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Understanding the continental divide: how do we explain the different developments between the American and Canadian systems for managing health risks?

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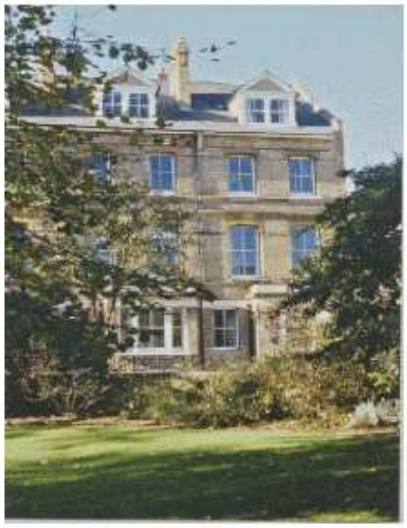

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Abstract:

The United States and Canada are two countries that share many similarities as those in Europe. However, while geographic proximity, similar economic structure and shared histories are what some argue led European countries to converge upon a common method of financing health care post-WWII, the same variables have not produced this between the United States and Canada. This is puzzling, because prior to 1966, when Canada completed the change to a single payer, universal health care system, both countries financed their health systems largely through the market and their costs for health care, as a percentage of GDP was identical.

Considering these circumstances and that numerous American interests groups and presidential administration's that have called for a single payer, tax based systems, whilst in Canada, the conservative governments of the 1980's tried to implement market based financing, it is interesting to examine why financing health care in the United States and Canada has continued to be so different.

1. Inconsistency in the Industrialised World

1.1: Introduction

The arrival of the industrial revolution ushered in a new era of thought on the status of citizenship, public needs and social risks in societies that Pierson (1998) identifies as shifting from agrarian, localised and traditional to industrialised, national and modern[1]. Often, these new ideas redefined the connection between the worker and what Esping-Andersen (1999) defines as the "welfare triad" – the relationship between the state, market and family in securing personal welfare. Since changes to this relationship were not localised, but affected a majority, it drew attention to social risks and the reality these must be acknowledged and managed in an industrialised society.

During the late 19th and early 20th century, managing health risks in industrialised societies gained importance, evidenced by Wilensky's (1975) argument that a healthy workforce was fundamental to maintaining productivity. During this period, several industrialised countries emphasized improving personal health by improving public conditions, thus recognising communal diseases and the benefit of better sanitation. However, most did not address management of comprehensive health risks until after WWII. [2]

Many identify the post WWII period as one of rapid initial reform that created more comprehensive and universal welfare state. Pierson (1998) argues that these commitments were based on the idea of shared citizenship, induced by a high degree of social solidarity created by a collective experience of austerity, mutual mortal danger and a fear of an uncertain future. This was known as the "post war consensus" in Europe, and "the post World War II capital labour accord" in the U.S.

However, even though "similar problems suggest similar solutions" (Blank and Burau, 2004, p. 211), systems for managing health risks, i.e. how citizens within a country pay for

[1] However describing specifically the U.S. in this passage, these qualities has external validity and could apply to other countries, specifically that of Canada, and many European counties.
[2] One deviation to note was the National Health Insurance Legislation of 1911 proposed by Lloyd George for Great Britain (Briggs, 2000).

healthcare — whether that be through the market (private insurance), a social insurance system or through direct state intervention (national insurance) — emerged in different ways within industrialised countries. This occurred because countries during the "post war consensus/ World War II capital labour accord" mediated the appropriate relationship between the state, market and family as a tool for managing health risks differently. [3] Furthermore, "country specific contexts in the form of historical legacies, cultural orientations or political systems were prominent and salient forces in shaping health policies that led to both embedded systems and differences." (*ibid*)

Despite what seem to suggest countless unique health systems in industrialised countries, "at the root, [systems for managing health risks] represent variants or combinations of a limited number of types" (Blank and Buaru, 2004, p. 23). Certainly real healthcare systems are more complex than their ideal types, but some argue that the similarities allow for the creation of typologies to "simplify what can be a complicated set of cross-cutting dimensions." (*ibid*)

Blank and Buaru (2004) identify a typology of a completely free market system with no government involvement at one extreme, and a direct tax system supported by government monopoly of provision and funding of all healthcare services at the other extreme (Blank and Buaru, 2004)[4]. Accordingly, countries fall into categories between these extremes based on similarities[5].

This typology[6], however, raises the question of why a country is located in a particular category. Some relate this to the relative importance of equity and access to health services. Here, a high level of importance often leads to an increased role for government in managing health risks, whilst a low level will frequently leave health risks to be managed in the market

[3] This variation is feasible because, either or all three of Esping-Andersen's "welfare triad" can achieve the management of social risks or "welfare". Therefore, when discussing health, state sponsored programs are not the only provider of "welfare".

[4] Within this typology, we can identify four main types of financing: direct tax/general revenue, social or state insurance, private insurance and direct payment by users (Blank and Buaru, 2004).

[5] The most common categories are the private insurance (or consumer sovereignty) model, best represented by the U.S., the social insurance model, best represented by Germany and Japan and the national health service model, best represented by the United Kingdom, Sweden, New Zealand and Canada (although these countries have moved away from a pure model to varying degrees) (Blank and Buaru, 2004).

[6] Within each type, however, there might be many variants. For instance, a direct tax might be levied by the central government, by sub-units such as states or provinces, or by a combination of governments (see Canada). A social insurance system might be based on a single national scheme or on multiple insurance schemes more or less rigidly regulated or controlled by the government (see Germany) (Blank and Buara, 2004).

(Blank and Buaru, 2004). Nevertheless, others argue that this is more complex and countries develop systems based on pressures from individual actors in society and circumstances such as constitutional arrangements, political structure and political traditions.

For example, Korpi's (1989) and Esping-Andersen's (1990) "power resource" theory, claims the development of the welfare state depends on the success of labour unions and social democratic parties in their struggle against the economic powers of capitalism. Alternatively, Skocpol and Amenta subscribe to the "historical institutionalism" theory, which argues, "both states and their policies are made and remade in a never-ending flow of politics" (1986, p. 151). Here, formal rules of behaviour are established by institutions, such as constitutional structure and political tradition. Others cite case specific variables, such as the role of third parties in producing the structural reform necessary for national health insurance or the presence of strong medical lobby groups as a reason for a largely private system.

1.1.1: Thesis Question

Because there is no commonly accepted explanation for different systems to manage health risks, further investigation is necessary to understand why two countries, such as the U.S. and Canada, reside in different categories within the typology. Specifically, a historical comparison of health policy development is useful. This will answer the thesis question: "what variables led the U.S. and Canada to develop different systems for managing health risks?"Furthermore, Lipset claims, "nations can be understood only in a comparative perspective" (1990, p. XIII).

Here, Canada manages health risks collectively through a national health insurance system and a direct-tax model of finance[7], whilst the U.S. manages risks through the market and a private insurance system (White, 1995) — even though prior to 1966 both systems relied mainly on the market and fringe benefits to manage risks (Mainoi, 1997).

1.1.2: Why the U.S. and Canada?

[7] In 1971, when all 10 provinces ratified the Canada Health Act, it brought national health insurance to Canada. At that time, health care costs consumed 7.4 percent of national income in Canada and 7.6 percent in the U.S (Lipset, 1993).

Not only is an analysis of the U.S. and Canada useful because, as Lipset claims, "the increasingly similar the units being compared are, the more possible it should be to isolate the factors responsible for differences between them" (1990, p. XIII), but also because they have geographic proximity, similar economic structures and shared histories. These variables are important, as we see that they often determine where countries appear in the typology described above.

For example, each Scandinavian country (Sweden, Denmark, Norway and Finland) has the direct-tax/general revenue type of financing. Furthermore, they have geographic proximity and all employ a form of "mixed economy" that is distinct from "mixed economies" in other parts of Europe. This economy is maintained through extensive redistribution of social risks and wealth through state intervention. Furthermore, if we consider Sweden, we see that Norway, Denmark and Finland are Sweden's largest import partners, providing 8.7%, 6.5% and 5.7% of total imports respectively. These countries are also Sweden's largest export partners, absorbing 8.9%, 7.8% and 5.8% of Sweden's exports, respectively (https://www.cia.gov).

