

# The Changing Influence of the Canadian Single-Payer Model in America's National Healthcare Debate

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If imitation is the sincerest form of flattery, then Canadians have good reason to feel rebuffed by their southern neighbors when it comes to healthcare reform. Amidst a perpetual crisis of rising costs and millions of uninsured, the United States has continued to brush aside the Canadian single-payer model of national health insurance despite its record of universal coverage, cost-constraint, and broad popular support. To be sure, the Canadian model has received consideration by Americans both inside and outside of government. As early as 1975, the health policy book, *National Health Insurance*, asked this poignant question in its subtitle: *Can We Learn from Canada?*<sup>1</sup> Yet time and again, the answer has been to reject Canada's approach in favor of various homegrown alternatives, none of which has yet proved able to survive the American political gauntlet. And so, the healthcare crisis continues to smolder...

The purpose of this article is to examine the role of the Canadian healthcare model within America's health reform debate. Although the single-payer system is not now, and never has been, a truly serious contender for adoption, its influence is evident within the areas of policy design, rhetorical discourse, and the formation of group conflict within

US health reform politics. In addition, an analysis of reaction to the Canadian model can shed light on three important conceptual topics in the study of US healthcare policymaking.

First is the issue of cross-national learning. From a rationality perspective, fact-based learning represents a basic ingredient of public policy development, one that is essential for well-informed assessment of programmatic alternatives. In the area of healthcare reform, awareness of the structure and functioning of other national health systems is a form of "exogenous learning"<sup>2</sup> that is especially relevant for a country like the United States, which is an "outlier" with regard to coverage and financing trends within the community of advanced welfare states. How American officials, industry groups, and advocates have reacted to Canadian healthcare—arguably, the most relevant among all national models due to Canada's geographic proximity, cultural affinity, and richly-documented performance offers a valuable case study of cross-national learning and the ways that this process may become distorted.

Second, treatment of the Canadian experience within America's health reform debate has bearing on the framing of solutions in healthcare problem definition. Problem definition refers

to the dynamic by which problems and solutions are identified as part of the process of political agenda setting.<sup>3</sup> The availability of a plausible policy solution can determine whether policymakers are willing to recognize the existence of a problem. Further, according to political scientist John Kingdon, the likelihood of policy change depends on the convergence of favorable political conditions and concern about a public issue, on the one hand, with a feasible policy proposal, on the other.<sup>4</sup> In this regard, the role of the Canadian model within America's health reform debate raises two central questions: Why has the single-payer approach been rejected as a feasible policy proposal? What impact has this rejection had on the characterization of other solutions?

Third, a longitudinal investigation of the discussion of Canadian healthcare offers a fascinating view of the evolution of America's healthcare policy domain. As Burstein (1991) has written, a policy domain consists of "components of the political system organized around substantive issues."<sup>5</sup> Not only are policy domains defined by the groups and institutions that are involved in decision making, but also "domains are cultural constructs around which organizations and individuals orient their actions."<sup>6</sup> Notwithstanding certain recent proposals for expanding the role of private insurance within Canadian healthcare, the single-payer model has remained remarkably stable over time as a form of policy design for national healthcare reform. It is, in this sense, a constant stimulus, and changing American reactions to the Canadian system offer a revealing reflection of shifting ideas, attitudes, and politics inside the US health policy domain. Such shifts will

be important to understand for anyone trying to gauge probable outcomes from America's contemporary healthcare debate.

The starting point for this discussion, then, is a trip to an earlier—if not more innocent—time when Americans last confronted the flaws of their healthcare system on the national political stage.

### **The Clinton Era Healthcare Debate**

Looking back from the vantage point of 2008, mindful of the bruising defeat ultimately suffered by the Clinton Administration and its allies, it may be hard to recall how imminent, even unstoppable, the movement for healthcare reform seemed in the early 1990s. Writing in the *Boston Globe* in May of 1991, economic reporter David Warsh offered this pithy assessment: "How is health reform going to come to America? There is no longer much doubt that something big is going to happen to this Mitchneresque [sic] landscape."<sup>7</sup> In so far as the stage was indeed being set by a combination of epic themes and gripping detail, stylistic hallmarks of the historical novelist James Michener, Warsh called attention to a few critical developments on the contemporary national scene: 25 million uninsured for a year or more, with 10 million more than this on any given day; the dampening economic effect of a doubling of healthcare's share of the GNP since 1960; and widespread public concern over the complexity, discontinuities, and affordability of receiving medical care.

