Making Single-Payer Reform Work for Behavioral Health Care: Lessons From Canada and the United States

International Journal of Health Services
2020, Vol. 50(3) 334–349

DOI: 10.1177/0020731420906746
journals.sagepub.com/home/joh
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Abstract

The claim is often made that the adoption of single-payer health care in the United States would result in dramatic improvement of services for people with mental health and substance use disorders. Evidence from this sector in countries with such frameworks is mixed, however, presenting both positive and negative lessons for an American audience. Focusing on Canada as an example, this article sheds light on this topic by drawing on sources in the professional and academic literature, government reports, news stories and features, and research on-site by the author. A concluding section highlights key policy issues that American single-payer advocates will need to address for meaningful reform of the behavioral health care sector.

Keywords

Affordable Care Act, behavioral health care, Canadian health care, health insurance, health reform, Medicare for All, mental health care, single-payer, substance use treatment

In 2018 the United States held its ninth consecutive national election of the 21st century in which a large segment of voters viewed health care as an important issue of concern.[1–9] For many "progressive" Democrat candidates, however, the framing of debate had changed, with the fight for survival of the Affordable Care Act (ACA) now becoming less important than advocating for an ambitious new approach for health reform. The favored alternative? "Medicare for All," a strategy promising universal insurance and cost-control courtesy of an expanded role for government within the health sector.[10,11]

"Single-payer" health plans are currently under review by the legislatures of nearly 20 states.[12,13] Seven Medicare for All and Medicare expansion plans have been introduced in the 116th Congress.[14] As of November of 2019, 2 of the 3 leading candidates for the Democratic presidential nomination, Senator Elizabeth Warren (D-MA) and Senator Bernie Sanders (I-VT), were staunch supporters of the former, more far-reaching approach.

Whether the window of opportunity finally has opened, enabling triumph over the political, economic, and cultural obstacles that have long thwarted the single-payer movement in the United States, remains uncertain.[15,16] Overcoming controversy, however, is only 1 type of difficulty associated with the single-payer framework. Just as daunting is the task of configuring a single-payer model that builds on the strengths of U.S. health care while avoiding the shortcomings in other countries with universal systems of this kind.

One area expected to gain from single-payer reform in the United States is behavioral health care. Anticipated improvements include more reliable coverage, reduced out-of-pocket spending, better access to services, smaller insurance bureaucracy, expanded professional autonomy, and the broad promise of health care as a right.[17–19] In actual practice, when it comes to mental health and substance use disorder treatment, the

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experience of countries with single-payer health care is mixed, presenting both positive and negative lessons for outside observers.[20–22]

Focusing on Canada as an example, the purpose of this article is to shed light on this topic by drawing on sources in the professional and academic literature, government reports, and news media, as well as research on site by the author. Based on this analysis, a concluding section highlights key policy issues that American single-payer advocates will need to address for meaningful reform of the behavioral health care sector.

Canadian Health Care: A Deeper Dive

Shortly before introducing his Medicare for All Act in the U.S. Congress in September of 2017, Bernie Sanders authored an op-ed in the *New York Times* to prepare the way: "Now is the time to expand and improve Medicare to cover all Americans. This is not a radical idea. I live 50 miles south of the Canadian border. For decades, every man, woman, and child in Canada has been guaranteed health care through a single-payer, publicly funded health care program. This system has not only improved the lives of the Canadian people but has also saved families and businesses an immense amount of money."[23] The senator's statement was accurate as far as it went, but more details are required if we are to appreciate the issues that fuel debate within Canada itself over the provision of health care.

Notwithstanding a few states like California, Vermont, Colorado, and New York that have seriously considered their own versions of single-payer health care, the Canadian model is chiefly identified within U.S. health policy circles as a top-down strategy for reform at the national level. So dominant is this image that Senator Lindsey Graham (R-SC), when contrasting his own state-focused initiative with Sanders's Medicare for All proposal, characterized it as "a choice between Federalism vs. Socialism."[24] Yet only the financing of health care, not its ownership, may be described as "socialized" under single-payer health care, and federalism is a component of governance no less important in Canada than in the United States.

Tensions and trade-offs inherent to federalism as a political institution manifest themselves plainly in Canada. The intergovernmental partnership initiated under Canada's Medical Care Act in 1966 has never been a 50–50 proposition, fiscally speaking.[25] By 1975–1976, transfers from the federal government accounted for approximately 35% of provincial and territorial expenditures on health care on average. That figure plummeted below 15% in the late 1990s, after which it only partly climbed back to a level of about 23% in 2014–2015. The means by which Ottawa distributes funding have also changed over time. What began as a relatively straightforward formula for federal cost-sharing turned into a block grant in the 1970s, an arrangement later confirmed and fine-tuned under the Canada Health Act of 1984. When the Canada Health and Social Transfer program was adopted in 1995, and later separated into its different health and social components in 2004, it put allocations to the provinces increasingly on a per capita basis.[26] In addition, the federal government currently funds targeted special health initiatives, while "equalization payments" go to provinces viewed as having subpar fiscal capacity. Public financing of Canadian health care, always a controversial subject, has grown more nettlesome over time. Provincial authorities strained by economic downturns, rising health costs, and an aging population decry the constant battle to maintain federal support as their fiscal positions deteriorate.[27,28(chap. 1)]

