NATIONAL HEALTH INSURANCE IN THE UNITED STATES AND CANADA: RACE, TERRITORIAL INTEGRATION AND THE ROOTS OF DIFFERENCE

Gerard W. Boychuk
Associate Professor
Department of Political Science
University of Waterloo
gboychuk@uwaterloo.ca

Paper presented to the Annual Meeting of the Canadian Political Science Association, Vancouver, British Columbia, June 2008.

If an American were to visit Canada and vice versa and each visitor was then asked to summarize in a single phrase the most distinctive aspect of the political and social system of the country they had just visited, the Canadian observer would likely point to the prevalence of the politics of race in the United States and the American observer would likely point to the territorial politics of language and region in Canada--especially the issue of Québec's place in the Canadian federation. Despite these obvious differences, few comparative analyses of public health insurance policies in the two countries even consider the possibility that the stark differences between the two countries -- the United States being exceptional among all Western industrialized countries in not having universal health insurance coverage while Canada has universal public insurance for hospital and medical care services -- are shaped by the politics of race and the politics of territorial integration. Even fewer point to these factors as being essential explanations of these differences. The politics of race in the United States and the politics of territorial integration in Canada, however, provide powerful and compelling explanations for differences in the systems of public health insurance in these two countries.

The first section of the paper outlines the salience of the politics of race and the politics of territorial integration in the US and Canada respectively as well as considers existing explanations of the difference in public health insurance in the two countries. The following section examines the role of the politics of race in shaping the politics of public health insurance in the United States. The subsequent section considers the role of the politics of territorial integration in shaping public health insurance programs in Canada.

EXPLANATIONS FOR US AND CANADIAN DISTINCTIVENESS

Conventional explanations often attribute differences in public policies in the two countries to their distinct political cultures or political institutions. More recently, the most influential explanations draw on historical institutionalism and, especially, the concept of path dependence. Both sets of explanations of differences in public health insurance in the United States and Canada, however, pay little or no attention to the politics of race or the politics of territorial integration. Nonetheless, the centrality of these political dynamics in the political life of each country would lead one to expect that they would have a significant impact on major public policies such as public health insurance.

The Politics of Race in the United States

Sixty years ago, Swedish economist Gunnar Myrdal identified the problem of race, defined in terms of the black-white cleavage, as the central challenge facing American democracy--the essence of the "American dilemma."[1] Evocatively, Richard Iton argues that "…race is the ghost with a permanent seat at the table of American life, the spirit whose existence gives definition to all others."[2] The history of slavery, legal segregation, and state-sponsored racial discrimination in the United States as well as efforts to redress past discrimination have generated powerful political dynamics along the black-white racial cleavage and have imbued this cleavage with special political significance in the American system. Race has been an important factor in studies of partisanship and voting behaviour, public opinion, the nature of representation, and the mass media. Race has also played an important role as an explanatory factor with regard to public policy--especially in the area of welfare.[3]

There are two levels at which political dynamics generated by race may help explain divergence in public policy in the United States and Canada--direct and indirect. In regard to the former, other causal factors potentially may be explained, in turn, by the politics of race. For example, it has been argued that racial politics have played a determining role in undermining both union strength as well as the development of a conventional left in the American political system.[4] More broadly, the individualist political culture in the United States has been argued to be, at root, itself a reflection of the politics of race.[5]

There are also more direct links between the politics of race and public policy in the United States. Among the most notable arguments in this genre is the claim that a main barrier to public policy development can be traced to the role of race in southern politics and the resulting resistance to any federal programs that had the potential to challenge the racial status quo.[6] Using old age pensions as a specific example of the operation of this dynamic, Quadagno powerfully argues that "[r]ace was a key component in battles over New Deal policymaking."[7] Given the institutional structure of the American federal system, this influence was transmitted to the national level through southern congressional representatives, and its magnitude was amplified due to the peculiarities of congressional operation and the uncompetitive nature of party politics in the South, itself an artifact of the racial divide. As a result, southern representatives were able

to disproportionately maintain control of key congressional committees such as the powerful Ways and Means Committee in the House of Representatives and the Senate Finance Committee.