Although the Canadian model would come to play a vital part in the healthcare debate that unfolded in this period, American interest in the

healthcare arrangements of Canada predates this policy episode by at least two decades.<sup>8</sup> As early as 1971, Senator Edward Kennedy joined with Michigan Representative Martha Griffiths to propose a Canadian-inspired single-payer reform in which private insurers would be eliminated and a new National Health Board would be created to administer the program. Justifying his plan, Kennedy boldly said: “I do not believe we can afford the health insurance industry in this country—nor do I believe we have any responsibility to maintain it at the public’s expense now that its failure is apparent.”<sup>9</sup> Bowing to political pressure, Kennedy subsequently revised his plan so that the federal role would be lessened, public and private health plans would be allowed to coexist, and employers would be mandated to provide coverage for their workers. Even in this weakened form, however, the approach was attacked as excessively bureaucratic and destined to lead to “rationing” and poor quality care. It was a reaction foreshadowing many of the criticisms that would be leveled against government-sponsored health reform plans in the years ahead.

By the start of the 1990s, then, the Canadian healthcare model, now with approximately two decades of operational experience behind it, was very familiar among health policy experts and Washington policy makers. Among its leading proponents were liberal legislators from northern-tier states, such as Senator Paul Wellstone of Minnesota and Representative James McDermott of Washington, organized labor groups from the steel and auto industries, and consumer groups like Citizen Action and the publishers of *Consumer Reports* magazine.<sup>10</sup> Within the medical

community, Physicians for a National Health Program was an articulate, well-organized faction devoted to explaining the policy specifics of Canadian healthcare to fellow practitioners as well as a broader public audience. As to public perception, pollsters Robert Blendon and Humphrey Taylor released a widely cited comparative survey on healthcare in the United States, Britain, and Canada in 1988.<sup>11</sup> According to these data, not only were Americans much more likely to see their health system as having major problems than in the other two nations, but 61 percent said they would prefer the Canadian healthcare model to their own when read a description of its major features (another 29 percent favored the British system).

When public issues are framed for political debate, two dimensions of meaning may come into play.<sup>12</sup> An “instrumental” aspect focuses on the practical likelihood that the recommended policy remedy can produce the benefits promised by proponents. Cost-effectiveness is a primary concern within discussions of this nature. The “expressive” dimension refers to the degree to which a proposed policy’s design and methods of implementation embody acceptable values within the political and social systems. American advocates of a Canadian single-payer system attempted to argue their case on both instrumental and expressive grounds in the early 1990s.

Describing “The Physicians for a National Health Program Proposal” in the *Journal of the American Medical Association* in May of 1991, Dr. Kevin Grumbach and his colleagues promised the combination of “liberal benefits” with “conservative spending.”<sup>13</sup> Based on the Canadian example, they put

forward a single-payer health plan that would cover all Americans, offer a comprehensive package of benefits, minimize patient cost sharing, achieve major administrative savings, create long-term cost containment, and free physicians from bureaucratic interference in the practice of medicine. Senator Wellstone's "American Health Security Act" and other single-payer legislative proposals of the day, such as Congressman Martin Russo's "Universal Health Care Act," may have differed in regard to details of institutional configuration and financing, but all stressed a similar set of tangible outcomes. The U.S. General Accounting Office gave a timely boost to this instrumental argument for single-payer reform. In its June, 1991, report on the lessons of Canadian health insurance, the GAO concluded that "If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance coverage for the millions of Americans who are currently uninsured."<sup>14</sup> Furthermore, government analysts forecast that "if the single payer also had the authority and responsibility to oversee the system as a whole, as in Canada, it could potentially constrain the growth in long-run healthcare costs."<sup>15</sup>

The value-based appeal of Canadian healthcare was never advanced as vigorously before an American audience as the model's practical benefits. Nonetheless, even when presented as rhetorical subtext, the expressive argument contained several ingredients. These included the virtues of equity (financing through progressive taxation with a standard package of minimum benefits), access to healthcare as a social right, en-

hancement of professional autonomy, and rational control of the system via government planning and supervision as opposed to the erratic influence of private market forces.<sup>16</sup> Sometimes proponents sought to encapsulate a host of value-based arguments by means of an appeal to national pride, as in the following goad from Senator Paul Wellstone and public health expert Ellen R. Shaffer:

Every other industrialized nation has been able to use the power of a public authority to provide a secure and dependable environment for the healing arts. In every other industrialized nation people are far more satisfied with their health care system than we are in the United States, and by every measure of public health they are in better condition. Although costs may rise, these countries can and do use the lever of public control to recognize problems quickly and then move to address them. Surely with all our technology, creativity, and good will, Americans can borrow from their experience and do equally well.<sup>17</sup>

Yet politics is governed by powerful laws of inertia and, as E. E. Schattschneider has noted, "the mobilization of bias" is in favor of the status quo.<sup>18</sup> Except in the most unusual circumstances, it is much easier to block ambitious proposals for change than it is to gain acceptance for them. In his book, *The Rhetoric of Reaction*, Albert Hirschman identifies three powerful discursive themes that conservatives have at their

disposal in attacking progressive reforms.<sup>19</sup> First is “perversity,” or the prediction that government actions will backfire, only worsening the social problem that is being addressed. Second is “jeopardy,” or the idea that a new reform will undo an existing reform. Third is “futility,” or the general assertion that government is inept at social engineering and thus incapable of improving the status quo. These three arguments, which have been a standard part of reactionary ideology since at least the time of the French Revolution, were all clearly in evidence on the conservative side of the debate over Canadian-style single-payer reform in the early 1990s.