Dr. Danielle Martin and her Canadian colleagues describe their system as one of "deep public coverage of a narrow basket of services" due to ambiguity and exclusions under federal law.[29] Three different "layers" of financing exist: first, a strong level of support for hospital, diagnostic, and physician services viewed as medically necessary, or essential, forms of treatment; second, a group of services – e.g., outpatient prescription drugs, home care, long-term institutional care, and mental health care – that are encompassed by the government policy framework, but on a highly variable basis across provinces and territories; and, third, services generally excluded from Medicare, including dental care, routine eye care from non-physicians, and outpatient physical therapy. Private dollars are required to pay, in part or in whole, for items in the second and third of these tiers. For an area like behavioral health, services are not neatly categorizable. Different types of care, supplies, and supports fall into different baskets, resulting in discrepancies concerning the cost and amount of care available (Table 1).

The Canadian government pays approximately 70% of total annual health expenditures, with the remainder covered roughly equally by out-of-pocket payments and private insurance.[30] Although American terminology like "uninsurance" and "underinsurance" seldom surfaces in Canadian health policy discussions, it is possible for Canadians to find themselves at substantial financial risk under the single-payer system depending on their specific health care needs, place of residence, and access to supplemental private insurance.[31–33]

Waiting lines in Canada due to limitations on high-technology medical equipment and specialized services have long captured the attention of American observers. Nearly 3 decades ago, the U.S. General Accounting Office issued a report entitled *Canadian Health Insurance: Lessons for the United States*[34] that presented data for the province of Ontario. GAO's conclusion was

Table 1. Three Tiers of Coverage and Financing for Health Care in Canada with Behavioral Health Examples.

Tier	Description	Behavioral Health Examples
First	Universal coverage under public Medicare insurance with financing by federal, state, and territorial taxes	Hospital and physician services
Second	Services falling outside the national Medicare framework but supported and financed, to varying degrees, within the provinces and territories by a mix of public programs, private insurance coverage, and consumers' out-of-pocket payments	Outpatient prescription drugs Community mental health services Public residential rehab services for addictions
Third	Services with almost no coverage and financial support from public sources	Private psychological counseling and therapy by non-MD providers Private residential rehab services for addictions

Source: Martin et al.[29]

that, although scant evidence existed to support claims of patient deaths while on queue, or significant border-jumping to receive care at American facilities, waiting lists for nonemergency treatments and diagnostic procedures were common, sometimes long, and a potentially major inconvenience for patients. While rationing through queuing represents an explicit strategy for efficiency and cost-control in the Canadian system, it remains a source of some dissatisfaction among those served by the Medicare program. With federal funding cutbacks escalating the pressure for cost control, waiting times have worsened to the point where, notwithstanding a variety of attempted fixes, the delays for many procedures now exceed comparable indicators in other OECD countries.[35,36] In a 2011 survey of Canadians and Americans, 50% of the former responded "yes" to the question, "Over the past 2 years, have you or a member of your family had to wait longer than you thought was reasonable to get health care services?"[37(p35)] The American statistic was 31%.

Through expanded insurance coverage, increased access, and other actions, Canada's Medicare program was intended to reduce inequalities in the utilization of health services and the health status of the population. Improvements have occurred over the decades, and numerous indicators currently show Canada in a more positive light than its southern neighbor for overall health outcomes like life expectancy, infant mortality, a number of disease-specific measures, and important health access and quality metrics.[38]

Still, Canadian health disparities persist and have become the focus of government commissions and reports at both the federal and provincial levels.[39–41] Prominent areas of concern include unexplained or unjust discrepancies correlating with such variables as Aboriginal status, income, gender, and geographic location. The latest report on performance of the health system in Ontario spotlights variation in a number of risk factors affecting health and potential years of life lost based on socioeconomic determinants such as income and education and also place of residence within the province.[42] Other studies also document disparities for these variables, as well as unequal levels and types of health resources, across provinces and territories.[43–45] Referring to the growth of social science research information on the problem of health inequities in her country, Monique Bégin, former minister of National Health and Welfare Canada and a member of the WHO Commission on Social Determinants of Health, embraced that commission's final report in echoing: "[W]e have now accumulated indisputable evidence that '*social injustice is killing people on a grand scale*'" (emphasis in original).[46(p5)]

Behavioral Health Care in Canada: The Case of Nova Scotia

Research visits by the author in 1990 and 2018 provide a basis for snapshots of the struggle to reform the behavioral health sector in the province of Nova Scotia.