Germany, the Netherlands and France, use a variation of the social insurance model for managing health risks. They have geographic proximity and like the Scandinavian countries, have a "mixed economy." However, unlike the Scandinavian "mixed economy" the German, Dutch and French versions place less emphasis on the state as a tool for redistributing social risk and wealth. Instead, the preferred methods for securing personal welfare are through the family and association with employment groups (Esping-Andersen, 1990). Furthermore, these economies have become increasingly linked through monetary integration brought on by the Maastricht agreement (OECD Economic Survey of Germany, 2006).

Returning to the U.S. and Canada, we see not only that they share the longest common border in the world (8,891 kilometres), but the U.S. government claims that "economically and technologically [the U.S. and Canada] have developed in parallel" (2007, https://www.cia.gov). In addition, "as an affluent, high-tech industrial society in the trillion-dollar class, Canada resembles the U.S. in its market-oriented economic system, pattern of production, and affluent living standards" (*ibid*.). Finally, "since World War II, the impressive growth of the manufacturing, mining, and service sectors has transformed both nations from a largely rural economy into one primarily industrial and urban" (*ibid*).

Regarding trade, "the 1989 US-Canada Free Trade Agreement (FTA) and the 1994 North American Free Trade Agreement (NAFTA, which includes Mexico) began a dramatic increase in trade and economic integration [between the U.S. and Canada]" (https://www.cia.gov). As a result, "Canada enjoys a substantial trade surplus with its principal trading partner, the U.S., which absorbs about 85% of Canadian exports[8], whilst Canada is the largest foreign supplier of energy, including oil, gas, uranium, and electric power to the U.S."[9] (*ibid*).

Both the U.S. and Canada are products of European exploration and immigration, with a large influx of immigrants seeking economic prosperity and asylum from religious persecution (Adams, 2003). And, unlike their colonial predecessors, neither country has an influential monarch or formal aristocratic legacy.[10] Instead, each country has prospered under the guidance of a large middle class (Adams, 2003)[11].

Furthermore, ideas of rugged individualism, democracy and 'individual' or 'citizen' freedoms such as religion, speech and press (Lipset, 1993) distinguish both countries. The U.S. and Canada also simultaneously experienced the industrial revolution and the Great Depression, in addition to fighting along side one another in the First and Second World Wars (Adams, 2003).

Further parallels between the U.S. and Canada exist in the form of similar laws, languages and lifestyles (Lipset, 1993). For example, both countries have written constitutions. The U.S. signed theirs in 1787, whilst the Canadians have the *Constitution Act of 1867* (formerly the *British North America Act, 1867*). Additionally, even though there is a parliamentary system in Canada and a presidential system in the U.S., each county's constitution is based on federalism (Adams, 2003).

Since the 1960's, however, the U.S. and Canada have developed markedly different ways of managing health risks[12] even though geographic proximity, economic structure and shared

[8] Additionally, 56.7% of Canada's imports come from the U.S. (https://www.cia.gov).
[9] As of June 29th, 2007, 1 Canadian dollar was worth $0.9385 U.S. Dollar.
[10] Even though Queen Elizabeth II of Great Britain is the official head of state in Canada.
[11] There are also commonalities in leisure activity and sport (canada.ca), whilst American broadcasts makes up a significant portion of television watched in Canada (Maioni, 1997).
[12] This distinction is based on the dominant tool of financing healthcare, because in Canada, the various levels of government pay for about 70% of Canadians' healthcare costs and various, however marginal, market tools finance the rest (White, 1995). In addition, the U.S. has a Medicare and Medicaid system that provides healthcare for the elderly, poor and, in

histories would suggest otherwise.

1.2: Methodology

In the following sections, I describe the differences between the American and Canadian methods of managing health risks, followed by an analysis of the policies that led to these differences after WWII[13]. This will identify the variables that most influenced policy and explain why the American and Canadian systems for managing health risks developed differently.

For the analysis I use current and historical information on healthcare systems and periods of important health reforms in both the U.S. and Canada. In addition, I consider the political structures and constitutional arrangements, "American exceptionalism" and potential links between Canada and traditional European values.

This comparative study corresponds to Bennett and Walker's (1998) view of general comparative analysis as a potentially unifying tool aimed at understanding the aspirations and intentions of the institutions and actors involved, either actively or passively. This analysis also supplements the debates between Korpi (1989) and Esping-Andersen (1990), Skocpol and Amenta (1986), and amongst the many others who have tried to explain differences in welfare state development generally and specifically, the different development of systems for managing health risks in the U.S. and Canada.

2. The United States

2.1: The American Health System

The World Health Organisation places the total healthcare spending in the U.S. at 15.2% of GDP (WHO, 2006). The OECD maintains that "the U.S. has the highest share of GDP in the OECD, more than six percentage points higher than the average of 8.6%" (2005, p. 1). In comparison, "Switzerland and Germany allocated 11% and 11.5% of their GDP to health,

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many cases, children who cannot receive healthcare through the market.

[13] As mentioned, this period is significant because of widespread health reforms in industrialised countries.

respectively, and Canada and France about 10%" (*ibid*). Also noteworthy is that the U.S. ranks far ahead of other OECD countries in terms of total health spending per capita at $5,635 USD – more than twice the OECD average in 2003 of $2,307 USD (OECD, 2005).

The statistics above depict the U.S. as an outlier in healthcare spending, however, this is not abnormal, as further comparative analysis suggests that the U.S. system for managing health risks runs counter to many OECD trends. In particular, the OECD asserts that "the public sector is the main source of health funding in all OECD countries, except for the U.S., Mexico and Korea" (2005, p. 1). The U.S. government's revenue spending accounts for only 44% of total healthcare financing, whilst the average in OECD countries is 72% (OECD, 2005).

According to the U.S. government (2004), around 57.1% of citizens have private health insurance, which they either secure through their employer or purchase individually. Government health insurance programs cover an additional 27.2 %[14] of the population (79.1 million people). This leaves the percentage of people who are uninsured at 15.7% (46.6 million people) (US Census, 2004).

Of these individuals with insurance – most of which is financed either by private or government sources – roughly 67% have insurance in the category of "managed care" (2007AIS Health Market Data Report)[15]. There are two categories of "Managed care": privately secured[16] and government financed, including the Medicare (not to be confused with the Canadian NHS system) and Medicaid programs. However, these government programs exist only to provide a safety net for the most vulnerable citizens who fall victim to market inefficiencies, namely, the elderly and the poor.

In essence, the U.S. manages health risks through a mix of private sources and government safety nets, whereby private financing is preferred. Considering that the OECD identifies the U.S. as one of the only OECD countries that do not manage the majority of its health risks through public sources, we must ask why. What has led to the development of this system?

2.2: History of American Health Policy and Reform

[14] 12.9 % of this (37.5 million people), is made up of Medicaid recipients (US Census, 2004).
[15] This number includes enrolment in HMOs, PPOs, POS, Medicare, Medicaid and FFS managed medical plans (AIS Health Market Data, 2007)
[16] Including employer financed.

There are many explanations for America's unique status as an outlier in financing healthcare. One of the most common theoretical explanations is, as Quadagno states, "the lack of national health insurance in the [U.S.] is the prime example of a larger historic issue captured by the phrase 'American exceptionalism'" (2004, p. 26). Thus, different cultural values explain the difference between the U.S. and other OECD countries.

Lipset (1996) argues that central to the exceptionalist idea is a set of immutable American values including liberty, equalitarianism[17], individualism, anti-statism and laissez-faire, which, together with Puritanical morals, have made the U.S. a uniquely successful democratic and capitalist society.

Regarding healthcare, Marmor (1998) claims that in the U. S traditional concerns about access to medical care and the distribution of its costs are subordinate to concerns about controlling total costs of care. Consequently, access relies on individual ability to pay, thus creating a system of managing health risks that values personal responsibility. Many in the U.S. question whether healthcare is a "right" or rather a consumer product akin to a household appliance.