In 1991, Edmund Haislmaier, an analyst for the conservative Heritage Foundation, produced a lengthy critique of Canadian healthcare predicting numerous perverse consequences from any attempt to transplant the single-payer model in the US. His theme, in short, was that “The picture of the Canadian system painted by its proponents has seemed too good to be true.”<sup>20</sup> Relying heavily on a recent study of the Canadian health system published by the Health Insurance Association of America, Haislmaier argued that the Canadian approach would damage existing US healthcare by inflating government spending, instituting an inefficient government monopoly in the administration of healthcare, limiting physicians’ incomes, restricting clinical freedom, and lowering the quality of care. Well-funded lobby groups like the American Medical Association (AMA) and Health Insurance Association of America (HIAA) worked hard to popularize such claims, rendering them in simpler, rhetorically potent form via what political scientist Theodore Marmor has called a campaign of “well-financed distortion.”<sup>21</sup> Marmor and other researchers<sup>22</sup> have traced how the public

was brought to fear the arrival of rationing, long waiting lines for care, and an intrusive takeover of the health system if single-payer advocates got their way.

Countering the pro-Canada message that Americans should feel embarrassment for lagging behind other nations in healthcare reform was the unabashed assertion that the United States already had the best healthcare system in the world and should do nothing to jeopardize this position. Hear Senator Phil Gramm, Texan Republican, on this theme in August of 1994:

I can hardly believe my ears when the health care system of the United States of America is compared unfavorably to the health care systems of Canada, Great Britain and Germany. Last year more people died in Canada waiting to get into the operating room than died on the operating table. People all over the world under government-dominated systems are dying because health care that is readily available in America is not available in those countries. And I want to begin my debate on this issue—since everybody is talking about what we are going to gain by vastly expanding the role of government in health care decisions, I want to start by talking about what we stand to lose.<sup>23</sup>

This jeopardy argument spawned numerous variants focusing on specific programs, protections, or values that supposedly would be put at risk by single-payer healthcare. When Republican Senator Alphonse D’Amato of New York faced a challenge from Democratic

state Attorney General Robert Abrams in the fall of 1991, he targeted the latter's support of Representative Russo's single-payer proposal by warning older voters that "Bob Abrams is going to double your Medicare payments."<sup>24</sup> In September of 1992, Massachusetts Representative Gerry Studds, another backer of Russo's bill, found himself defending against the charge that it would destroy the veterans' healthcare program.<sup>25</sup> The attack on Canadian healthcare reached fever pitch in California in 1994 when a single-payer initiative, Proposition 186, gained a place on the state ballot. Here, a powerful alliance of business groups, health insurers, the hospital industry, and the California Medical Association spent large sums to defeat the measure. Echoing charges being broadcast from one end of the state to the other, Richard M. Rosenberg, Bank of America CEO, wrote a commentary in the *Los Angeles Times* that stated: "At best, Proposition 186 threatens to derail California's long-awaited economic recovery. At worst, it could virtually disable the state's healthcare delivery system."<sup>26</sup> American Savings Bank crossed an ethical line from polemics to coercion when it sent an apocalyptic memo to employees cautioning that if Proposition 186 passed, the inevitable big tax increases would jeopardize their retirement plans and other benefits.<sup>27</sup>

Finally, a powerful sense of futility about the capabilities of government guided the rhetorical attack on single-payer healthcare. Opponents took aim at the Canadian approach by equating it with "big government run amok."<sup>28</sup> Turning to a phrase with powerful negative resonance from America's health insurance struggles of the 1950s and early 1960s, they labeled Canadian

healthcare as "socialized medicine" ("socialized financing of health care" would have been more accurate since most doctors and hospitals in Canada remain in the private sector). Next, the image of an ineffective bureaucratic monstrosity was conjured up by analogizing single-payer healthcare to various unpopular government agencies, including the Postal Service and Registry of Motor Vehicles. One clever conservative line about government health insurance quipped it would combine the efficiency of the Post Office with the compassion of the KGB.<sup>29</sup> In the California debate over Proposition 186, a family-practice physician from Santa Barbara published an editorial in which she described the perfect bumper sticker for opponents of the plan, "If you like California's public schools, you'll love single-payer health insurance."<sup>30</sup> Even if one conceded certain benefits that the single-payer system had produced for Canada, the effort to achieve these same results in the United States, according to conservative critics, would be futile because of stark differences between the two countries. The Heritage Foundation's Haislmaier hit home this point by contrasting Canada's parliamentary system with the separation of power between executive and legislative branches in the US. "Because of these significant political differences," Haislmaier wrote, "any national health system in the U.S. likely would quickly degenerate into pork-barrel politicking and legislative micro-management."<sup>31</sup>