Nova Scotia is the second smallest of the Canadian provinces geographically and seventh in population size with just under a million residents.[47(chap. 9),48] A formal mental health system was not initiated in Nova Scotia until the mid-1800s, when the Nova Scotia Hospital, an inpatient psychiatric facility, opened in Dartmouth. While development of alternative services over subsequent decades was slow, Nova Scotia emerged in the 1960s as a leader in community mental health programming across Canada and internationally. Building on this accomplishment, provincial leaders established organizational linkages across a spectrum of services – community-based mental health centers, psychiatric units in general hospitals, and 2 public psychiatric hospitals. By the 1990s, additional services and supports included rehabilitation centers and other residential options, as well as specialized resources for children

with mental health problems and for people battling addictions.

A myriad of payment sources and methodologies was in place for mental health and substance use treatment by the time the Nova Scotia Royal Commission on Health Care began its review of provincial health care in the late 1980s. Typical of medical providers in private practice was fee-for-service reimbursement, with smaller numbers of psychiatrists receiving payment via salary and contracts at hospitals and community clinics. Salary and contracts were the norm among non-MD professionals in most settings, except when private-paying patients and insurance companies agreed to pay fee-for-service for counseling outside the Medicare framework. Rehabilitative, residential, and related services provided in Homes for Special Care largely came out of the budget of the Department of Community Services, not the provincial health care envelope.

Contrary to the abstract notion of "single-payer" health care, then, an array of transactions and actors were actually involved in subsidizing services for those with behavioral health conditions in Nova Scotia, albeit not in a particularly well managed or coordinated manner. This situation posed a hindrance to the Royal Commission in its search for a strategy to improve the rationality of the system of care with its tendency to overprovide and overspend in some areas while neglecting others. Specific concerns noted by the commission were a lack of financial incentives for attracting psychiatrists to underserved regions outside Halifax; rapid growth in the practice of "GP psychiatry" with associated quality concerns; and the province's position as having one of the highest psychiatric hospitalization rates in all of Canada. By contrast, support services to maintain individuals with severe and chronic mental health problems in the community were undersupplied, distributed inequitably, and poorly funded in comparison with allocations for hospitals and physicians. One recommendation by the Royal Commission viewed as possibly beneficial for the behavioral health sector was a regionalization plan putting greater authority for health policy and financing decisions in the hands of public bodies on the subprovincial level.

After the creation of 4 regional health boards in 1996, the structure was further decentralized via replacement of the boards by 9 district health authorities in 2001.[49] Driving these reforms were high hopes of cost control through integration of services, efficiency gains, and improved coordination, all guided by a mechanism for citizen input. After a few years, however, the promised benefits of regionalization in Nova Scotia proved illusory for the most part, a casualty of limited transfers of funding from the province, disagreement about redistributing resources among different services and facilities, and administrative complexity across and within levels of health care governance inside the province. In 2016, a policy of recentralization was undertaken as the District Health Authorities became absorbed into a new Nova Scotia Health Authority.

This period of combined administrative experimentation and austerity produced few solutions for unmet community need, over-medicalization, and the fragmentation of services that had plagued behavioral health care since deinstitutionalization's onset in the 1960s. In the winter of 2017, an investigative reporting workshop at University of King's College in Halifax documented what many termed a crisis in mental health care in the province.[50] Among those deficiencies identified in the multipart newspaper series resulting from this investigation were disorganized services; long waiting lines for many community mental health services (up to a year or longer for the most specialized care or remote locations); a low supply of acute psychiatric beds; high use of hospital emergency departments by patients with mental health complaints; shortages of psychiatrists, psychologists, and other mental health and addictions clinicians; and inadequate housing options for people homeless and mentally ill.

When the Nova Scotia Legislature held a hearing on mental health strategy in April of 2018, another recitation of many of these same issues, along with a call for service expansion and coordination, came from witnesses representing the provincial Department of Health & Wellness and the Nova Scotia Health Authority. At one point, when a member of the assembly asked how Nova Scotia was "doing relative in the overall Canadian situation," the witness, a deputy minister for health & wellness, responded: "I think generally speaking, all provinces and territories … are focused on building a mental health and addiction system that really hasn't been a system per se."[51(p31)]

Behavioral Health Care in Canada: A National Perspective

Following WWII, heightened awareness of the scope of mental health problems, outrage over decaying public mental asylums, and new medications and social treatments prompted a call for community mental health services in Canada just as in the United States. Time had come for reallocation and reinvestment on a grand scale, but existing funding structures and priorities obstructed bold action inside this arena. Provincial mental hospitals in Canada had been omitted from coverage under the Hospital and Insurance and Diagnostic Services Act in 1957. Federal lawmakers extended this policy under the 1968 Medical Services Act creating Medicare.[52] While psychiatric services delivered by physicians and private hospitals enjoyed generous

backing, other forms of community treatment and support became a residual provincial responsibility paid for by a mix of health and social welfare dollars, as well as private sources, on a largely discretionary basis. It was a formula foreordaining the development of "two psychiatries," in Saskatchewan researcher Harley Dickinson's phrase, or a bifurcation between 2 coexisting but functionally separate zones of practice, one dominated by medical doctors, medical facilities, and treatment with psychotropic drugs versus another in which diagnosis and community-based treatments were carried out by nonmedical mental health professionals paid by salary in a mental health clinic setting.[53] This arrangement also assured that, overall, mental health financing would neither keep up with spending increases in traditional areas of health care, nor maintain consistency across provinces and territories.

