What Would Canada's Health System Cost America?

About $807 Billion a Year

Canada is often held up as the model for US health care. Lakebridge Institute priced what its provincial systems would actually cost if each state adopted one.

Lakebridge Institute · November 5, 2026 · All figures in 2020 US dollars unless noted

Canada comes up in almost every American argument about health care. Supporters of public coverage point to it as proof the model works; opponents point to it as a warning. Rarely does anyone ask a narrower question: what would it actually cost to run American health care by Canada's rules?

A Lakebridge Institute analysis puts a number on it. If each US state adopted the public-coverage rules of the Canadian province it most resembles, government health spending would rise by about **$807 billion a year**, or roughly **$2,454 for every American**. That is in 2020 dollars, the latest year with state-level spending data; in 2025 prices it is about $909 billion.

$807B	$2,454	40% → 71%
extra government spending a year	per person	government share of health spending

The figure is not a forecast and not a price tag for any bill in Congress. It is an accounting exercise: take what each state already spends on health care, apply a real, working Canadian system to it, and see how the bill shifts.

"Canada" is really ten systems

Canada has no single national health plan. Federal law requires every province to cover medically necessary hospital and physician care with no charges at the point of use, but everything beyond that is a provincial choice.

The result is coverage that is far more complete in some areas than others. Provincial governments pay 91% to 95% of hospital costs (Ontario, at 84.5%, is the exception) and 95% to 99% of physician costs. But they pay only about a quarter to a third of prescription drug costs, and between 2% and 18% of dental, vision and other professional care. Much of the rest is paid by employers, private insurance and patients themselves.

That matters for the American comparison. Adopting "the Canadian model" would not mean government pays for everything. It would mean government pays for nearly all hospital and doctor care, and much less of the rest.

How the estimate works

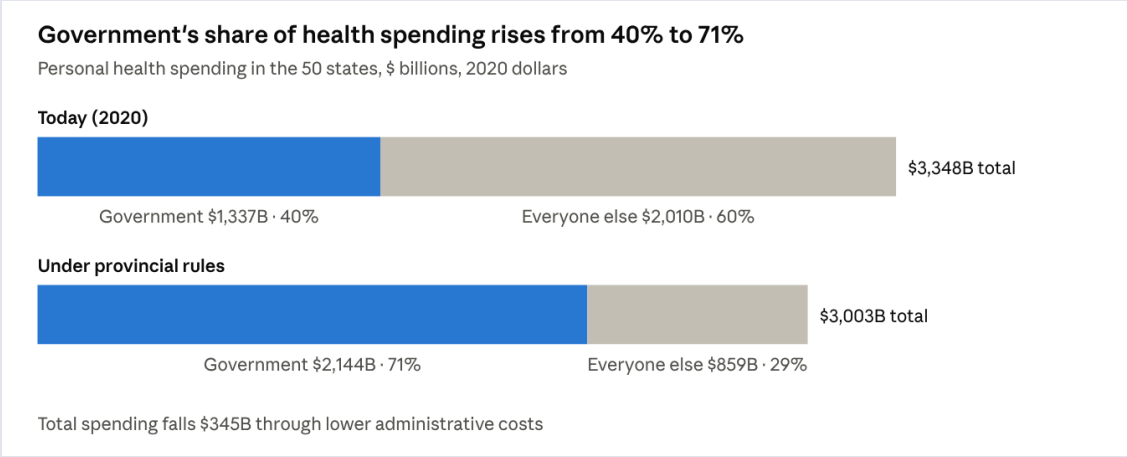
The analysis starts with what each state spent on health care in 2020, across nine types of care, using data from the Centers for Medicare & Medicaid Services. For each type of care it applies the share that a Canadian province's government pays, using data from the Canadian Institute for Health Information.

Each state is paired with the provinces it most resembles on ten measures, including population, age, income, rural share and politics. Rather than forcing a single match, each state gets a chance of following each province. Oklahoma and Kansas most likely follow Manitoba; California and New Jersey, Ontario; North Dakota and Wyoming, Saskatchewan. Manitoba is the most common match, for 14 states.

Medicare and Medicaid are folded into the provincial system rather than kept alongside it. Federal programs for specific groups, such as the Veterans Health Administration, military health care and the Indian Health Service, stay as they are, just as Canada keeps comparable programs outside its provincial plans. The analysis also assumes hospitals, doctors, nursing homes and home-health providers would spend less on administration, falling to Canada's level, which removes 14.4% of their costs. Prices and the amount of care people use are held at each state's 2020 levels.

Who would pay

The biggest change is not in how much the country spends on health care. It is in who writes the check.