Some argue that these values are rooted in an overall distrust of government (See Skocpol, 1992), stemming from America's Whig political tradition (Lipset, 1993). Moreover, Lipset suggests, "the American constitution and Bill of Rights were established deliberately to constrain governmental power, to make the executive ineffective, and subject to controls from the congress and house" (1993, p. 333). Thus, as Marmor *et al.,* argue, "because the state is equated with government, and liberty with limited government, it is easy to regard the welfare state as a threat to liberty" (1990, p. 5). These issues, coupled with the enduring public ambivalence toward government, are what Jacobs identifies as "the underlying source of America's impasse over healthcare reform" (1993, p. 630)[18].

[17] Defined as equality of opportunity, not reward.

[18] Marmor (1998) amends this values theory by identifying the importance of dominant ideological forces in shaping the values that influence policy outcomes. He suggests that values may not be entrenched, but rather fluid. He attributes a rise in classical liberal ideology in the 1970s and 1980s to a move towards pro-market values that emphasised competition in healthcare. Marmor claims that there is a "general ascendance in academic writing of a particular micro-economic approach to analysing public policy, or more accurately, the ascendance of economic analysis that had a deregulatory mission" (1998, p. 55). Milton Friedman's Chicago School of Economics and the writings of Alain Enthoven are examples of this.

A second common explanation for the lack of national health insurance is that the American political system hinders major reform. Oberlander says the system is "[confusing] the difference between feasibility with desirability and thus not separating out what is desirable from what is doable" (2003, p. 392). He claims that "the structure of U.S. political institutions create a number of barriers – such as constitutional arrangements, weak political parties and a complicated legislative process – that prevent the passage of any legislation as controversial, ideologically divisive, and threatening to powerful interests as national health insurance" (Oberlander, 2003, p. 394). Thus, "political consensus on a single piece of health reform legislation is a difficult task in the U.S." (*ibid*).

These theories, as mentioned, do not represent all of the explanations for the development of the American method of managing risks but they are the most common. A problem arises, however, where Skocpol notes "many scholars who talk about national values are vague about the processes through which they influence policymaking" (1992, p. 16). Furthermore, Oberlander's argument ignores major reforms such as social security, Medicare and Medicaid — suggesting that reform is feasible under the right conditions (2003).

We may find that the theories above are only part of the explanation and that they combined with external actors to influence the development of the American system for managing health risks. Thus, analysis of past reform proposals and resulting policies is essential. Specifically, post WWII proposals such as the Truman NHI campaign, the Medicare/Medicaid bills and the proposed Clinton health reforms, all of which paralleled Canada's establishment of a national health insurance.

In 1912 and in the 1930s we see proposals to manage health risks through sources other than the market.[19] The 1930s proposals led to numerous incremental reforms. However, it was not until the "post World War II capital labour accord" that an American president made a serious effort to enact national health insurance.

In 1947 President Truman proposed a direct tax "National Health Insurance" (NHI) in response to pressures of rising healthcare costs and the need to cover the returning troops from Europe (Goldfield, 1993). Unfortunately, attacks came from "physicians, hospitals, pharmaceutical firms, industrial manufactures, the growing private health insurance industry, and a labour movement that did not support compulsory insurance because it argued that bargaining for health benefits would gain new members for the union movement"

[19] The Committee on Costs of Medical Care (Kirkman-Liff, 2000).

(Kirkman-Liff, 2000, p. 23). This opposition kept the bill out of committee, however, President Truman was undeterred, and "following his victory in the 1948 election, he introduced a bill virtually identical to that submitted in 1947" (Goldfield, 1993, p. 3).

With this second bill, the president encountered additional problems including "the anti-Communist hysteria, which reached its height under McCarthyism, and spilled over into the debate over Truman's NHI proposal" (Goldfield, 1993, p. 3). Making matters worse, the American Medical Association (AMA) played into these fears and mounted a massive lobbying campaign in Congress against the bill[20] as well as one of the largest public relations efforts in U.S. history (Goldfield, 1993, Kirkman-Liff, 2004).

Goldfield notes that the resulting fears "played right into the hands of the Republican majority in Congress" (1993, p. 4) which did not support an increased government role in managing health risks. Regardless, a desperate Truman sent another special message to Congress requesting the passage of a comprehensive NHI proposal, but the bill never made it out of the Senate or the House committees (Goldfield, 1993, p. 4).

Many have pointed to the AMA and their power as the ultimate culprit in the defeat of Truman's NHI. Goldfield asserts that "during the war, there was a rise in favour of structural health reforms by doctors treating solders that indicated a preference for a form of practice other than the traditional solo, fee-for-service basis" (1993, p. 4). Despite physicians' preferences however, the AMA actively discouraged them from participating in medical practice that in their eyes defeated the medical profession's best interests (Goldfield, 1993). Nevertheless, as Goldfield argues, "the reality is, like the incremental reforms in the 1930s, the American middle class also realized that it had an alternative, such as state-based Blue Cross and Blue Shield programs" (1993, p. 4).[21] All in all we can attribute the downfall of Truman's proposals to a combination of "the unbending opposition of the medical profession, labour unions' preferences for collective bargaining[22], a Republican majority in

[20] The AMA argued: "If the Wagner-Murray-Dingell proposals were enacted into law, they would introduce a compulsory tax to pay for a compulsory service-medical, dental, and nursing care – directly affecting the most vital and most sacred function of each individual citizen of the U.S. If such a basis of centralized control is established, freedom can never be regained, our freedom of enterprise institutions would be destroyed and concepts which have made America what it is, and we as a people what we are, would be forfeited" (Goldfield, 1993, p. 3).

[21] These voluntary health insurance plans "exploded in popularity after the end of the Second World War. By 1946, more than 20 million Americans had enrolled in statewide Blue Cross plans for hospital care" (Goldfield, 1993, p. 4).

[22] As a result, between 1946 and 1957 the number of workers covered by collectively bargained health insurance agreements rose from one million to twelve million, plus an additional twenty

Congress that was ideologically opposed and the American public's relative contentment with voluntary health insurance" (Goldfield, 1993, p. 5).

Nevertheless, when the Democrats regained control of the White House in 1960, Congress and the Presidency found themselves in the same position they were after WWII — in a debate over ways to combat rising healthcare costs. However, in contrast to the past, the 1960s saw national health insurance take a back seat to focus on vulnerable groups such as the elderly and poor, resulting in the creation of the Medicare and Medicaid programs. Kirkman-Liff identifies these reforms as incremental because they "preserved the rest of healthcare" (2000, p.25).

Quadagno (2004) argues that Medicare and Medicaid passed Congress in part because of support from unions who were dissatisfied with collectively bargained health insurance plans that generally excluded retirees. Quadagno maintains that "whenever a union attempted to include health insurance for retirees in a collective bargaining agreement, it drove up costs and resulted in concessions on wages" (2004, p. 32). Thus "organized labour had an incentive to support a public health insurance program for the aged" (*ibid*). Because of this union support "AMA efforts were neutralized, despite employing every propaganda tactic it had learned from the bitter battles of the Truman era" (Marmor 2000, p. 38).

Another reason for the passing of Medicare and Medicaid was that "it became apparent that insuring the aged would never be profitable, thus insurance companies stopped actively opposing Medicare" (Quadagno, 2004 p. 32) and as McAdam and Scott point out, "1964 saw the election of a more liberal Congress" (2002, p. 25). With Medicare covering the elderly, Medicaid covering the poor and the working class managing health risks through employee provided, tax-subsidised insurance, the idea was that America would have universal health coverage (Kirkman-Liff, 2000). However, Democrats soon realized that this was not the case (Kirkman-Liff, 2000).

Fortunately, help for the Democrats came when Walter Reuther, president of the United Auto Workers (UAW) made a fiery speech before the American Public Health Association in 1968 where he proclaimed, "the only way to remove economic barriers to care and contain healthcare costs was through a single federal program" (Quadagno, 2004, p. 33). To rationalise this apparent about-face, Reuther reasoned that rising health insurance premiums

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million dependents
(Klein 2003)

were assuming a larger share of the total wage package with each new contract.