A procession of white papers and special reports in Canada have attempted to bring the gap between needs and services in the behavioral health sector to the forefront. Spanning more than 5 decades, a sampling of publications includes entries from the federal government (e.g., *Out of the Shadows At Last* [2006],[54] *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* [2012][55]), the provinces (e.g., *Building Community Support for People* (Ontario) [1988],[56] *Putting People First* (Ontario) [1993],[57] *Healthy Minds, Healthy People* (British Columbia) [2010],[58] *The Action Plan for Mental Health in New Brunswick, 2011–18* (New Brunswick) [2010],[59] *Study of Mental Health and Well-Being of Quebec Adults* (Quebec) [2010],[60] *Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan* (Saskatchewan) [2014][61]), and private advocacy groups (*More for the Mind* [1963],[62] *A Call for Action* [2000][63]).

Program and planning documents like these have produced a sophisticated dialogue inside the behavioral health field while maintaining pressure for resource development. After the Quebec survey of mental disorders and services utilization in 2010 and a follow-up study in 2013, the province announced a program covering psychotherapy by non-MD therapists with public insurance funds, the first such venture in Canada.[64] Responding to personnel shortages, Saskatchewan, Alberta, and British Columbia opened the door to a bigger role for social workers in diagnosing addictions and mental disorders.[65] Nova Scotia is the site of a new "Choice and Partnership" initiative to expedite first appointments with a mental health clinician while enhancing the linkage between client goals and treatment plans.[51]

Yet, despite these and other kinds of model programs over the years, the successes of the community care movement in Canada have been modest in scale. If the proliferation of landmark reports attests to the desire for reform, it also signals frustration over the failure to attain this goal. As Katherine Fierlbeck, professor of political science at Dalhousie University and the author of *Health Care in Canada* (2011), has observed: "Notwithstanding the real progress made in thinking about how one ought to approach mental health care, policy reform in mental health care seems more like a continuous reiteration of policy goals than an attempt to understand why these goals remain so difficult to achieve."[28(p209)] Key to the latter, for Fierlbeck and other analysts,[66] are the structural realities of federalism with its dispersal of resources and authority across a plethora of jurisdictions and agencies; a national health program that prioritizes medical care, relatively narrowly defined, above other needed interventions for well-being and functioning of the population; the persistence of stigma; and the political weakness of behavioral health care consumers and their allies inside the health domain.

Until recently Canadian officials had done less to map out a systematic action agenda for substance use disorders than for mental health care.[67] Since substance use and mental health problems are often co-occurring, many affected individuals have relied on psychiatric and community mental health providers for assistance despite growing awareness of the inadequacy of this situation with respect to the scope of coverage and therapeutic options. In fact, consumers with concurrent disorders often encounter difficulty in accessing appropriate dual-diagnosis services due to competing perspectives on the "primary issue" needing attention. In 2006, the landmark Kirby report on mental health and illness in Canada made this point and concluded: "In Canada, the treatment of addiction, like that of mental health, is not a 'system.' Its evolution has been fragmented, chronically underfunded, and has occurred in the shadow of stigma and government inattention."[54(p205)]

A decade later, Canadian researchers who assessed the status of addiction services across the country determined that demand for treatment had increased, but access continued to be hampered by a host of barriers ranging from limited funding, to questionable program priorities, to insufficient outreach to high-risk subgroups of the population.[68] When the opioid crisis hit Canada full force at mid-decade,[69] conditions were ripe for a tragic loss of life, followed by the urgent scramble to mount an effective response, including preventive, treatment, rehabilitative, and criminal enforcement activities.[70]

Empirical data collection as much as politics and social values informs the culture of public problem solving in Canada. A strong emphasis on lesson learning guides policy development as specialists inside and outside of government vigilantly monitor the activities of other nations. In behavioral health, even a country like

the United States, whose framework for health care is anathema to most Canadians, has produced model programs subsequently embraced across the provinces.[71]