Both in terms of direct and indirect influence on public policy, the politics of race is typically perceived to have limited the development of strong social policy in the United States. However, as argued below, the politics of race can also be expected to have had a qualitative impact on social policy--not just limiting the scope of public provision but also altering its essential characteristics. Identifying this influence can be challenging as many policy debates in the United States have racial subtexts that are deeply coded. One of the most infamous examples is President Reagan's use of the term "welfare queens," which was widely understood as a reference to *black* single mothers. As Quadagno argues: "Politicians say they are talking about social programs, but people understand that they're really taking about race. There is good reason for Americans to understand coded messages about social policy as substitutes for discussions of race, for real linkages between race and social policy exist."[8]

Territorial Politics in the Canadian Federation

Territorial integration, especially responding to the challenges posed by Québec nationalism to the territorial integrity of the Canadian state, has always been and continues to be *the* central issue of Canadian statecraft. Powerful territorially defined dynamics have resulted from the interplay of cultural, linguistic, and economic tensions in the Canadian federation and the institution of federalism. These territorial dynamics have been reinforced by the degree to which various societal cleavages in Canada align with territorial boundaries, most notably in the case of Québec. Québec constitutes a distinct, predominantly French-speaking, society within Canada. Concern over linguistic and cultural assimilation into English-speaking North America has resulted in strong popular and elite attachment in Québec to the provincial government--as opposed to the federal government--as a bulwark against assimilationist pressures. Québec nationalism continues to pose a significant challenge to the continued existence of the Canadian federal state. As testament to the immediacy of territorial politics in Canada, the referendum on Québec sovereignty held in 1995 was defeated by only the narrowest of margins--50.6 percent to 49.4 percent.

Territorial politics have deep roots in the history of the Canadian federation. It is not surprising that the politics of social policy in Canada have been swept up in these political

struggles. Postwar social programs, according to Banting, "…quickly emerged as important instruments of legitimation for a federal system facing serious regional challenges, and some of the most bitter battles in subsequent decades were fought over which level of government would control these levers of cultural definition." As he notes:

> Social programs controlled by the central government can become instruments of nation building, helping to mediate regional tensions and strengthen the state against centrifugal forces rooted in territorial politics. Alternatively, social programs designed and controlled at the regional level can become instruments for strengthening regional cultures and enhancing the significance of local communities in the lives of citizens, thereby reinforcing differentiation and centrifugal tendencies at the national level.[9]

Of central importance in the Canadian context has been the emergence of a dynamic that Banting terms competitive state-building in which different levels of government compete vigorously to occupy political space:

> Governments in Canada have long recognized the potential of social programs as instruments of statecraft, to be harnessed to nation-building agendas. This can be seen most clearly in the protracted struggle between the federal government and the province of Québec for the commanding position in the politics of welfare during the second half of the 1960s and 1970s. The intensity of these disputes can be understood only by appreciating the extent to which the two governments vied to retain the loyalty of Quebecers and to protect and enhance their institutional power.[10]

These dynamics have had significant impacts on social policy in Canada. First, they have placed limits on federal social policy resulting from the politics of Canadian federalism that dictate, in many instances, that provincial agreement is required--either politically or constitutionally--for federal policy initiatives. As argued below, a national program for health insurance, for example, would have been implemented decades earlier and on a more comprehensive basis had it not been for resistance from the government of Québec. A separate dynamic--distinct from the constraining impact of federalism --results from the pressure placed on the federal government to respond to social policy initiatives in Québec in order to bolster its own position *vis-à-vis* citizens in Québec and perform its territorially integrative function. That is, the federal government must continually reposition itself in the field of social policy in order to maintain and reinforce its claim to be the central repository of social rights in Canada. It must

do so to counter continuing sovereignist claims in Québec that "…the only political choice left for Quebeckers who wish to preserve their social programs, and therefore their identity, is sovereignty."[11] Thus, new social policy initiatives in Québec always place the federal government in the position of having to decide whether to cede the initiative to the provincial government or to challenge the provincial government as the primary guarantor of the social rights of Québec citizens through social policy initiatives and programs of its own.

Existing Explanations of US-Canada Distinctiveness

Conventional explanations of differences in public health insurance in the two countries tend to focus on the distinct political cultures or political institutions of the two countries and, more recently, historical institutionalism and the concept of path dependence.

Political Culture

Political cultural arguments are epitomized by Lipset's well-known formulation: "The two countries differ in their basic organizing principles. Canada has been and is a more class-aware, elitist, law-abiding, statist, collectivity-oriented, and particularistic (group-oriented) society than the United States."[12] Lipset argues that "[t]he differences between the two countries are particularly striking with respect to the role of government in medical care."[13] (1990: 138) Following this type of argument, Kudrle and Marmor give explanatory pre-eminence to ideological differences between the two countries: "In every policy area it appears that general public as well as elite opinion was at least as supportive of state action in Canada as in the United States at a given time and often, as in the case of public health-care, considerably more supportive. This support appears to underlie not just the typically earlier enactment of policy in Canada but also subsequent changes [including] the rapid development of Medicare after hospital insurance…"[14]