Thus, in an attempt to appease union voters and address rising healthcare costs, Democrats and Republicans drafted competing NHI plans. Democratic Senator Ted Kennedy proposed a Medicare style plan (CNHI), whilst Republican President Nixon saw the introduction of HMOs as an incremental reform that could control costs without government control of the health system. Accordingly, he proposed the National Health Insurance Partnership Act (Quadagno, 2004).

With both parties acknowledging the need for structural change, many concluded that, "given the right political conditions and strategic decisions, things could turn out differently than past attempts" (Oberlander, 2003, p. 396). Indeed, this almost happened, as bi-partisanship brought the U.S. "tantalizingly close to passing universal health insurance" (Oberlander, 2003, p. 396). However, because of the Vietnam War, the OPEC oil crisis and the Watergate scandal, America was reminded of its mistrust of government (Marmor, 1998). The bi-partisan compromise unravelled and a weakened version of Nixon's HMO proposal was passed

Nixon, Kennedy and later Ford tried to resurrect the idea of universal coverage, however eroding union support and intensive lobbying on behalf of the AMA saw support for reform wane. Furthermore, Neo-conservative ideology was on the rise, culminating in the election of Ronald Regan in 1980, whom Krikman-Liff argue did nothing but keep the U.S. as an outlier in financing healthcare and coverage (2000).

The 1980s also saw a continued growth of HMOs, "the movement of large corporations to self-insurance" (Kirkman-Liff, 2000, p. 28) and one unsuccessful proposal to expand Medicare to include the cost of "catastrophic illness[23]." Additionally, market friendly incremental reforms weakened the existing government programs by narrowing eligibility for Medicaid and restructuring Medicare (Kirkman-Liff, 2000). Thus, in the 1980s, ideology denied hope of structural reform; resulting in a series of alternate incremental reforms.

Kirkman-Liff claims that "during the 1992 election there mistakenly appeared to be

[23] This proposal received the support from the majority of the actors who had opposed structural reform before, excluding the Pharmaceutical Manufacturer's Association. However, because of claims of inadequacy by the elderly and intense lobbying by the PMA, "on October 4, 1989 the House voted to repeal the program it had approved just 16 months earlier" (Quadagno, 2004, p. 36).

substantial support for structural reform of the system" (2000, p. 35)[24], which encouraged a newly elected President Bill Clinton to propose a German-style compulsory workplace insurance, with finances and care integrated into managed care plans that would compete for members. Initially, this plan saw a 71% approval rating (Blendon et al,. 1995) and the AFL-CIO[25] promised they would be the "storm troopers" for national health insurance (Quadagno, 2004). However, a crisis in Somalia and a battle over NAFTA occupied the president's attention, prolonging the planning period. Just five months after Clinton proposed his plan to Congress, support had dropped to 43% as many began to lose faith in the government's ability to complete a sound structural reform (Blendon et al,. 1995). Skocpol (1996) suggests that contributing to this drop were stakeholder groups that now had time to attack, such as the Health Insurance Association of America, which spent more than $15 million in a multifaceted advertising campaign that zeroed in on fears about how existing insurance coverage would be affected.

Skocpol (1996) argues that the complexity of the plan turned away the moderates in the electorate who had some interest in structural reform and could have supported a simple proposal. Businesses also rallied against the plan, as many believed they had already solved cost issues through managed care and felt the Clinton proposal would use some of these savings to subsidise those previously uninsured (Kirkman-Liff, 2000). The elderly feared existing health services provided by Medicare would decrease in quality with a universal system, fears that some argue were stirred up by a newly elected Republican majority in congress that resurrected the negative spectre of "socialised medicine" used against the Truman proposals (Blendon et al, .1995).

Finally, Quadagno (2004) argues that Clinton lost support of labour by promoting NAFTA, seen by the unions as an effort to shift production to low-wage countries with lax environmental and labour standards. Thus, Kirkman-Liff (2000) claims that what ultimately killed the Clinton reforms was both the past history of incremental reforms that created a powerful network of groups interested in preserving the current system, and a decline in public faith in the government's ability to implement comprehensive structural reform.[26]

Despite additional incremental reforms since the failed Clinton plan, these periods represent the major debates and provide a good assessment of the themes that have kept the U.S.

[24] In 1993, there were thirty-seven million Americans uninsured (Clinton, 2004)
[25] American Federation of Labour – Congress of Industrial Organisations
[26] Others identify unfavourable media coverage and improving economic conditions as major factors for the failure of the Clinton reforms.

managing health risks through the market. Lobbying, the power of stakeholders to influence the public, weak union support for structural reforms, a legislative structure that discourages major reform, partisanship, and the negative subtext "socialised medicine" contributed to this outcome. Thus, combining the theoretical explanations with specific actors help explain the present American situation and suggest that the United States and Canada went separate ways because different actors and political pressures were involved.

3. Canada

3.1: The Canadian Health Care System

The World Health Organisation identifies Canada's total healthcare spending at 9.8% of GDP (WHO, 2007). At this percentage, Canada ranks above the OECD average of 8.6% GDP, placing it in 7th place for total percentage of health spending of GDP (WHO, 2007, OECD, 2005). Additionally, Canada ranks 8th out of OECD countries regarding per capita spending at $3,173 USD (OECD, 2005).

However, unlike the U.S., Canada is similar to other OECD countries in that it has a single payer, largely publicly funded national health insurance system (NHI) for managing health risks. This system is called Medicare, which is defined as "a national health insurance program, designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis" (2007, http://www.hc-sc.gc.ca). Instead of having a single national plan, however, these services are provided by 13 interlocking provincial and territorial health insurance plans, all of which have similar features and basic standards of coverage.

"Roles and responsibilities for the system are shared between the federal and provincial-territorial governments, whilst criteria and conditions are specified that must be satisfied by the provincial and territorial healthcare insurance plans in order for them to qualify for their full share of the federal cash contribution, available under the Canada

Health Transfer program" (Health Canada, 2007).[27] Deber and Barabek (1998, p. 75) claim that this uses "extensive 'fiscal federalism' as a policy vehicle whereby resources are transferred from richer provinces to the rest of the country". The rational behind this transfer is the fear that left alone, "the poorer provinces would clearly have less ability to sustain such healthcare programs" (*ibid*), thus contradicting what Iglehart (2000) identifies as Canada's great commitment to communal obligations.

Accordingly, Naylor (1999, p. 12) claims, "the system is characterized by highly monopsonistic public financing coupled with private delivery mechanisms, [whilst] the vast majority of physicians remain in fee-for-service private practice, even though tied tightly to negotiated fee schedules. Hospitals are typically structured as private, non-profit corporations funded primarily by annual global budgets which are determined through negotiations with the provincial ministries of health" (*ibid*).

Yet despite promoting universal coverage, general government expenditure on health as percentage of total expenditure only accounts for 69.8%[28], whilst private expenditure stands at 30.2% (WHO, 2007). Although 91% of hospital spending and 99% of physician spending — services defined as comprehensive under the Canada Health Act — come from public sources, the majority of spending on such categories as other health professionals (homeopathic), drugs, and nursing homes come from private sources (Deber and Barabek, 1998).

The latter categories are outside the "comprehensive" definition of the Canada Health Act and are what many call 'creeping de-insurance' or 'passive privatisation' (Deber and Barabek, 1998). However, despite Canada adopting similar market-based tools for managing health risks as other OECD countries[29], Deber and Barabek (1998, p. 73) claim "Canada to date has largely resisted market-based approaches for services other than at the margin" (1998, p. 73). Thus, with the U.S. relying so heavily on market tools for managing health risks, and considering Canada and the U.S. had very similar healthcare systems in the early 1960s,

[27]Naylor identifies these conditions as "universal coverage of all provincial residents on uniform terms and conditions, public nonprofit administration, portability of benefits among provinces, comprehensive coverage of all necessary services provided by medical practitioners and hospitals; and maintenance of reasonable access to insured services, un-precluded or unimpeded, either directly or indirectly, by charges or other means"[27] (1999, p. 11).
[28] Down from 74.1% in 1997 (Deber and Swan, 1997)
[29] Unlike other industrialized nations, Canada has essentially no parallel private system, because investor-owned carriers are barred from covering any services that are publicly insured. Canada has embraced private delivery of services by both nonprofits and investor-owned providers, but preserves public financing to contain costs and maintain equity (Naylor, 1999)

what has led Canada to develop such a different system since then?