Not surprisingly in view of this comparative orientation, findings by Canadian analysts,[72] the World Health Organization (2011),[73] and OECD (2014)[74] concerning international patterns of government mental health and addictions spending have sparked concern among Canadians. Approximately 7% of public health spending in Canada goes to these 2 areas, a figure well below what nations like Sweden, New Zealand, and the United Kingdom devote. It also falls below the goal of 9% of health spending on mental health and addictions set by the Canadian government in its mental health strategy for the nation. Additional research on the provinces focusing on hospital, clinical professional services, and psychotropic medications points to an overall decline in the percentage of public health expenditures for mental health care between FY2003 and FY2013, and large variation in expenditures from province to province.[75] In 2016, as part of a new Health Accord, the federal government put more money into the pot with a promised special transfer of $5 billion to the provinces and territories for mental health services over the next decade. Whether this full disbursement will come about, and where exactly it will go considering issues of targeting, accountability, and federal tightening of the health budget, are concerns that have been articulated by Canadian mental health policy experts.[52]

Using Medicare for All as a Catalyst and a Building Block in the United States

Significant improvements in behavioral health care have occurred in the United States due to the Affordable Care Act. More remains to be done. As of 2018, 9.4% of the U.S. population lacked health insurance. This statistic is down from 16.0% in 2010, the year when the ACA was adopted and incremental implementation of its provisions began. Still, those without coverage currently top 30 million, a number that is up from 2015.[76]

Bolstered with authority from federal parity statutes, the ACA made large strides in combating underinsurance among people in need of mental health and substance use services. However, partly as a consequence of the ACA, an increasing segment of the private health insurance market now consists of plans with high deductibles and out-of-pocket payments likely to deter help-seeking for a stigmatized group of conditions like behavioral health disorders.[77–79] Meanwhile, private insurers are evading the legal requirement for equal treatment of mental illnesses-addictions and physical illnesses by applying stringent medical necessity criteria to the former. Patrick Kennedy, previously a member of Congress and now an outspoken activist on this issue, has called for a nationwide campaign of investigation of health insurers by state legislatures, state attorneys general, and other regulatory agencies to root out this practice.[80,81]

A universal single-payer health plan run by government would remedy a litany of insurance market ills in the United States by sheltering everyone under a broad package of behavioral health care services managed according to standardized guidelines and eliminating profit-based incentives for arbitrary denials of care. (This scenario presumes strenuous regulation of the insurance industry if private companies acquire an administrative role under the new framework.[82]) Undertaking a national project of this kind would be a bold stroke, one inspired by an ethical and pragmatic commitment unparalleled in the crazy-quilt history of American health policy making.

Yet the agenda for fundamental reform of behavioral health care transcends a narrow fix of the insurance market, no matter how useful the latter may be. For this is a sector whose long-term history of resource deprivation, geographic inequities, fragmentation, and insularity shapes the contemporary era, perpetuating treatment disparities across social groups, slowing the diffusion of clinical and administrative best practices, and generating inefficiency and management constraints at all levels. Despite recent gains in insurance coverage, it remains true that fewer than half of all adults with a mental illness received treatment during the preceding year.[83]

Transformation as the Goal of Reform

Several high-level commissions and groups have formulated ambitious proposals for behavioral health care in the United States by approaching it as a distinctive sector having its own history, knowledge base, treatment challenges, and values.[84–87] An increasingly well-defined goal emerging from this work has been "transformation," or a shift from the dominant biomedical model to an integrated array of biomedical, psychosocial, educational, and supportive community services set within a "recovery" paradigm of consumer autonomy, personal well-being, and a holistic conception of quality of life.[88] Even the conservative Heritage Foundation, characterizing the mental health system as "broken," has called for an expansion of community services with greater consumer choice.[89]

The upshot is that, to advance the movement for behavioral health reform in the United States, single-payer health care must do more than increase the number of people eligible for coverage while marginally expanding the services previously paid for by private insurers. What is called for is new flexibility in

operationalizing the concept of "patient-centered care," taking into account a matrix of factors that includes evidence-based research as well as sensitivity to the life circumstances and preferences of individuals receiving treatment. Cost-consciousness continues to be imperative, perhaps more so than ever given persistent health care inflationary trends. But if cost control is not balanced by an overarching therapeutic orientation, quality of care ultimately will lose out to other institutional, professional, market, and political priorities. So indicates the richly documented history of U.S. mental health policy.[90–92]

Proponents of an American single-payer program are well aware of treatment shortcomings for behavioral health that cry out for new resources and creative program development. When questioned by a national coalition of advocacy organizations in this sector, Senators Warren and Sanders each offered detailed lists of actions meant to respond to a host of issues, including suicide prevention, the opioid crisis, mental illness and addiction problems in the criminal justice system, the access barriers faced by marginalized groups of the population, and more.[93] At the time of this writing, former vice president Joe Biden, who recommends expanding the Affordable Care Act rather than a more far-reaching overhaul of the health system, had not explained how his plan would deal with the coalition group's agenda of pressing needs and problems.