Marmor explains that a triad of forces pushed aside the Canadian model in the early 1990s.<sup>32</sup> Politicians, including Hillary Clinton and her husband, concluded that single-payer healthcare was a political impossibility due to its non-incremental nature and the list of powerful interests within the healthcare industry lined up

against it. Recognizing the political calculus that had been made, journalists merely followed where the policy spotlight was cast, rather than continuing to explore the merits of a single-payer approach. Similarly, any health policy experts who wanted to remain relevant in the decision making process narrowed their focus to the main alternatives on the table.

But if the Canadian single-payer model was “the missing alternative” on the agenda of US health reform in this period, this is not to say it did not have an important influence on the outcome of deliberations. The single-payer contingency within Congress attracted as many as eighty adherents; although some consented to give support to President Clinton’s proposal, others remained aloof. Ironically, conservatives claimed that Clinton’s “managed competition” framework was really a single-payer system in disguise based on its use of monopsony buying power at the regional level and its seeming encouragement of single-payer innovations in the states.<sup>33</sup> The result was that, although top leaders inside the Democratic party never took it seriously as a policy model to be explored, the Canadian single-payer proposal was a political liability for the Clinton Administration due to the paradox of its appealing coherency, on the one hand, and unpalatable foreignness, on the other. Also, many of the well-honed arguments against this model were simply redirected at the Clinton plan by opponents and with devastating effect.

### **Fast Forward. The Canadian Model in 2008**

Following the demise of the Clinton plan, healthcare policy making in the US entered a period of relative dormancy as managed care underwent its rapid rise and

decline and attention shifted from the federal government to the states. Yet healthcare reform has once again re-emerged as a dominant national policy issue owing to increasing numbers of uninsured and underinsured, steadily rising costs, political pressures for reform from diverse constituencies, and the mind-concentrating effect of a new presidential campaign. Despite significant alterations in the American health policy landscape since the early 1990s, the Canadian single-payer system endures as a preferred solution among, at least, some groups, keeping it a part of the national healthcare reform dialogue. At the same time, the Canadian model continues to excite an energetic negative response from those who insist it has little to teach an American audience. In broad outlines, then, the controversy over Canada reprises much of what was being said in the early 1990s, but certain changes of substance and style in today’s dialogue are instructive.

As the 2008 presidential campaign began to take shape, Drew Altman, president of the Kaiser Family Foundation, announced: “We’re at the beginning of the next great debate about health reform...and the words ‘universal coverage’ are back at the center of the debate.”<sup>34</sup> Altman’s prediction has proven correct, but the “center of the debate” has shifted decidedly to the right in recent years—even among Democrats. Popular understanding of the phrase “universal coverage” carries fewer assumptions of a government-controlled system than it did in the past, encompassing instead a panoply of new possibilities including individual mandates, private coverage subsidies, health savings accounts, and other market-based approaches. In healthcare

reform, the “policy primeval soup,” political scientist John Kingdon’s term for the collection of ideas on how to solve a social problem, is a much different dish than what was simmering on the political stove just a decade ago.<sup>35</sup>

A December 2007 Kaiser Family Foundation poll found that healthcare ranked second only to Iraq on the list of issues the public wanted to hear presidential candidates talk about, and considerably ahead of both the economy and immigration.<sup>36</sup> Recognizing popular concern, office-seekers responded quickly. John Edwards was first to announce a universal healthcare plan. He proposed a system requiring employers to cover their workers or pay into a fund that would help individuals buy insurance through new regional “Health Care Markets.”<sup>37</sup> Hillary Clinton is once again at the center of the national debate, but much has changed since she took part in the “scarring” battles of the past.<sup>38</sup> Clinton followed Edwards with a plan that would leave the existing system largely in place—a dramatic departure from 15 years ago—achieving universal access mainly through a combination of subsidies for the poor and individual mandates for those who can afford to purchase insurance.<sup>39</sup> Barack Obama’s plan resembles Clinton’s but leaves out two critical features: an individual mandate for adults and a guarantee to cover all Americans.<sup>40</sup> This latter omission contradicts what Clinton calls a “core Democratic value and a moral principle,”<sup>41</sup> and it violates the assumption that “universal” coverage should, at the least, mean guaranteed coverage for all.