3.2: History of Canadian Health Policy and Reform

Many argue that Canada's system for managing health risks mirrors those seen in Europe because of a shared set of values based around communal obligations (Naylor, 1999). Lipset notes that when Friedrich Engels visited Canada in 1888, he observed that "Canadians resembled Europeans" in the way that "the northern country was more class aware, law abiding, statist, collectively oriented, and particularlist than its southern counterpart" (Lipset, 1993, p. 332). Engels argued that "Canadians show more respect for the state than Americans" (*ibid*).

Lipset argues that a preservation of European values is not surprising because "Canada evolved out of the conditions of a counterrevolution [to the American Revolution] that preserved a monarchally legitimated society" (1993, p. 332). Much of the Canadian political structure is patterned after European systems that preceded it. These systems valued collective identity and a strong state more than the American system did. For example, the American constitution speaks of "life", "liberty" and the "pursuit" of happiness, thus emphasising individualism, whilst Canada's first constitution emphasised "peace", "order" and "good government".

The Canadian political tradition upholds these values by being "Tory and monarchical, thus approving of a strong state, with an executive that almost invariably has its way with parliament" (Lipset, 1993, p. 333). Therefore, Lipset argues, "this tradition has helped to legitimise the welfare state and foster a rise of a strong social democratic party with the help of Canadian unions, who have been more approving of socialist and labour party political agendas than the unions in the U.S." (1993, p. 333).

Many attribute the rise of leftist parties as a major reason for the development of the Canadian health system. Conservatives, however, have not been afraid to embrace a strong state either. Conservative Prime Minister Brian Mulroney referred to the welfare state as "Canada's secret trust" in his 1989 re-election campaign (Lipset, 1993, p. 334).

Nevertheless, these are only two theoretical explanations for the development of Canada's system of managing health risks. Whichever theoretical explanation one embraces, Peters identifies "compassion leading to collective responsibility" (1995, p. 4) at the underpinning. A Canadian Policy Research Networks (CPRN) study claims that "Canadians see healthcare as part of the foundation of the Canadian identity, a 'right' that all enjoy" (Peters, 1995, p. 15). Moreover, Canadians do not want to see a two-tiered system that could either disadvantage those who cannot afford to pay or would favour the affluent. Peters maintains "Canadians accept that trade-offs in healthcare are necessary, thus reaffirming the principle of universality"[30] (1995, p. 15).

However, this embrace of collective values seems to run counter to other social policies that lead many to place Canada into the same "liberal" welfare state typology category as the U.S. (see Esping-Andersen, 1990). If Canada is "liberal" it contradicts those who explain its differences from the U.S. as a product of shared European values, because Esping-Anderson (1990) would classify these European countries in either the "conservative" or "social democratic" categories. Additionally, in accordance with the "power resources" model of welfare state emergence, one can also assume a strong social democratic party would be more successful at promoting additional generous social programs (see Korpi, 1989; Andersen, 1985).

Like the U.S., we find that the theories above are only part of the explanation and that a study of the structural reforms which moved Canada away from a market centred system is needed to better understand the development of its system for managing health risks.

Maioni (1997, p. 414) maintains that "prior to 1940, the Canadian government spent little time addressing health reform". Deber and Barabek (1998) claim that the reason for this is that healthcare sat at the centre of constitutional uncertainty regarding the jurisdiction for its administration. Section 92 of the *Constitution Act, 1867* exclusively assigned the powers for "the establishment, maintenance and management of hospitals, asylums, charities and Eleemosynary[31] Institutions to provincial legislatures" (Government of Canada, 1982). Accordingly, provinces may have legislative authority over hospitals, yet the federal

[30] Also worth noting is that Lipset claims much of what Canadian intellectuals, "both scholars and creative artists write about their own country is presented in a comparative context, that is with reference to the U.S." (1990, p. xv). They frequently describe what Canada is about by stressing what it is not, the U.S.

[31] Eleemosynary institutions are charity houses, usually set up to provide room and board, food and services to the poor. Most are run by either religious orders or the state (Merriam-Webster, 2008).

government often claimed this was not across-the-board 'authority' over healthcare. Maioni claims "this uncertainty was somewhat attenuated by the release of the *Royal Commission of Dominion-Provincial Relations* in 1940, which advocated that the federal government had a role in financing health insurance programs, even though care was under provincial jurisdiction" (1997, p. 414).

Despite the booming wartime economy and the rhetoric of post-war security enforcing the idea that the federal government had the responsibility to ensure the social well-being of citizens, Maioni (1997, p. 414) maintains "the liberal cabinet [nonetheless] remained divided on the government's role in social welfare". However, during the 1940's "a rise of a social democratic third party helped rouse the government's interest in health reform" (*ibid*).

In 1942, Maioni (1997) claims that the CCF party [32] quickly gathered momentum in both federal and provincial politics on the heels of *The Marsh Report*[33] and the rising interest in national health insurance, as evidenced by a nation-wide 75% approval rating. The Liberal government began to fear that opposing the CCF's health reform platform would threaten their electoral support in the working class, because "organised labour supported a contributory health program that would ensure similar standards of care for workers across the country" (Maioni, 1997, p. 415). Thus, in 1943, Prime Minister King appointed a special committee to address the issue of health.

In response, the Canadian Medical Association came out against the idea of national health insurance and instead supported voluntary insurance plans, whilst proclaiming that public funds should only cover low wage or indigent patients (Stevenson et al., 1988). However, in contrast to the success of the AMA in blocking legislation in the U.S., the unions counteracted the CMA and by 1944 "the CCF had won a majority of the popular vote in British Columbia, became the official opposition in Ontario, and routed the Liberals and took office in Saskatchewan" (Stevenson et al., 1988, p. 415).

In the meantime, though, King's committee raised doubts about the financial and constitutional feasibility of national health insurance. Thus, due to partisan opposition and a lack of agreement between the federal government and the provinces on the fiscal

[32] Co-Operative Commonwealth Federation: founded in 1932 as a federation of independent labour representatives.
[33] Canada's version of Britain's Beveridge plan (Maioni, 1997).

arrangements necessary for a national health insurance, reform was stalled[34] (Maioni, 1997).

Even so, this did not stop the CCF from pursing their objectives at the provincial level. The CCF controlled Saskatchewan legislature implemented a hospital insurance plan in 1946 with the Saskatchewan Hospitalisation Act[35], which guaranteed free hospital care for much of the population (Houston, 2003). In 1948, the Alberta Medical Association supported a prepaid health insurance that, combined with the CCF and labour backing, led to the government-created "Medical Services Incorporated", providing more than 90% of Albertans with prepaid medical care (CMA, 2007). Finally, because of the popularity of the Saskatchewan plan, British Columbia created a similar plan in 1948.

In 1955, the Ontario Conservative legislative majority reacted to pressure from the CCF and its labour allies to develop hospital insurance like Saskatchewan, Alberta and British Columbia. Yet, unlike their predecessors, the Conservatives in Ontario "insisted on federal cost-sharing guarantees beforehand[36]" (Maioni, 1997, p. 417) even though King's successor, Louis St. Laurent, favoured a voluntary health insurance plan. In the end, the popularity of the Saskatchewan plan and an alliance between CCF and the Canadian labour movement, creating the New Democratic Party (NDP), trumped St. Laurent and heavy lobbying from the CMA to pressure the Liberals into pursuing a national hospital insurance (Maioni, 1997). Accordingly, "Canada laid the cornerstone for a national system in 1957 with federal legislation for coverage of hospital care and related diagnostic services (Hospital Insurance and Diagnostic Service Act), where, in accordance with the Canadian constitution, the federal government provided cash transfers to any province that agreed to operate a universal hospitalization[37] scheme with first-dollar coverage" (Iglehart 2000, p. 2009).