It just may be that the Medicare for All framework incorporates precisely the kind of grand reformist vision most likely to spur engagement with dysfunction inside the behavioral health field. Yet, for such engagement to occur, an *enlarged* Medicare must be a substantially *new* Medicare that goes beyond the existing 55-year-old program, whose performance has been marred by gaps in the coverage of long-term care services for people with dementias; a cap on lifetime psychiatric hospitalization benefits; and limited psychiatric rehabilitation, case management, and other services and supports for people with chronic disorders who seek an active path to recovery in the community.[94] Here, the Medicaid program,[95,96] as well as the Affordable Care Act,[97] have valuable guidance to offer concerning the broad package of benefits that must be in place if the objective is a flexible array of resources for individuals with the most severe behavioral health conditions.

Innovation

The Affordable Care Act is also relevant to this Medicare for All discussion on the topic of innovation. For nearly a decade, the former has promoted team-based care and delivery system improvements in the provision of services for targeted groups of patients with complex illnesses by means of programs like Accountable Care Organizations (ACOs), Medical Homes, Health Homes, and the State Innovation Models Initiative.[98] This commitment to innovation, never a strong point in the financing of behavioral health care under Canada's federal Medicare program, although some provinces have been more creative,[99,100] merits continuation under any future American single-payer initiative, presuming the careful evaluation of cost-effectiveness and promised administrative rationalization. While a program like Accountable Care Organizations has grown rapidly over the past decade, commercial payers have dominated,[101] and the original federal "architecture" for the initiative did little to encourage attention to behavioral health.[102] To the extent that ACOs and other vehicles of payment reform come to be applied to patients with mental health and substance use disorders, it will require dealing with the recognized possibilities of risk avoidance regarding "socially disadvantaged" and "clinically at-risk" populations[103] by providers and management entities that seek to conserve resources either by lowering the quality or quantity of care or by "cherry picking" the patients they serve.[104] This does not mean that delivery and payment reforms have no appeal in the area of behavioral health, only that there is a need for appreciating the distinctive circumstances of this patient group, which varies widely in terms of condition severity, chronicity, and access barriers.[105] The public governance task of fine-tuning management options, reporting requirements, and payment incentives in order to diversify organizational participation, while also ensuring accountability for the services provided to those with behavioral health problems, illustrates the programmatic challenges and opportunities to be expected with the shift to single-payer health care.

On a macro level, structures and techniques must be present to channel resources to geographic areas and population groups currently facing the greatest undersupplies of professional and organizational infrastructure. And when innovations with proven clinical and administrative benefit do emerge, they too belong on the list for active dissemination via the structure of the universal health program; otherwise the occurrence of innovation will simply afford added stimulus for worsening inequities within the system. This is one distributive task that might be facilitated by provisions for new national and regional health budgets under a Medicare for All program.

In an international advisory on good governance for the mental health sector, the OECD has called for frameworks that "encourage desirable provider behavior" while producing "good outcomes" for consumers.[74(p16)] Payment alternatives that depart from established fee-for-service methods should be included as part of this effort under an American single-payer plan. Financing

provisions for incentivizing the integration of primary care and specialty services for people with mental health and substance use disorders represent one example of a project that has gained strong backing from the Medicare program,[106] the National Institute of Mental Health,[107] and other groups[108,109] during recent years.

Intergovernmental Coordination

Canada presents ample evidence of the adverse impact when a single-payer system operates in the context of a strained relationship between national and subnational governments. For behavioral health, the consequences have included funding shortfalls, a conflicted policy agenda, and confused lines of accountability for responding to unmet population needs and administrative deficits. The United States has its own telling examples of a troubled partnership between levels of government. Ten years after adoption of the ACA, 14 states have not approved Medicaid expansion, and 20 state attorneys general and governors are collaborating in the latest lawsuit to declare the ACA unconstitutional.[110] Single-payer health care offers no panacea for eradicating the deep historical and sociopolitical divisions underlying this disharmony, yet a policy breakthrough of this kind could mark a watershed moment for institutional review and adjustment.

The intergovernmental perspective is crucial for understanding development of the behavioral health sector in the United States.[111] For 150 years, dating back to the time when public mental hospitals first opened their doors around the turn of the 19th century, states assumed the lead role. Aside from the founding of St. Elizabeth's Hospital in Washington, DC, in 1855, the federal government resisted becoming involved in delivering, or paying for, mental health services in this period. This stance changed dramatically after WWII with the National Mental Health Act of 1946, the Mental Health Study Act of 1955, and the Community Mental Health Centers Act of 1963.[112] Collectively, these laws created a new stream of mental health research and training funds, a National Institute of Mental Health to supervise the grants, and a spreading network of community facilities operated according to federal guidelines. The goal of national policymakers was to increase availability of mental health and substance use treatment services to the population while reducing an outmoded practice of long-term hospitalization in state institutions.