Interest group politics are also argued to have been conditioned by the political culture of each country. For example, Tuohy argues that physicians' perceptions of their own interests – especially as represented by the Canadian Medical Association (CMA) and the American Medical Association (AMA) – were substantially different in the two countries and that such differences reflected broader differences in political culture: "One of the key manifestations of the 'tory streak' in the health care arena in Canada…has been in patterns of *medical* opinion, and

in positions taken by organized medicine at critical junctures and in the ongoing playing out of the logic of the respective systems."[15] (Tuohy, 1999: 117) In this interpretation, the cultural predisposition of the Canadian medical profession explains, for example, why it was supportive of universal public health insurance in the 1940s while the AMA was not.

Political Institutions

Formal political institutions have also long been argued to be key to explaining divergence in public health insurance in the two countries. The most common explanation for the slow and limited development of public health insurance coverage in the United States is the role of interest groups – especially the AMA – operating in a context of high levels of institutional fragmentation.[16] These explanations typically focus on the American presidential system and weak political parties -- the corollary of the separation of legislative and executive powers which differs starkly from Canada's fusion-of-powers system.

A second institutional difference is that, while both systems are federal, they are distinct in regard to the level of centralization in regard to public health insurance. The Canadian health care system is highly decentralized. Provinces are granted the preponderance of jurisdictional authority for health care under the Canadian constitution.[17] However, the federal government has involved itself in the provision of health care primarily through the use of the federal spending power which allows the federal government to make transfers to the provinces attaching whatever conditions it wishes so long as it does not undertake to legislate directly within a field of provincial jurisdiction. This power underpins the CHA which is the legislative basis of the Canadian health care system. Similarly, primary responsibility for publicly provided health care resides with the American states by virtue of the 10th Amendment which states that any powers that are not constitutionally delegated to the federal government are reserved for the states. A central role for the federal government in health care provision has evolved through its taxing power (e.g. providing tax subsidies for employer-sponsored health insurance coverage), spending power (e.g. making conditional transfers to the states under programs such as Medicaid), and power to regulate interstate commerce (e.g. prohibiting states from regulating health insurance provided by self-insuring employers.) Through these mechanisms, the federal government plays a more direct and immediate role in shaping public health insurance in the United States than has been the case for the federal government in Canada. The greater level of

provincial responsibility for health care in Canada is argued to have provided third-parties at the provincial level with greater ability to implement provincial systems of public health insurance thereby more powerfully influencing national-level policy in these regards.[18]

Historical Institutionalism

Recently, the most influential academic literature examining the differences in public health insurance in the two countries draws heavily on the historical institutionalist approach.[19] (Hacker, 1998; Maioni, 1998; Tuohy, 1999; Hacker, 2002) This approach focuses on the unfolding of the process of policy development over time including the effects of policies and institutions in shaping the subsequent politics of a policy field. (See esp. Pierson and Skocpol, 2002.)

Path dependence is increasingly a central concept in the historical institutional approach. In turn, critical junctures, sequencing, and positive feedback are crucial elements in the overall concept of path dependence.[20] The starting point in the unfolding of a path dependent process is a critical juncture or choice point when a confluence of events opens a "window of opportunity" for change to take place and the options for policy change are, at least relatively, open and contingent.[21] Secondly, sequencing, the order in which events happen, is important in determining outcomes. A different sequence of the exact same events may result in a substantially different outcome.[22] An additional important concept related to timing and sequencing is conjuncture or intercurrence – how the timing of a critical juncture in one process fits with the timing and sequence of other distinct but simultaneously unfolding processes.[23] A final central element of path dependence is positive feedback -- earlier policy outcomes creating conditions favourable to further development along an existing path. At the same time, development along a given path may also create constraints on the range of possible future paths of development. In the strongest versions of path dependence, this creates 'lock-in'.

