"Satisficing" is a word mashup satisfactory and sufficient, describing the result of believing that perfection is the enemy of good – creating something good but not optimal. As the drums beat louder for Medicare for All, our northern neighbor’s single-payer health system is the subject of an article finding that yes, it is satisficing; but in the exploration of its benefits and limitations serves to inform our discussion, here in the states.

Canada’s Health System

Canadian health coverage

- Applies to everyone legally in Canada.
- Is good at any hospital and with any physician.
- There are no co-payments or pre-authorizations, payment is prompt.
- Is both safe and effective (although everyone quibbles about which metrics are correct).
- Encourages and provides access to primary care creating continuity.
- Has lower administrative costs.
- It is portable across the nations but since benefits are determined on a provincial basis, it is not identical care.
- Out-patient drug costs are not covered.
- There are waiting lines to see specialists and to undergo surgery, longer than currently experienced in the US and probably less than the lines in the UK.
- Cost is controlled by provincial governments determining and capping physician and hospital payments.
Good not great, satisficing.

The Canadian system effectively caps physician income. When those limitations were put in place, physicians moved - to better financial situations, like the US. And fewer physicians resulted in longer lines and less access. We are effectively moving to cap physician income now in the US. It is difficult to find another country which pays so well and affords us so much, so a physician migration is unlikely. But fewer individuals may opt for a career being a doctor when their skills might be deployed in other growth professions without such limitations, or they will accept a “better life-work balance,” trading time for money and in the process creating hourly, shift workers.

As we have attempted here, the Canadian system initiated a voluntary program of capitated fees for primary care, one payment to cover all annual services, in place of fee-for-service. Those with less complicated patients participated, those with more complex patients (therefore requiring more care) did not. In the US similar capitated programs, whether described as medical homes or bundled care, suffered the same fate – if you could turn a “profit” you participate. Otherwise, you did not. All the recent media coverage of “risk corridor” payments is about the government giving insurance companies reimbursing them for monies they lost.

Our system of available health care services or benefits is a mess, determined by federal regulations, like being able to include your less than 26-year old child on your plan; what insurance companies offer, like vision or dental, or what costs they shift to you through co-payments; and by how much you spend, the bronze, silver and gold health exchange programs. But even a lopsided marketplace offers some alternatives; in Canada, there is a monolithic payer.

In the Canadian system, provincial governments define the covered benefits and pay the costs – because these expenses consume 40% of their budgets, they are subject to both financial and political pressures. Politicians do what they do best, pandering to those who can help them at election time. 85% of nurses are represented by organized labor, and physicians’ professional societies are more directly involved in fee negotiation than the little “change in fee dance” we do annually with CMS. Despite their differences, they reach an equipoise, a symbiosis where neither group is willing to make sacrifices, to their incomes or constituency. Good pay, little change – just like many of our government funded programs here. While the government is the single-payer and regulator, it is not held accountable, just like here. The term, fight city-hall comes to mind.

We continue to confuse and conflate two issues, health care, what you actually get is different than payment. Perhaps that is the limitation in our viewpoint, always coupling product and price. A single payer Medicare for All will enact significant regulatory cost control, at the risk of hospital closures and physician flight to other remunerative careers, but satisfying many patients cost concerns. But a single health system will not result from a single payer. If the government is the only payer, who will they serve; themselves or us?
Congress requires that its members and staff participate in the insurance exchange, choosing one of the 57 plans available. If they select a gold plan, the federal government will pick up 72% of the cost. If instead, they choose a less expensive plan, then their expenditures are not subsidized. This is government-speak for ‘forcing them’ to choose the gold plan.

Whatever system we have moving forward I make only one request. Whatever Congress decides, they cannot exempt themselves but must demonstrate that they are using the same system.

Source: Lessons from the Canadian experience with single-payer health insurance: Just comfortable enough with the status quo DOI:10.1001/jamainternmed.2018.3568