Medicare and Medicaid arrived in 1965, 2 federal programs providing insurance coverage for mental health and addiction services in the private sector for the elderly and recipients of public assistance. The federal government operated Medicare, while Medicaid functioned under joint federal-state control. A variant of this latter model was also employed for the State Children's Health Insurance Program, established in 1997. And over time, the states became increasingly active sponsors in their own right of deinstitutionalization and community care for mental health and substance use problems, dipping into state coffers and resorting to Medicaid for this purpose, along with assistance from an assortment of special funding initiatives and block grants from the federal government. In 2016, Congress passed the 21st Century Cures Act, a law intended, among other things, to strengthen the institutional structure for mental health and substance use services at the national level and to channel new resources from the federal government to the states for specified priorities within this program area.[113]

A classic scholarly debate concerns whether a layer-cake or marble-cake provides the better image of federalism in the United States.[114] The first symbolizes a clearly delineated set of responsibilities for each level of government; the second depicts a blended set of shared activities. For a policy area like behavioral health, the blending is obvious and has become only more pronounced over time, if in a way that varies across the type of care, severity of illness, and patient group. Overall, Medicaid has proven to be the most significant government program for people with mental health and substance use disorders. This is true whether measured in terms of dollars spent or the spectrum of specialty services made available by the program.[115] At the same time, the national picture of public financing for behavioral health care has become distorted and haphazard due to the opportunity seized on by states – some much more eagerly than others – to expand the population and services they cover by drawing down Medicaid matching dollars.[116]

How would an American single-payer endeavor come to grips with this intricacy as it universalizes (or expands) insurance coverage in the United States? This is a central question not to be sidestepped by any serious attempt at behavioral health reform. In his structural analysis of the role of government in U.S. mental health care, historian Gerald Grob cautioned: "However the federal government deals with health policy, it is essential that those involved in its formulation and implementation be aware that intergovernmental rivalries have the potential to alter priorities and policies in unanticipated and not always beneficial ways. ... those who emphasize substance to the exclusion of structure, at least within the American context, may unknowingly promote unpredictable consequences that are not always to their liking."[111(pp496–497)]

Up until recently, the leading single-payer proponents have been reticent about discussing some rather basic issues raised by their proposals. It was November of 2019, some 9 months after her entry into the race for the Democratic nomination, when Senator Warren gave

in to pressure for details on her financing plan for Medicare for All.[117] Once made known, the expenditure projection drew fire on grounds of credibility and feasibility, requiring ongoing explanation from the candidate. Within a matter of weeks, Senator Warren followed up with a multifaceted "transition plan" discussing the timetable and multiple moving parts associated with her approach to implementing single-payer health care.[118] Progressives enthusiastic about the long-awaited arrival of Medicare for All, however, voiced dismay about Warren's gradual roll-out of her plan over several years.[119] And for those concerned about behavioral health care, the transition document contained little information apart from the issue of the opioid epidemic and parity insurance coverage. Meanwhile, Senator Sanders has persisted in talking about "options" and generalities concerning his own plan, going little beyond the data provided with the release of his legislative proposal.[120]

With regard to intergovernmental components, it was April of 2019 when the Sanders's team updated its single-payer bill to include long-term care services, putting home and community-based services under Medicare for All while consigning institutional long-term care services to a kind of residual Medicaid program [Sec. 901(a)(3)(A)(i)].[121,122] By contrast, the statute introduced in the House by Rep. Pramila Jayapal (D-WA) in February of 2019 places the coverage of long-term care services under a universal Medicare program without secondary tiering under Medicaid [Sec. 204(d)(1-6)].[123] Another section in the Sanders's bill [Sec. 901(a)(3)(A)(ii)] seems to make room for varying levels of community services for behavioral health care across the states.

How well do these alternative legislative visions fulfill the needs and preferences of people with behavioral health problems? What services will actually be covered at different levels? How will they be delivered? Can the Medicare for All program produce a true partnership between the national government and the states inside the behavioral health domain, or will the 2 emerge as weakly coupled structural entities, much as often happens under the Canadian health plan? These are just a few quandaries of intergovernmental design and management being provoked by the prospect of a single-payer system,[124] albeit with few answers beyond the nod to a largely inchoate notion of regionalization.

While the Medicare for All debate draws attention to reform on the federal level, it is important not to lose sight of the critical functions played by State Mental Health Authorities (SMHA) in supporting the behavioral health "ecosystem" at ground level by direct provision of services, regulatory oversight, harmonization of state and federal funding streams, and the building of connections across many different agencies and departments that serve individuals with mental health and substance use problems.[125] Of necessity, any new national health program would redefine the arena in which these SMHAs operate. Conversely, the effectiveness of reform for the behavioral health sector will hinge, in part, on optimizing SMHA contributions to the new alignment of resources and relationships that is brought into being.

Sustaining Transformation Through Planning

Replacing the enduring jigsaw puzzle of U.S. health care with a governmental framework that is centrally organized, administratively streamlined, and inclusive of the entire population will entail a commitment to strategic and operational planning unprecedented in the history of social policy in this country. Nothing less promises to suffice for navigating the changeover to such a massively different system, providing for its long-term maintenance, and addressing major points of friction, or disconnection, across the component parts of a newly aggregated whole. Of particular significance in determining the future of behavioral health care will be this latter task of internal organizational adjustment.