On the Republican side, Governor Mitt Romney, well known for his vital role in the adoption of Massachusetts’

healthcare initiative in 2006, offered a plan that would encourage state-based movement toward expanded coverage.<sup>42</sup> John McCain, now his party’s nominee, has proposed improving access largely through changes in the tax code, thereby promoting individual incentives for purchasing health insurance.<sup>43</sup> Though distinct in many ways, the common thread running through Democratic and Republican plans alike is an emphasis on individual responsibility within a competitive health insurance market.

Despite this mainstream drift toward more conservative policy solutions, the single-payer approach has not completely slipped into obscurity. The credit for such goes, most of all, to Ohio Representative and presidential candidate Dennis Kucinich. Along with Democrat John Conyers of Michigan, Kucinich co-sponsored the United States National Health Insurance Act (HR 676)—a bill that would create a universal, single-payer, not-for-profit healthcare system—and he made advocating for its passage a central feature of his now defunct presidential campaign.<sup>44</sup> In an interview with the *Boston Globe*, Kucinich emphasized the distinctiveness of his plan among the field of alternatives put forward by his Democratic rivals: “One of the greatest hoaxes of this campaign—everyone’s for universal healthcare. It’s like a mantra. But when you get into the details, you find out that all the other candidates are talking about maintaining the existing for-profit system.”<sup>45</sup> Although elements of the single-payer idea are being actively explored in a few states, California and Wisconsin among them, Kucinich stands alone among major figures running for president to have advanced a plan mirroring the Canadian model. (This statement excludes Ralph Nader, who did not enter the race until February of 2008.)

## INTERNATIONAL

Kucinich's plan boasts a coterie of hard-line supporters, including 75 members of Congress and 298 union organizations in 43 states.<sup>46</sup> The perennially pro-Canadian Physicians for a National Health Program (PNHP) has rallied behind HR 676, as has the National Association for the Advancement of Colored People and the National Organization for Women. Much as Senator Wellstone and the "American Health Security Act" did during the early 1990s, Kucinich and his proposal have provided current advocates of the single-payer healthcare model with a rallying point for political mobilization. However, the rhetoric of today's single-payer advocates is much less likely to focus explicitly on Canada and its accomplishments than in the past.

The contemporary value-based argument for single-payer reform rests, as it always has, on an appeal to equity, social rights, and rational planning. What is different today is that advocates favor a popular American policy example as their point of reference. Despite striking similarities to the Canadian model, Kucinich's legislative proposal for a national healthcare system has been marketed as "Medicare for All." Along these same lines, when announcing its support for an "expanded Medicare" system, the *Providence Journal* described the virtues of this strategy as follows:

We would prefer an expanded Medicare program—that is, a basic package of government-provided benefits that allows the purchase of private coverage for the extras. Medicare is simple and its beneficiaries, the elderly and disabled, seem generally to be happy customers. Moreover, the administrative overhead is a tiny 2 percent

of Medicare spending compared with private insurers' average of 25 percent. Unlike Medicare, for-profit insurance companies spend money on such things as advertising, executives and, of course, giving a return to investors....Yes, a Massachusetts-style system relying on private coverage is better than nothing, a lot better. But making health coverage a simple government benefit makes the most sense of all, and it also takes the job of covering workers off the backs of employers, where it never belonged in the first place.<sup>47</sup>

Why do advocates of national health insurance now point to Medicare rather than Canadian healthcare as their frame of reference? As the nation's largest health insurance program, currently covering almost 40 million Americans, Medicare is widely considered to be popular and efficient. A 2005 Harris Interactive/Wall Street Journal poll found that 96 percent of Americans "strongly" or "somewhat" support Medicare.<sup>48</sup> On the other hand, a recent national survey conducted by researchers at the Harvard School of Public Health documents shifting American perceptions of Canadian healthcare since the early 1990s.<sup>49</sup> The plurality of those surveyed in this country, or 40 percent, now say the US has a better healthcare system than Canada. Smaller numbers prefer US healthcare to the systems in Great Britain (37 percent) and France (31 percent). Moreover, while large numbers of respondents felt unprepared to make a comparative judgment in regard to healthcare in Great Britain and France (40 and 53 percent respectively), only

26 percent answered “do not know” when considering Canada. In short, Americans not only appraise Canadian healthcare negatively in greater numbers than before, they also feel knowledgeable about this topic. It is a finding anti-Canada mudslingers can view with satisfaction, and today’s remaining American single-payer advocates are taking such public disenchantment seriously.

A strategic plan for those involved in health reform campaigns on the federal and state levels has been formulated by the Herndon Alliance, a nationwide nonpartisan coalition of more than 100 minority, faith, labor, advocacy, business, and healthcare provider organizations.<sup>50</sup> Based on innovative methods of value-based polling, the group recommends a communication approach that identifies certain words and phrases advocates should use to invoke or avoid a predictable political response. Among the positively-charged phrases to emerge from their research are “American health care,” “choice and control,” and “personal and shared responsibility.” Phrases that elicit negative response include “Canadian style health care” and “universal coverage.” Interestingly, the Alliance concluded that “Medicare for all” also carries negative associations, suggesting it may not be the safe moniker that single-payer advocates are looking for after all.