Drawing on this conceptual imagery, the recent examinations of divergence in the US and Canadian health care systems have a number of common threads. First, public health insurance in the two countries is typically argued to have developed from a roughly common starting point at which time it seemed at least plausible that they might follow the same path of development. At some point, different developments took place in each country that launched each on a distinctive path. These differences then became self-reinforcing so that, over time, the two

countries increasingly diverged. Tuohy's account of the development of distinct systems of health insurance in Canada and the United States is a good example of a historical institutional interpretation which places heavy explanatory weight on contingency. For Tuohy, the emergence of different systems of health insurance ultimately comes down to the accident of strategic miscalculation by proponents of reform in the United States. First, American states did not become the "loci of experimentation with governmental hospital insurance" as was the case in the Canadian provinces due to policy inertia in the American states which led reformers to focus their efforts at the national level.[24] This was a strategic choice which, made differently, could have led to similar outcomes in the two countries according to Tuohy. Another key factor for Tuohy is that Democratic policymakers failed to push for universal national health insurance in 1965 in the wake of the Johnson landslide. In Tuohy's judgment "…it is quite conceivable that had a different strategic judgment been made and the introduction of universal national health insurance had been attempted, the subsequent history of American health policy would have been very different."[25]

Secondly, the timing of events in the development of public health insurance are also critical in historical institutionalist accounts both in terms of sequencing (the order in which events occurred) as well as conjunctures (the intercurrence of developments in public health insurance with other processes occurring in the broader political realm). Jacob Hacker develops an impressive version of the importance of sequencing in public health insurance reform:

> Three questions of sequence are particularly important in determining the path countries eventually take: whether governments fail to enact national health insurance before a sizable proportion of the public enrolled in physician-dominated private insurance plans, whether initial public insurance programs are focused on residual populations such as the elderly and the very poor, and whether efforts to build up the medical industry preceded the universalization of access. Countries that do all these things, as the United States did, are left facing virtually insuperable political barriers to the passage of national health insurance.[26]

For Hacker, differences in the degree of private voluntary insurance coverage were key in shaping the distinct trajectories of public health insurance development in the United States and Canada. The paper later returns to a consideration of this particular path dependence argument.

Thirdly, a central element of historical institutionalist interpretations is policy feedback – the recognition that health insurance policy itself contributed significantly to shaping the subsequent political struggles over policy.[27] Categorical programs, Medicare and Medicaid, are argued to have stemmed the tide in the United States for more radical policy innovation such as universal health insurance – effects which have been argued to have been relatively automatic, if not inevitable.[28] For Hacker, the focus of initial public programs on residual populations such as the aged or the poor had three effects which stemmed further development of universal public health insurance: initial programs were expensive as the cost of covering the elderly and poor are very high; they focused on groups largely outside the mainstream of the economy; and, finally, both public health insurance for the aged and poor piggybacked on existing programs (Social Security and Aid to Families with Dependent Children [AFDC]) to which their political fortunes would become closely tied. (Hacker, 1998: 128) For Maioni, policy outcomes in the 1960s, which were strongly shaped by earlier developments, in turn "created very different settings for the politics of health care in subsequent decades by changing the incentives and interests of actors and groups in the policy process."[29] Following this emphasis on 'lock-in,' Tuohy's account also rests quite heavily on determinism after the initial critical juncture. She examines how policies "have their 'legatory' effect – not simply by habit or accustomation, but rather through the logics that they establish, logics with their own dynamics that over time can either reinforce or transform the structural and institutional characteristics of the health care system."[30]

Public Health Insurance in the United States and Canada

To date, no mainstream comparative works consider the politics of race and the politics of territorial integration as providing a central and essential explanation for why the contemporary health care systems in the two countries look so different. The following section sketches out the influence of the politics of race on the development of public health insurance in the United States and the effects of the politics of territorial integration on its divergent path of development in Canada.

Health Care and the Politics of Race in the United States

The politics of race were a central fixture of the period in which American public health insurance policy initially emerged and help to explain both the lack of national public health

insurance as well as the specific structure and characteristics of the programs that did develop. While significantly more subtle than in earlier periods and often latent, the politics of race continue to play an important role in the politics of contemporary health care reform, most notably, in the proposed Clinton reforms of the early to mid-1990s.

The politics of race had not been a significant barrier to the inception of public health insurance prior to the end of World War II. Had a national program of health insurance been implemented before this point, it almost certainly would have adopted the racialized cast of the existing social programs comprising the American welfare state. To this point, southern Democrats in Congress maintained an effective veto over new programs and, as a result, retained powerful mechanisms to ensure that new programs would not challenge the existing racial status quo. These mechanisms included the ability to make programs less racially inclusive where they were national (as in the case of Social Security which excluded most African Americans in the South from eligibility), the option of leaving administration to state or local administration where programs were inclusive (as in the case of *Aid to Families with Dependent Children* [AFDC] where state administration often meant that African Americans were denied benefits or paid lower benefits than white recipients), and the ability to block the inclusion of non-discrimination clauses. In this period "when affirmative action was white," major social programs were designed to confer advantage on whites.[31] Health insurance was not included in the wave of legislation enacted in the mid-1930s which comprised Roosevelt's New Deal primarily because it simply did not address directly the main policy problem generated by the Great Depression: the need for income maintenance in the face of large-scale job losses and job insecurity. However, the failure to include national health insurance in the New Deal was fraught with political significance; it meant that health insurance reform would be pushed into a period where it would become deeply entangled with the politics of civil rights.