Currently, a state-level planning process for mental health services is mandated by federal statute, the Public Health Service Act (as amended). This law has required the formation of state mental health planning councils throughout the country, whose main responsibility is reviewing annual state mental health block grant applications. No requirement ties planning for the Substance Abuse Prevention and Treatment Block Grant to these councils, although federal authorities have recommended making the link. States vary with respect to the amount and kinds of data they include in their planning exercises, as well as the sophistication with which they carry out such tasks as performance evaluation for existing treatment programs, identification of service gaps, and the development of new projects to address changing organizational and budgetary conditions inside the behavioral health setting. A review commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA), focusing on the extent to which state mental health planning councils conducted mental health and substance use planning in an integrated manner, found that 13 states were "well integrated," 23 states showed "moderate integration," and 12 states showed "little or no integration."[126] Criteria for choosing stakeholder groups to become part of council membership differed across states.

The single-payer bills of Sanders and Jayapal each broach the issue of planning under Title IV on "General Duties of the Secretary," vacillating between tasks that are stated very broadly (planning for capital

expenditures and service delivery) or in highly specific terms (planning for health professional education funding). Both bills refer vaguely to encouraging states to develop their own regional planning mechanisms. The Sanders bill relies on state planning in the area of long-term care, while the Jayapal bill would institute a new federal advisory commission.

No matter whether it is the Sanders bill, the Jayapal bill, or some other Medicare for All legislation that ultimately comes to fruition, one hopes for the emergence of a more cohesive planning function based not simply on upgrading and linking mental health and substance use planning in all states, but also embedding behavioral health care within a robust planning mechanism for the single-payer program as a whole. More than a quarter century has passed since the United States adopted a national health planning process. The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) gave birth to a venture that was proactive, population-based, multilevel, concerned with the distinction between needs and demands, and broadly participatory.[127] Critics complained about the conflicts that arose between different stakeholder groups under the law – providers, consumers, insurers, local officials, health planning staff – but painful discussions about resource reallocation and the injection of rational problem-solving into a deeply political environment could hardly proceed otherwise. By the early 1980s, the federal planning law had ended due to controversy, bureaucratic excesses, and perhaps most importantly, the program's unfortunate intersection with a rising tide of neoconservatism in the American polity. Viewed from a vantage point more than 3 decades later, this abandonment denotes a decisive turning point, one where the United States drifted away from the goals of "rationalization of health care and expanded entitlement" in favor of a market-driven orientation with its financial determination of winners and losers.[128(p401)] In so far as the single-payer movement now aims to reverse this policy choice by resurrecting the public interest as a primary touchstone for systemic action while discarding the precept of market supremacy, the neglected experience of national health planning returns to mind along with its vision of a well-ordered health care system in which all groups and illness experiences will receive their due.

Conclusion

Acknowledging the vagueness of Medicare for All proposals in the United States, Adam Green, cofounder of the Progressive Change Campaign Committee, reportedly has dubbed this attribute of "pleasant ambiguity" an appealing political advantage enabling Democrats to "wrap themselves in the flag of Medicare," a popular existing program.[129] For those intent on comprehending the national health care debate, this observation is unsatisfying, perhaps even a bit cynical, and thankfully various tools have surfaced from organizations like the Kaiser Family Foundation,[130] the Commonwealth Fund,[131] and major newspapers for methodically viewing the rival plans in Congress. With regard to behavioral health care, however, such comparisons yield limited insight because existing bills present only a broad suggestion of the changes one might expect beyond coverage for a stated list of specialty services.

Time has come for greater transparency about where the new vision for U.S. health care leads and what it means for mental health and addiction services. By recasting behavioral health resources in terms of a blueprint for coordinated multilevel management, one that speaks plainly to programmatic phase-in and future ongoing operations, the architects of health reform could shed light on many unknowns. Such a discussion might even attract attention from other nations already operating single-payer health care frameworks, whose light as beacons of reform has often dimmed when it comes to mental health and substance use services.

Acknowledgments

For assistance with background information on the history and current status of behavioral health services in the Canadian province of Nova Scotia, the author is grateful for the opportunity to conduct interviews with Professor Katherine Fierlbeck, Department of Political Science, Dalhousie University; Judith Fingard, Adjunct Professor, Department of History, Dalhousie University; John Rutherford, Adjunct Professor, Department of Medical Neuroscience, Dalhousie University; and Sheila Wildeman, Associate Professor, School of Law, Dalhousie University. Gabriel Morris, a Northeastern University undergraduate, provided valuable help in researching current Medicare for All and Medicare expansion proposals in the U.S. Congress.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The author's 1990 research visit to Nova Scotia that is summarized in this article was funded by a Canadian Studies Grant from the Canadian Embassy. A 2018 re-visit to the province was supported by the Faculty Development Fund of the Political Science Department, Northeastern University.

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