Nevertheless, this did not appease the NDP in their quest for comprehensive health care and in 1961, with money saved through the new federal transfer system; Saskatchewan's Premier Tommy Douglas sought to extend hospital insurance to ambulatory care. Douglas proposed a program that combined private fee-for-service delivery with public administration and

[34] This was coupled with anti-social rhetoric of the Conservative opposition to the Liberals.
[35] Houston (2003) claims that Saskatchewan was first, due to strong communal values that had already been seen in the "wheat pool" of health risks some years earlier.
[36] There is little doubt that these demands were influenced by the difficulties that other provinces had in financing hospital insurance without federal support (Maioni, 1997).
[37] This set the foundation for the five requirements later outlined in the 1984 Canada Health Act: university, accessibility, comprehensiveness, portability and public administration (Deber and Barabek, 1998).

finance, prompting Conservative accusations of "socialised medicine" and vehement opposition by Saskatchewan's medical profession. This even led to an unsuccessful medical strike in July of 1962 that eventually caused a loss of prestige for the medical lobby (Stevenson et al., 1988). However, like hospital insurance, this plan was equally popular and spurred a new round of health reform debates with support for complete public control of health services coming from farmers and labour, whilst the medical lobby, business interests and private insurance companies advocated voluntary insurance programs with means tested safety nets (Houston, 2003, Maioni, 1997).

By 1964, the Liberals were a minority party in the Canadian Parliament, giving the NDP[38] the balance of power in the House of Commons and the ability to pressure the Liberal government to formulate legislation that would satisfy them (Maioni, 1997). In response, Prime Minister Lester Pearson established the *Royal Commission on Health Services*, which, in accord with NDP reform goals, recommended that nationwide public health insurance, similar to the Saskatchewan plan, would benefit Canada by extending insurance to physician services outside of hospitals. In 1966 Pearson introduced the Medical Care Act as a compromise that acknowledged the right of government to operate and introduce a public health insurance program, but which also allowed physicians to practice outside of the programs and to "extra-bill" patients above government insurance rates (Stevenson, et al., 1988). This act extended the HIDS Act cost sharing to allow each province to establish a universal health care plan, ultimately leading to the Medicare system.

The result, Naylor notes, was "medical insurance being added in 1968, again with conditional transfer to provinces that relied on precedent by the federal-provincial hospital insurance arrangements and the Saskatchewan medical arrangements" (1999, p. 11). During the legislating process the bill received little partisan opposition, because the popularity of national insurance had became "politically potent and no party could afford to be seen as opposed"

[38] This new party demanded action on public medical insurance and lobbied the public for their support by exploiting the Liberal failure at bringing this about and the progress in Saskatchewan (Maioni, 1997).

(Maioni, 1997, p. 417). Additionally, Stevenson *et al*. (1998, p. 68) maintain that "although the CMA made its objections clear, it was somewhat assuaged by the retention of fee-for-service delivery[39]" (1998, p. 68). Thus, "by 1971, all ten provinces had adopted hospital and medical insurance programs that met the basic requirements established by Parliament to qualify for federal funds covering 50 percent of the programs' costs" (Iglehart, 2000, p. 2010).

Deber and Barabek claim that "reliance upon fiscal federalism worked [here], as long as the federal government was willing to transfer enough money to the provinces" (1998, p. 77) and "providers were content to operate within government insurance plans as long as they received sufficient resources from the provinces" (Deber and Barabek, 1998, p. 79). However, Naylor points out that "by the late 1970s inflationary pressures led provincial governments to take an increasingly hard line in collective bargaining with organized medicine" (1999, p. 12). Furthermore, "with price inflation, caps on fee increases, and rapid growth in physician supply for some urban markets, real medical take-home incomes began to decline and a sizeable minority of medical practitioners responded by levying extra-billing to patients above and beyond the negotiated fee schedule" (*ibid*). This led to widespread concern that Medicare's accessibility principles were being eroded (Stevenson *et al.,* 1988).

The response by the federal government was "the 1984 Canada Health Act, which consolidated previous health insurance legislation" (Naylor, 1999, p. 11). "This legislation reduced federal transfers to provinces that allowed hospitals to levy user fees or doctors to charge patients more than negotiated tariffs" (*ibid*). Within two years all the provinces had passed legislation to abolish extra-billing, despite the vigorous protests of organized medicine claiming that elimination of extra billing was an assault on their autonomy. This underscored the provinces' commitment to a publicly financed system that granted equal standing to everyone regardless of income (Iglehart, 2000).

The 1980's and early 1990's saw slower economic growth and deficit spending. At the same time, the 1993 election saw a collapse of two of Canada's three national parties, "leaving the Liberals without a coherent opposition" (Deber and Barabek, 1998, p. 80) and relatively free

[39] Physician compliance was further assured by windfall professional income gains realised in the early years of Medicare's operation. This resulted from the fact that physicians were not virtually guaranteed payment for every service provided (Stevenson *et al.,* 1988).

to reduce transfers to the provinces[40].

Weak opposition to the Liberals, coupled with growing pro-market ideology[41] has led Canada towards to some incremental reforms such as contracting out non essential services as defined by the Canada Health Act, rationing, more flexible regionalism, and market instruments in sectors not included in the definition 'comprehensiveness', and thus not subject to federal policy control (Deber and Barabek, 1998). Still, neo-conservatives have discovered that there is little public support for an overall privatising of health care financing (Deber and Barabek, 1998). Thus, reforms have stayed at the margin and private insurance for 'covered' services has remained taboo in most provinces[42].

Accordingly, the reform proposals (or lack thereof) of the 1980s and 1990s seem subject to the same pressures that led to the development of the Canadian system for managing health risks in the first place. These pressures were strong public and union support for a universal system, the ability for third parties to raise awareness of issues, threats to the balance of power in Parliament, forced compromises, a weak CMA/medical lobby, parties less stable and partisan than those in the U.S. and a pre-eminence of policy study. Therefore, when compared to the American trajectory, we see that different actors and pressures are a driving force behind the dissimilar developments for managing health risks in the U.S. and Canada.

4. Discussion and Conclusion:

4.1: Discussion

The previous two chapters have described the American and Canadian systems for managing

[40] For example, in 1980 the federal contribution amounted to 44.6% of the $14.1 billion collectively spent by provincial plans. A decade later, the plans collectively spent $39.2 billion, with 36.7% coming from federal contribution and by 1997 the plans collectively spent $54 billion with federal contributions sinking to 23% (Deber and Barabek, 1998).

[41] The main pressure came from the western-based Reform and Progressive Conservative parties that argued for smaller government and tax cuts and spoke in favour of the growth of private medicine and the withdrawal of federal attempts to impose standards in areas of provincial jurisdiction. Additionally, "consumerism has led people to expect services beyond the level that can easily be justified as a compelling national priority, particularly if such expenditures are at the expense of other policy areas" (Deber and Barabek, 1998, p. 87).

[42] In June 2005, the Canadian Supreme Court ruled in Chaoulli vs. Quebec that Quebec's prohibition of private health for medically necessary services was unconstitutional, potentially opening up the door to much more private sector reform in healthcare. However, to date this has not spread outside Quebec.

health risks and provided a historical examination of policy development and reform in both countries. Through this, we were able to identify circumstances and individual actors that influenced different policy outcomes in the U.S and Canada. Furthermore, variations in the responses to pressures from key actors also help explain why the U.S. and Canada have developed different systems for managing health risks.

A key factor in both countries is unique national values. Whether it is 'American Exceptionalism' or the preservation of European values in Canada, each helps explain the underlying rational for the American and Canadian health systems. Two values identified in the analysis that had a noticeable impact on policy were each country's attitude toward the appropriate role of government and their emphasis on equality.