There is no doubt that leading political candidates are going to greater lengths than ever before to distance themselves from single-payer healthcare and its language. Although Edwards and Obama have at times remarked that single-payer, universal healthcare is their “preferred” system, both have been loath to embrace this model in their presidential campaigns. A television ad recently aired by the Clinton team attacks Obama for saying in a speech

to members of the AFL-CIO in 2003 that he was “a proponent of single-payer, universal health care.”<sup>51</sup> Seeking to deflect this criticism, Obama has had to dodge and dart: “What I said was that if I were starting from scratch, if we didn’t have a system in which employers had typically provided health care, I would probably go with a single-payer system.” Obama’s rhetorical dexterity allowed him to weather this storm, but the fact that he was vehemently attacked for only passively supporting a single-payer approach is telling. That this attack came from a professed advocate of universal healthcare who has also consulted closely with Canadian single-payer experts in the past underscores the surreal quality of the episode. Elizabeth Edwards, speaking on behalf of her husband, also has discussed obstacles facing a Canadian system in America: “Single payer is not going to pass in this country. It is not going to happen. We may get to single payer, but we are not going to jump to single payer. John is in favor of bold moves about a lot of things, but we have to be realistic and the point is to get people covered.”<sup>52</sup> The message is clear: Support for a single-payer healthcare system, or a model recognized to be based on the Canadian system, is simply not a politically-viable position in American politics today, not even in a Democratic Party primary.

For their part, proponents of an incremental and/or market-oriented policy approach often employ the Canadian system to denigrate a strong governmental role in healthcare, be it a single-payer system or not. Using time-tested strategies of the past, these groups and individuals reinforce the notion that American healthcare is—or should be—the envy of the world, and they forswear any fundamental change that would jeopardize

this supposed distinction. Before leaving the presidential race, Republican Rudy Giuliani, a fierce opponent of universal healthcare, frequently reiterated that the US provides the “best medical care in the world,” while criticizing the Democratic candidates for looking to “the socialized medical systems of Europe, Canada, and Cuba” for their reform ideas.<sup>53</sup> Various critics have also replayed the idea that government involvement in healthcare represents an unacceptable intrusion into the private realm and, as such, a disturbingly un-American solution. John McCain warned a crowd of voters at a Reagan Day dinner in Milwaukee this past February that “If you like Senator Obama’s plan and Senator Clinton’s plan, go to Canada or one of the European countries before you make that decision.”<sup>54</sup> Even if the plans from both Democratic candidates differ markedly from the Canadian and European models, McCain’s strategy is clear: to define universal healthcare as an *imported* solution. David Brooks, a conservative columnist for the *New York Times*, recently weighed in on the prospect of a single-payer healthcare system and came to a similar conclusion:

Some liberals, believing that government should step in as employers withdraw, support a European-style, single-payer health care system. That would be fine if we were Europeans. But Americans, who are more individualistic and pluralistic, will not likely embrace a system that forces them to defer to the central government when it comes to making fundamental health care choices.<sup>55</sup>

In a recent interview, Representative Dave Camp, ranking Republican Mem-

ber on the House Health Subcommittee, made this anti-foreign sentiment even more explicit:

I firmly believe we can and should solve America’s health care crisis in an American way. If we choose to go down the path that Western Europe or Canada has, it will be no surprise when we come to the same destination—a universal health care system that leaves your family dog with better coverage and care than you get.<sup>56</sup>

Representative Camp’s critique may have been over the top, but it is paralleled by the more staid writings of conservative policy analysts. Dr. Kevin Fleming of the Heritage Foundation responded in 2006 to what he perceived as a renewed interest in “socialized medicine” by publishing a scathing critique of the British and Canadian single-payer systems. Similar to the analysis offered by Haislmaier fifteen years earlier, Fleming argued that in these systems, “health care is subject to bureaucratic and political rationing and driven by political and budgetary pressures. This leads to inevitable adverse effects, including: long waits and reduced quality...funding crises...new inequalities... labor strikes and personnel shortages... outdated facilities and equipment... politicization and lost liberty.”<sup>57</sup> Fleming urged policymakers to explore the “abundance of practical alternatives to a single payer system.” To be sure, waiting lists are a functional element of Canadian healthcare, inherent in the design of a system that is overt about the process of priority setting. Even so, the specter of growing lines for various

forms of diagnosis and surgery in recent years has, in the words of the *New York Times*, “marred” the image of the Canadian system in the eyes of many Americans.<sup>58</sup> It also continues to provide Canadian detractors with a serviceable symbol for rhetorical exploitation