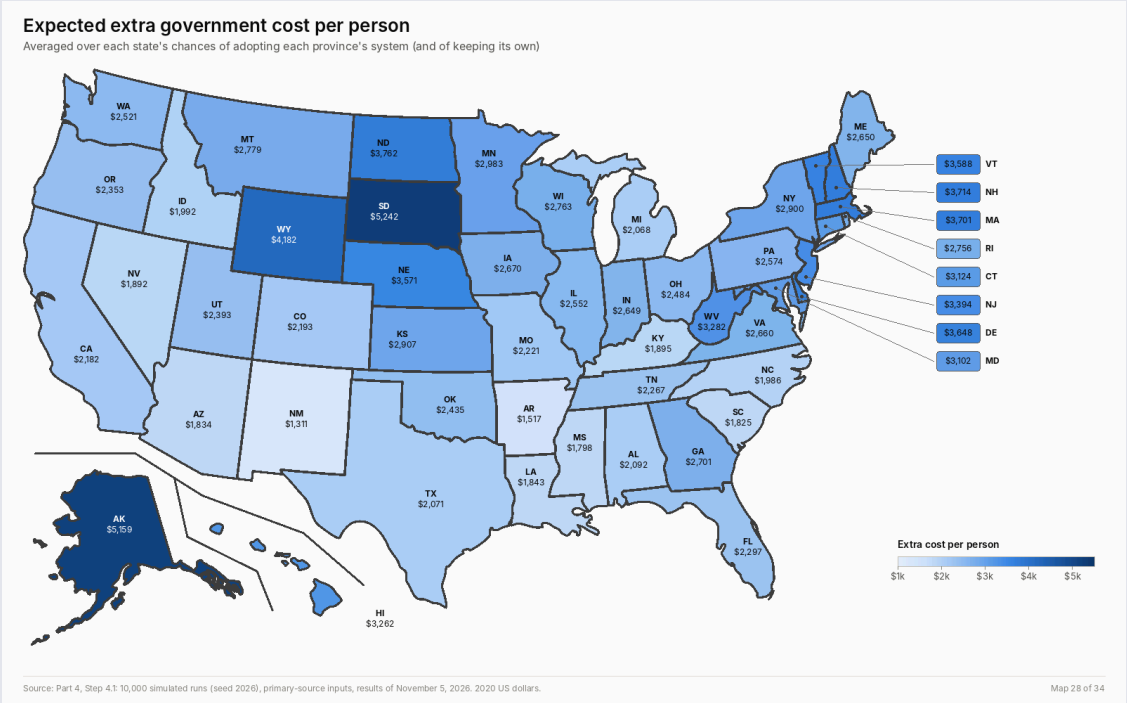


Source: Lakebridge Institute technical report, Section 7.2 · CMS state health spending 2020 · CIHI provincial shares

Today, Medicare and Medicaid pay about 40% of personal health spending. Under provincial rules, government would pay about 71%. Employers, households and private insurers would pay about $1.15 trillion less, while government would pay $807 billion more. The difference between those two figures, about $345 billion, is the savings from lower administrative costs.

Where it costs the most

The cost per person varies fourfold from state to state, from **$1,311 in New Mexico** to **$5,242 in South Dakota**. Two facts explain almost all of the difference: how much a state spends on health care per person, and how much of that Medicare and Medicaid already cover. States that spend heavily and where government pays little today, such as South Dakota, Alaska and Wyoming, see the largest increases per person. States where Medicare and Medicaid already pay close to half, such as New Mexico and Arkansas, see the smallest.



Expected extra government cost per person, by state, in 2020 dollars. Source: Lakebridge Institute technical report, Map 28.

In total dollars, the largest states dominate. California ($85.9 billion), Texas ($60.8 billion), New York ($56.1 billion) and Florida ($49.9 billion) together account for nearly a third of the national cost.

This is not Medicare for All

Published estimates of Medicare for All run much higher, for a simple reason: they price a different policy. Medicare for All proposals would cover nearly all care, including drugs, dental, vision and often long-term care, with little or no cost to patients. Canada's provinces do not. Under their rules, most drug, dental and long-term care spending stays private, and about 29% of American health spending would remain outside government.

The design choice runs the other way, too. This estimate folds Medicare and Medicaid into the provincial system. Keeping both programs exactly as they are and adding provincial-style coverage for everyone else would cost more: about $1.11 trillion a year.

What could change the number

The $807 billion figure rests on assumptions, and changing them moves it more than anything else in the analysis:

- **Smaller administrative savings.** If hospitals and doctors cut only half as much paperwork, the cost rises to about $960 billion.
- **More use of care.** When care is cheaper at the point of use, people use more of it. Using the Congressional Budget Office's estimate of that effect, the cost rises to about $957 billion; at the high end of published estimates, about $1.06 trillion.
- **A different year.** 2020 was a pandemic year. Using 2019 data instead gives about $725 billion.

Taken one at a time, these checks put the cost between roughly $725 billion and $1.06 trillion a year. By contrast, the method used to pair states with provinces barely matters: every method tested lands between about $804 billion and $822 billion. Which province's rules are used matters more. Applying a single province's rules to every state gives anywhere from $753 billion (New Brunswick) to $912 billion (Newfoundland and Labrador).

The bottom line

Canada's provincial systems are a real, working model, not a hypothetical. Applied to American health spending, they would shift roughly $725 billion to $1.06 trillion a year of costs onto government budgets, while shrinking total spending through lower administrative costs. They would also leave a large share of drug, dental and long-term care where it is today: with patients, employers and private insurers.

The estimate leaves out several things that matter: how taxes would change to pay for it, how costs would be split between Washington and the states, a transition period, and how hospitals and doctors would respond if they were paid like their Canadian counterparts.

The full technical report, with the data, methods, every state's results and 34 maps, is available from Lakebridge Institute.

Source: Lakebridge Institute. *Provincial Rules, American States: The Government Cost of Canadian-Style Health Coverage in the United States*. Technical report. November 2026.