In the U.S., Goldfield recognizes "the American concept of the inherent rights and sanctity of the individual" (1993, p.4) as an important measuring stick for government involvement. If Americans perceive a threat to these rights, support for proposed legislation will die. For example, Americans responding to such threats posed by the Truman NHI proposals chose to support voluntary insurance over an increased role of government despite rising healthcare costs and the "post World War II capital labour accord" (Kirkman-Liff, 2000). The Whig-inspired American political tradition defined as "liberty is equated with limited government" (Marmor, 1995) views government intervention as appropriate only when there are no viable alternatives[43]. Concerning the Truman NHI proposals, Kirkman-Liff asserts that "Americans found an alternative in voluntary insurance programs like Blue Cross and Blue Shield" (2000, p. 23).

Alternatively Lipset argues "Canadians have more respect for the state than Americans do" (1993, p. 332). Canada maintains the Tory political tradition, which unlike that of the Whig, approves of a strong state and places greater value in communal obligations (Iglehart, 2000). For example, the *Constitution Act, 1867* acknowledged a strong state by assigning the responsibility for managing health risks to provincial governments. Some argue, too, that the 75% approval rating for national health insurance during the King reforms was due to the Tory tradition (Maioni, 1997), which established early on that an increased role of government was a viable option for reform.

[43] The wartime price and wage freezes brought compromise between autoworkers and the government for non-taxable health benefits from the employer (Kirkman-Liff, 2000). As a result, a large portion of the working class had health coverage and thus opponents of the Truman proposals argued that these incremental reforms adequately covered the middle-class, whilst the poor received sufficient healthcare through public hospitals. Thus there was no need for government intervention.

The equality issue is reflected in the two countries' bills of rights. "The American Bill of Rights fosters concern for personal rights and litigiousness, whilst the Canadian Charter of Rights and Freedoms stresses group rights" (Lipset, 1993, p. 332). For Americans personal rights mean personal responsibility for securing risks, leading to "the broad acceptance among the insured and non-poor that inequality for the poor and uninsured is legitimate" (Kirkman-Liff, 2000, p. 32). Moreover, "health coverage [in America] has never been seen as a right or societal obligation, but simply as a voluntary purchase by the consumer" (Kirkman-Liff 2000, p. 31).

In Canada, however, group rights are interpreted as societal obligations to ensure relative equality and universalism in certain cases. For instance, Naylor identifies "universal coverage of all provincial residents on uniform terms and conditions" (1999, p. 11) as prerequisite for provinces to receive federal transfers under the Canada Health Act. Derber and Baranek maintain that "threats to Medicare are a perennial election issue, but the public strongly opposes a two-tiered system" (1998, p. 85), because "it could disadvantage Canadians who cannot afford to pay" (Peters, 1995, p. 15).

In the first chapter, it was presumed that the U.S. and Canada shared many values; these values are not all encompassing, however. As the analysis shows, differing values partly determined why Canada adopted a single-payer, universal coverage system, whilst the U.S. did not. Superficial comparisons of the two countries are misleading, since subtleties in their political traditions and constitutions offset similarities in economic structure, federal systems and language. When advocates of a single payer system for the U.S. point to Canada and suggest "if it happened there, it can happen in the U.S.", they are ignoring that Canada values collectivism and group rights, whilst the U.S. emphasises individualism and personal responsibility.

However, the analysis also reveals that Canada's choice of adopting a universal, single payer system whilst the U.S. extends beyond values to differences in political structure. Canada was able to enact structural reform whereas the U.S. was not because, as Hacker (1998) argues, the U.S. political system diffuses authority, thereby allowing only incremental reforms.

In the U.S., national government divides power among three branches, each with its own independent authority, responsibilities, and bases of support. Within the legislature, power is divided further between the House of Representatives and the Senate as well as amongst numerous committees and subcommittees where legislative measures can be delayed or

blocked (Quadagno, 2004). Furthermore the elections of the executive and legislative branches are separate[44], a source of potential stalemate if different parties control the presidency and Congress (Brooks, 2000).[45] Maioni (1997, p. 412) explains that this decentralization impedes policy innovation by increasing the number of "veto" points where opponents can block policy reform and by allowing special interests greater access.

Canada has a parliamentary government where the executive branch is dependent on the direct or indirect support of the parliament, often expressed through a vote of confidence, thereby eliminating a clear separation of powers between the two institutions (Brooks, 2000). Some believe that this reduces the veto points and makes it easier for Canada to produce structural reform.

The inability to enact structural health reform in the American system was critical, as the resulting incremental reforms are what Kirkman-Liff argues, "partially killed the Clinton proposals by creating a powerful network of groups that were interested in preserving the current system" (2000, p. 36). Still, structural reform is not impossible in the U.S., as Congress did pass social security legislation. Thus, "veto points" do not explain the whole story.

The analysis identifies two additional reasons for Canada producing structural health reform, whilst the U.S. did not: they are "the way formal institutions condition the crucial role of political parties in the policy process" (Maioni, 1997, p. 412), and the greater access interest groups have to elected officials in the U.S.

Maioni (1997, p. 412) attributes structural reform in Canada to "third parties being able to exert considerable influence in the development of health policy... Formal rules within the Canadian political structure[46], such as those governing a parliamentary government, can offer opportunities for third party formation and efficiency that the American system cannot".[47]

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[44] The idea is that with separate elections, it will "slow down the policymaking process and prevent major and abrupt shifts" (Quadagno, 2004, p. 27).
[45] Canadians do not vote directly for the Prime Minister, nor do they vote for senators (Brooks, 2000).
[46] However, like the U.S., Canada has a single member, plurality electoral systems that usually reinforces two-party dominance and reduces the potential for third party representation (Maioni, 1997).
[47] Moreover, in the U.S., "third-parties have limited potential as an independent political force because of the complex rules of the committee system and control by the two-party-caucus" (Maioni, 1997, p. 413).

One of these rules concerns parliamentary party discipline, as "major parties in Canada are less capable of absorbing dissident factions, groups and individuals either in or out of parliament" (Maioni, 1997, p. 413). By contrast, in the U.S. "broad coalitions represented under major party labels allow them to absorb protest movements more readily, especially given the structural barriers imposed on ballot access and the primary system of candidate selection" (*ibid*). Hence, although the presence of third-party candidates in the U.S. have been influential in modifying major party platforms and realigning their base, only rarely have these parties functioned as autonomous political forces.

In Canada third parties acted as "issue entrepreneurs" in the national health insurance debate. They were able to promote national health insurance as an alternative to policy makers and sustain it in a prominent national forum — the House of Commons (Maioni, 1997). This caught the attention of mainstream parties in part because in Canada third parties can pose an electoral threat, particularly if their support is regionally concentrated. Often, their platforms serve as lightning rods for voter dissent (*ibid*). "Under minority governments, third parties hold an effective balance of power over government and its policies, which also reduces the ability for partisanship" (Maioni, 1997 p. 413).

Maioni claims "the presence of a third party in Canada spurred universal health insurance to national prominence as a viable alternative in the health reform debate and focused powerful political pressure that led to the passage of legislation" (1997, p. 413). Since third parties were largely absent in the U.S. this provides another explanation for why structural reform came about in Canada and not in the U.S.

A second reason for the failure of structural reform in the U.S. is the greater access that interest groups have to elected officials. Maioni (1997) identifies the diffused political authority and weaker party discipline in the American system as reasons why elected officials are more prone to external influence. Lipset (1996) adds that candidates for office largely depend on raising their own campaign funds, making them vulnerable to appeals by interest groups and lobbying organizations.

In the U.S., "fundamental reform poses a threat to interests invested in maintaining the medical status quo, including physicians, hospitals, insurers, pharmaceutical companies, and suppliers of medical technology" (Oberlander 2003, p. 395). "National health spending

represents these parties' income, thus, they are opposed to any reform that will slow down the resources society is transferring to them" (*ibid*). Accordingly, groups such as the AMA[48] invest heavily in lobbying efforts and Political Action Committees[49] in hopes to sway elected officials in favour of their preferred approach to policy.