Coinciding with the kickoff of the presidential campaign, the release of Michael Moore’s “Sicko” called attention to the Canadian single-payer system within the realm of pop culture in an unprecedented way. By means of comparisons among the US, Canadian, and other national healthcare models, Moore’s documentary exposed embarrassing gaps and flaws within the American way of healthcare.<sup>59</sup> Moreover, those who visit the “Sicko” website are directed to the “Canadian Waiting Room,” a link that presents positive stories about the Canadian healthcare system.<sup>60</sup> According to a Kaiser Foundation poll, among those familiar with the film, 54 percent agree “the U.S. should have a free, universal, government-financed health care system,” although only 37 percent said they were more likely “to think that other countries have a better approach to health care than the U.S.” as a result of the film.<sup>61</sup> Yet, whatever the impact on those who view or hear about “Sicko,” there is an obvious political downside when a marginal left-wing critic like Moore steps into the role of national salesperson for the Canadian model. A propagandistic film of this nature also invites counter-propaganda and the conservative response has been vigorous.

Much of the onslaught has come via the world wide web and the “blogosphere,” a ubiquitous electronic medium for political dialogue in 2008 that did not even exist during the health reform debate of 1993-94. Among other things,

Moore has been lambasted for “obnoxious bomb-throwing arguments,”<sup>62</sup> “mendacity writ large,”<sup>63</sup> “liberal nonsense,”<sup>64</sup> and “hypocrisy and manipulation.”<sup>65</sup> An article in *American Thinker*, the conservative online publication, elaborated: “It’s as if he [Moore] believes that he’s finally connected with an issue—socialized medicine (or “universal health care”)—that is poised to change history—to wrestle private enterprise-driven health care to the ground, once and for all, and to snuff the last breaths of freedom, autonomy, and choice out of it.”<sup>66</sup> The “anti-Michael Moore” has also come forward in the form of Stuart Browning, an independent American filmmaker who produced a video titled “A Short Course in Brain Surgery.”<sup>67</sup> Browning’s YouTube offering, which has registered over two million viewers, tells the tale of Lindsay McCreith, a retired auto-body shop owner and resident of Ontario, who is suing the provincial government for not providing him with timely medical treatment for a brain tumor. Rather than wait for an MRI and subsequent surgery in his home country, McCreith traveled to Buffalo, New York, to pay for what his doctor calls life-saving treatment. Browning aims to upend Moore’s flattering depiction of Canada’s single-payer model using the same technique of powerful visuals combined with poignant, if deliberately selected, case material and moral outrage for which Moore has become renowned. Attacks such as Browning’s also tap mischievously into the policy debate currently emerging within Canada over creation of a limited role for private health insurance. Anyone wanting context or balance in examining this noteworthy development, however, will need to search elsewhere.<sup>68</sup>

### **Discussion and Conclusion**

At the time of this writing, a hard-fought battle for the Democratic presidential nomination is ongoing whose unusual character is marked by the protracted nature of the conflict, disputes over rules of the game, and the very types of candidates who stand poised to assume their party's mantle of leadership. Whatever the outcome, it will be historic. As soon as this contest is settled, another will shift into high gear pitting the Democratic and Republican standard-bearers against each other in a general election campaign and highlighting alternative views of the nation's involvements abroad, maintenance of homeland security, stimulation of the economy, and the role of government in a free society. Many sharp distinctions and contrasts will be put forward concerning the nation's public policy agenda for the next four years.

When it comes to healthcare, however, the range of options already seems, both philosophically and programmatically, remarkably restricted. As if by prior mutual consent, whichever candidate takes over the country's helm, the dominant place of the private market in health service financing and delivery is assured, while individuals and families will continue to bear a large share of responsibility for obtaining adequate insurance protection. The experiences of other nations that could point to meaningful alternatives in the design of healthcare reform are, at best, being ignored or, at worst, manipulated for polemical attack. The topic of Canada and its single-payer system offers a prime example of this collective narrowing of focus. Never a mainstream solution in discussions of America's healthcare crisis, the Canadian model has now been pushed to the far sidelines politically by Republicans and most Democrats, its lin-

gering presence primarily one of caricature and fringe curiosity.

Three conceptual interests—cross-national learning, problem definition, and the evolution of policy domains—have served to frame this investigation. The time has come to reflect briefly on some of the implications of our analysis in relation to these subjects.

