

Would a Medicare-for-all system lower healthcare costs in the United States?

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In many countries, such as Australia, Canada, France, and Germany, just to name a few, the government provides healthcare. These countries are the principal buyers of the inputs (pharmaceuticals, medical equipment, the wages of healthcare professionals, etc.) in their healthcare market and can negotiate lower prices for these healthcare inputs. The United States is not one of these countries. U.S. healthcare spending is roughly 18 percent of gross domestic product. If the United States had a Medicare-for-all system, would the U.S. government be able to use its “monopsony power” to curb healthcare spending?

In [“The opportunities and limitations of monopsony power in healthcare: evidence from the United States and Canada”](#) (National Bureau of Economic Research, Working Paper 26122, July 2019), Jullian Chown, David Dranove, Craig Garthwaite, and Jordan Keener (all of Northwestern University) imagine a counterfactual model of healthcare in the United States. In this model, the U.S. government would provide Medicare for all. They use this model to try to predict to what extent the U.S. government could use monopsony power to lower healthcare input prices, specifically labor and pharmaceuticals. Prices in these two areas account for 60 percent and 15 percent of all U.S. healthcare spending, respectively.

The authors compare their model’s price predictions to Canadian prices, because Canada provides “the best evidence of the potential optimal savings available from the creation of a single monopsonist in the United States.” A single payer system, such as the Canadian healthcare system, has been widely believed to depress wages of doctors, nurses, and other healthcare providers. Critics of a Medicare-for-all system worry that provider wages in the United States would drop to Canadian levels. However, the authors point out that this is not the case. Highly educated Canadian healthcare workers earn about 26 percent less than highly educated U.S. healthcare workers. If Canadian monopsony power were the reason for this wage gap, then we would not see this wage gap appear when comparing other highly educated employees in other areas of the economy. But, it does appear. Other similarly skilled, highly educated Canadian workers make 22 percent less than their U.S. counterparts. This 4-percentage point difference could be caused by many things, such as inefficiencies in the U.S. healthcare system, entry barriers into the healthcare field, tuition or licensing requirements, general conditions in the broader labor market, or, yes, the limited use of monopsony power by the Canadian government. However, the principal reason for the wage gap is not Canada’s use of monopsony power.

Canada does not use its monopsony power to negotiate provider wages because the labor supply of healthcare workers is elastic in the long run. If the Canadian government restricted wages, current healthcare workers would begin to seek different jobs and perspective medical students would study different subjects, shrinking the future

supply of healthcare workers. The United States, like Canada, would want to avoid this reallocation of talent and limit its use of monopsony power in the labor market.

In the long run, the relative size of a country's pharmaceutical industry in the global market dictates the extent to which the country can use its monopsony power to suppress drug prices. Canada is able to depress drug prices. A consistent basket of pharmaceutical goods was 54 percent cheaper in Canada than those in the United States. If the United States were to use its monopsony power to this extent, it may not be possible, because the two countries face different long-run elasticities of supply. Canada is a relatively small part of the overall global market for pharmaceuticals, accounting for just 2.8 percent of global spending in the market. Canada does not affect global profits, which suggests that the long-run elasticity of supply for pharmaceuticals that it faces is relatively inelastic. This finding is why the Canadian monopsonist can leverage its buyer power in the market for pharmaceuticals. The United States accounts for 36.9 percent of global pharmaceutical spending, so any success that it might have capping prices would almost surely affect the long-run supply of pharmaceuticals. This result would most likely reallocate production capacity and reduce innovations.