An example of lobbying success in blocking structural change is seen in the AMA's efforts against the Truman reforms and the reintroduction of the term "socialised medicine" during the Clinton proposals. Some argue that during the Clinton proposals the drop from a 71% approval rating for national health insurance to a 43% rating over a five-month span was largely due to lobby efforts and PACs that persuaded politicians and their constituents to abandon support (Blendon et al,. 1995).

The weakening of support for the Clinton reforms came as politicians knew support from these PACs and lobby groups was crucial to their re-election. Thus, they did not want to alienate them[50]. Consequently, we see that lobbyists and PACs are additional barriers of structural reforms, as the only way a politician can avoid offending his or her contributors is by supporting the smallest incremental reforms (Kirkman-Liff, 2000).

Private sources also fund Canadian candidates and parties, but Canadian election rules impose strict spending limits. Others link Canada's impassive response to CMA lobbying efforts to unsuccessful professional strikes that weakened the prestige of the medical lobby, in addition to the stronger party discipline and concentrated authority already mentioned, which tend to shelter Canadian officials from outside influence (Scarrow, 2007).

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[48] For example, Glabman maintains that the AMA is "the third-largest lobbying group in the U.S." In 2000 alone, it spent about $17 million in lobbying efforts on elected officials", including campaign contributions" (2002, p. 1). Furthermore, in 2000, non-physician health groups, such as the American Hospital Association at $12 million and Blue Cross at $8 million, were the sixth and eighteenth largest spenders respectively on lobby efforts in Washington. Nevertheless, collectively, healthcare groups spent $209 million in 2000 to gain passage of bills that benefit their members or to sideline legislation that might harm them *(ibid).*

[49] PACs raise money from individuals (doctors) and give it bundled to politicians for campaign expenses. According to Kirkman-Liff, the PAC process has "institutionalised the role of money in politics" (2000, p. 35). As a result, many elected officials spend half their time fundraising, often by meeting with PAC representatives. Here, PACs can donate up to $5,000 per election to a candidate, whilst individual contributions are limited to $2,500 per election (Che and Gale, 1998).

[50] Historically, groups fronting the medical profession have been successful at lobbying elected officials against national health insurance because "their adversaries, the millions of uninsured Americans, are a group in statistical terms only, with little in common, except that they are uninsured" (Oberlander, 2003, p. 395). They are a diverse group politically, geographically, and ethnically, with no organization, few financial resources, and little political influence. Hence, "it is no accident that whilst the lists of medical lobbying groups and trade associations are endless, few prominent national groups advocate for the uninsured" (*ibid*.).

Though these differences may have explanatory value, the analysis has identified an additional, possibly more significant, reason to explain the different ways the U.S. and Canada mediated the medical lobby. The CMA encountered strong opposition from the labour movement in Canada, whilst the AMA and American labour often cooperated. Thus, another circumstance is that strong union support in Canada contributed to the production of national health insurance, whilst weak union support in the U.S. stalled reform.

Canadian labour support was a major factor in the electoral success of the CCF party during the 1944 provincial elections. As mentioned earlier, this third party promoted national health insurance on its platform and exerted strong pressure on the Liberal party to introduce structural change in 1957 and 1966. Conversely, a lack of mobilisation by unions, coupled with fear that a larger role of government threatened their autonomy, limited opposition to the anti-socialist forces and the AMA during the Truman proposals. Furthermore, proposals were only incremental, because unions did not require comprehensive coverage (Quadagno, 2004).

Lipset argues that in theory this was because of "the American labour movement, both in its moderate form as the AFL and its revolutionary class conscious form as the IWW[51] rejecting socialism as a goal" (1995, p. 333). In contrast "Canadian union organisations have been much more approving of socialist and labour party objectives" (*ibid*).[52]

Another factor to consider is that Lipset argues the U.S. promotes weak unions, whilst Canada promotes strong unions. He maintains that "the U.S. has the weakest union movement in terms of the proportion of workers who are union members (union density), in the industrialised world" (1995, p. 117). For example, "The percentage of Canadians belonging to unions is between 36-38%, whilst American union membership is only 15%" (*ibid*)[53]. Therefore, some argue that the result is weakened union lobbying power and influence on policy outcome in the U.S. and furthermore, even if the American labour movement had supported national health insurance, they would not have had the same

[51] Industrial Workers of the World.
[52] Additionally, "since the 1930's, unions in Canada have been much more involved in mobilisation through social democratic parties" (Lipset, 1995, p. 333).
[53] This is again explained by Canada's Tory political tradition, which is more social democratic, thereby more conducive to union organisation. Furthermore, Lipset claims, "the legal environment in Canada affords greater protection as compared to those in the U.S." In Canada, federal and provincial union representation legislation has encouraged labour organisation, whist "the American legal scheme allows, rather than encourages, collective bargaining" (1995. p. 122).

impact as Canadian unions.

Considering this, if the support for national health insurance by Canadian unions was a contributing factor to its success, whilst an absence of union support in the U.S. contributed to its failure, we can acknowledge the "power resource" theory as a partial explanation for different welfare state developments, which views the welfare states in Western, capitalist democracies as a product of trade union mobilization (Korpi 1989; Esping-Andersen 1990).

Another factor to consider is a process defined by Pierson as "path dependency." This emphasises the causal relevance of preceding stages in a temporal sequence — early policy choices in the U.S. and Canada – on subsequent policy options. Thus, policies are not only a product of politics, but also produce their own politics by giving rise to widespread public expectations and vast networks of interests (Pierson, 2001).

In the instance of path dependency, early policy choices narrow future options by driving policy down self-reinforcing paths that become increasingly difficult to alter. Some argue that both the U.S. and Canada reflect this principle and are experiencing what Pierson (2001) identifies as a circumstance of increasing returns, in which the probability of further steps along the same path increases with each move forward. This is because the relative benefits of the current activity compared with other possible options increases over time[54].

4.2: Conclusion

The U.S. and Canada share a geographic proximity, have similar economic structures and shared histories, but they have fundamentally different systems for managing health care risks. This analysis has attempted to identify the complex circumstances and array of individual actors that have led to these differences[55].

[54] Here, the costs of exit or switching to some previously plausible alternative rise with time (Pierson, 2001).
[55] It is important to note that this analysis specifically addresses the divergences between the American and Canadian health systems. An assessment of two other countries may identify a different set of circumstances and individual actors that influenced policy outcome. For instance, some argue one reason the British National Health Service came about was that health minister Aneurin Bevan was able to divide and cajole opposition, as well as offer lucrative payment

While Korpi's and Esping-Andersen's "power resource" theory and the "historical institutionalism" theory advanced by Skocpol and Amenta seem to have explanatory value, these are not the only explanations for the adoption of a universal, single payer system in Canada, and a market-based system in the U.S. Other factors are conflicting values, the presence of third parties in Canada, the stronger influence of the medical lobby in the U.S. and systems of government that allowed for structural reform in Canada and prevented it in the U.S.

If we accept Pierson's theories of "path dependency" and "increasing returns", it is reasonable to assume that the preferred systems for managing health risks in the U.S. and Canada will remain intact. Even though Freeman (2000) points out that economic downturn and rising healthcare costs led to an "epidemic" rhetoric[56] inside policy circles of many European countries, resulting in "some convergence between systems from different directions, on what the OECD has identified as the "public contract model of health provision" (Freeman, 2000, p. 54). The present analysis shows that this has occurred neither in the U.S. nor in Canada. Instead, each system continues down its own trajectory. Thus, we may assume that the circumstances and individual actors that determined how the U.S. and Canada manage health risks are powerful and nothing short of tremendous political will can change them.

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structures to consultants. With this, Bevan stated, "I stuffed their mouths with gold" (Moran, 1999 p. 23).

[56] Propaganda of the 1970's and 1980's claimed that economic performance was being inhibited by the ever increasing "social wage", which was the proportion of earnings absorbed by taxes and contributions to finance welfare. To spend more on health care would progressively reduce the capacity of the economy to fund it at all (Freeman, 2000).

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