care: taxation and the alternatives. In: Mossialos E, Dixon A, Figueras J, Kutzin J, eds. *Funding Health Care: Options for Europe*. Buckingham, UK: Open University Press; 2002:31–58.

11. Winters JA. *Oligarchy*. Cambridge, UK: Cambridge University Press; 2011.

12. Gilens M, Page BI. Testing theories of American politics: elites, interest groups, and average citizens. *Perspect Polit*. 2014; 12(3):564–581.

13. Fox DM. *Health Politics, Health Policies: The British and American Experience, 1911–1965*. Princeton, NJ: Princeton University Press; 1986.

14. McDonough JE. *Inside National Health Reform*. Berkeley, CA: University of California Press; 2011.

15. Saldin RP. *When Bad Policy Makes Good Politics: Running the Numbers on Health Reform*. Oxford, UK: Oxford University Press; 2017.

16. Blumenthal D, Morone JA. *The Heart of Power: Health and Politics in the Oval Office*. Berkeley, CA: University of California Press; 2009.

17. White J. Budget-makers and health care systems. *Health Policy*. 2013;112(3): 163–171.

18. McDaid D, Sassi F, Merkur S. *Promoting Health, Preventing Disease: The Economic Case*. New York, NY: Open University Press; 2015

19. Evans RG. Going for the gold: the redistributive agenda behind market-based health care reform. *J Health Polit Policy Law*. 1997;22(2):427–465.

20. Powell M. Who killed the English National Health Service? *Int J Health Policy Manag*. 2015;4(5):267–269.

21. Klein R. Rhetoric and reality in the English National Health Service: comment on "Who killed the English National Health Service?" *Int J Health Policy Manag*. 2015;4(9):621–623.

22. Gordon S. *The Battle for Veterans' Healthcare: Dispatches From the Front Lines of Policy Making and Patient Care*. Ithaca, NY: Cornell University Press; 2017.

23. Swenson P, Greer SL. Foul weather friends: big business and health care reform in the 1990s in historical perspective. *J Health Polit Policy Law*. 2002;27(4): 605–638.

24. Martin CJ. Stuck in neutral: big business and the politics of national health reform. *J Health Polit Policy Law*. 1995; 20(2):431–436.

25. Rothstein B. The future of the universal welfare state: an institutionalist approach. In: Kuhnle S, ed. *The Survival of the European Welfare State*. Abingdon, UK: Routledge; 2003:217–233.

26. Burke S, Barry S, Siersbaek R, Johnston B, Ní Fhallúin M, Thomas S. Sláintecare—A ten-year plan to achieve universal healthcare in Ireland. *Health Policy*. 2018;122(12):1278–1282.

27. Cylus J, Papanicolas I, Constantinou E, Theodorou M. Moving forward: lessons for Cyprus as it implements its health insurance scheme. *Health Policy*. 2013; 110(1):1–5.