A number of authors have stressed the cultural factors that present barriers to America's learning lessons from abroad in healthcare reform. Often, this argument has emphasized broad social values like individualism, distrust of government, and support for free enterprise that purportedly define a distinctive American character. Without entering into the debate over how much these psychosocial traits really do distinguish the United States from other similar nations or what their significance might be in shaping preferences for a specific policy area such as healthcare, a fuller understanding of American antipathy to the Canadian healthcare model depends on connecting culture and politics. In particular, it is important to recognize the way that values and institutional structure have combined in the US to ingrain certain "logics of action," in James Morone's phrase. More than fifteen years ago, Morone identified several public policy patterns of this kind, including "the faith in impersonal gimmicks, an ascetic's stance toward public administration, a penchant for implicit solutions, a marked preference for respectable clients, and the difficulties of negotiating programs through an intricate political stalemate."<sup>69</sup> In every case, this American pattern is violated by the Canadian single-payer model, which embodies centralized policy design, public control, overt choice, universal-

ism, and decisive political intervention. Thus, the colorful rhetoric of waiting lines, high taxes, and big-brother bureaucracy is at once a screen and a clue for the real issues at the heart of the Canadian healthcare debate. It is difficult for the US to learn from Canada's example, not because we understand too little about how the single-payer model operates in practice (although problems of objective information and discourse do exist), but because "it is difficult to imagine a lesson that is more foreign to the American experience."<sup>70</sup> As single-payer opponents have demonstrated time and time again, a discrepancy of this magnitude proves very easy to exploit in terms of symbols and anecdotes, and the barriers to programmatic learning will be raised to the extent that the lesson being taught implies significant sociopolitical transformation.

American rejection of the Canadian model is also consistent with assertions regarding the impact of problem-definition on public policy-making. According to this perspective, a solution must be successfully framed as effective, affordable, and politically acceptable for it to be viable.<sup>71</sup> The evidence suggests that pro-Canadian single-payer advocates have not managed to build this case convincingly outside of the small world of academic publishing, or beyond a modest contingent of liberal-leaning politicians and activist groups and organizations. We have already noted the political-cultural context that works against this proposal. There are strategic difficulties as well with the way the argument has been made. The most powerful case on behalf of single-payer systems, intellectually speaking, and the one that has been favored by advocates, packages the reform as a global response to the question, "How can the ailing US health system be fixed once and for all,


and in comprehensive fashion?" However, many Americans still appear reasonably satisfied with their country's healthcare arrangements overall; for them, reform means fixing the specific broken pieces and dysfunctional practices that create a degree of personal disadvantage. As Katherine Fierlbeck astutely notes in regard to American reactions to Canada's rationing methods, "That Canada does much better at providing access to these services for lower-income individuals is not necessarily a relevant consideration for those in pain who can afford to avoid queues."<sup>72</sup> Likewise, Hillary Clinton demonstrates her appreciation of the need to preserve large elements of the status quo in promising a health plan that essentially changes nothing you might not want it to change:

Hillary's American Health Choices Plan covers all Americans and improves health care by lowering costs and improving quality. It speaks to American values, American families, and American jobs.

It puts the consumer in the driver's seat by offering more choices and lowering costs. If you're one of the tens of million Americans without coverage or if you don't like the coverage you have, you will have a choice of plans to pick from and that coverage will be affordable. Of course, if you like the plan you have, you can keep it.<sup>73</sup>

In short, a central irony underlies the failure of single-payer reform from the standpoint of problem definition: the solution it promises to deliver would "fix" too much for too many, overstepping the bounds of demand for change.

The policy domain in which healthcare policy is constructed has changed too many ways since the early 1990s to be exhaustively catalogued here. The strong alliance among insurers, physicians, and hospitals that once proved so formidable a political force has been fragmented by the struggles over managed care. Over the past decade, many businesses have opted to “dis-insure,” or scale back on the coverage they provide, exacerbating tension over distribution of the burden of healthcare costs and destabilizing the employment-based insurance system. Noteworthy state-level reforms, such as in Massachusetts, have emerged from unusual cooperative efforts involving politicians from both sides of the aisle, as well as leaders from the healthcare industry, medical professions, business, and consumer advocacy communities. In the abstract, such developments might seem to bode well for a renewal of interest in single-payer reform; in reality, as we have seen, the limited popularity of single-payer serves as a gauge of how disparate trends and tendencies in the current era are moving health reformers to the middle and right. The focus of innovation in health policy today lies not in devising an expanded, more directly controlling role for government, but rather in making the private market more efficient and in delineating the responsibilities of private citizens, all within a framework supervised, at greater or lesser distance, by public authorities. Significantly, the pollster Robert Blendon, whose work did much to suggest the Canadian system as a plausible model for US health reform in the early 1990s, has written of the nation entering a period in which incremental and hybrid solutions hold popular appeal, not major system change.<sup>74</sup> So it is that the demand for action may persist but, as the debate over Canadian single-payer in the United

States well demonstrates, neither clarity of purpose nor a responsible form of public rhetoric are likely to prevail in the absence of more effective leadership on this issue. 

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