In the immediate postwar period, the ability of the South to enforce an effective policy of segregation on the federal government was challenged as was the racial status quo in the South. The federal government abandoned its official policy of racial segregation beginning with the integration of the American Armed forces by executive order in July 1948. As the federal government became more clearly committed to desegregation after World War II, federal intervention in virtually any policy area could be construed as a potential future challenge to the racial status quo. Due to the highly segregated nature of health services provision in the United

States, especially--but not exclusively--in the South, it was virtually inevitable that the politics of public health insurance would become inextricably entwined with the emerging political battles over civil rights. This certainly proved to be the case with President Harry S. Truman's attempts-- the first by an American president--to enact national public health insurance in the period from 1948-50. Truman's linking of civil rights and health insurance in his 1947 State of the Nation address and his appointment of a high profile integrationist to lead his administration's health care reform exacerbated southern fears that a national program would challenge the racial segregation of health services in the South. The southern congressional coalition still retained sufficient political resources to resist such initiatives. In this context, progress on national public health insurance met powerful resistance.

In the face of southern intransigence, federal policy-makers quickly came to the realization that some sort of compromise was required. Providing public health insurance to the aged through Social Security--an approach later to become known as Medicare--would symbolically recreate the compromises of the New Deal in which southern opposition to Social Security was eased by making farm workers and domestic servants (a large proportion of the African-American population in the South) ineligible.[32] This alternative proposal developed too late in the Truman presidency; with the election in 1952 of Dwight D. Eisenhower, who was staunchly opposed to public health insurance, reform would have to wait until the election of John F. Kennedy in 1960.

By the 1960s, circumstances relating to both civil rights and public health insurance had changed dramatically. Segregation in health care services had come on the defensive even in the absence of federal programs. Segregation in education had been found unconstitutional in 1954, and there was every reason to believe that similar court challenges would emerge in the area of health services. The passage of the *Civil Rights Act, 1964* made such challenges even more likely. Moreover, the provision of the existing federal program for cost-sharing hospital construction enacted in 1946, which explicitly allowed segregation, was struck down in 1962 by the Supreme Court. Southern representatives had always been in a paradoxical position in regard to federal programs,[33] On the one hand, such programs represented injections of federal financial support into a region where it was often desperately needed. On the other, they presented the risk of federal intrusion into matters of states' rights--especially the ability to maintain legal segregation. The increasing inevitability of desegregation of health services altered the

calculation of this balance. Desegregation of health services (for example, through court challenges) in the absence of a federal program (which would otherwise transfer much-needed federal funds to southern states) would be the worst possible outcome from this point of view.

The looming prospect of hospital integration thus generated the possibility for compromise. For their part, southern lawmakers needed to be able to support health legislation without appearing to be promoting hospital integration and the financial incentives would have to be sufficient to help them sell the program politically. Thus, the administration adopted a deliberate strategy of uncoupling the issue of health insurance from the issue of civil rights, although it was proceeding on both fronts simultaneously--a significant shift in strategy from the late 1940s. The administration strove to ensure that the civil rights implications of the Medicare program were never discussed on the congressional floor, and African-American organizations were conspicuously absent from discussions surrounding Medicare, including the proceedings of congressional committees. Medicaid, a program of federal cost-sharing for medical services provided to needy persons, was added at the last minute and would sweeten the deal for southern representatives, further tilting the balance between the risk of federal intrusion and the flow of federal funds toward the latter. (Not surprisingly, the matching formula favoured poorer states, including virtually all southern states.) At the same time, Medicaid recreated the AFDC compromise in the New Deal and left eligibility, benefit levels, and administration to the states. In order to ensure the limited enforcement of the Civil Rights Act, nursing home care would be included in the Medicaid program for the needy rather than the Medicare program for the aged.

In anticipation of resistance by southern hospitals to the enforcement of civil rights compliance--a key concern of Medicare policy-makers at the program's inception and an issue with which President Johnson himself would become personally concerned--the resulting package included financial terms that were extremely favourable to hospitals and the medical profession in order to prevent broader physician and hospital opposition. These compromises greatly contributed to the overall costs of the program as well as its lack of fiscal controls which, in turn, significantly constrained future reforms. Together these factors dashed the hopes of liberal reformers and assuaged the concern of conservative opponents that Medicare would act as a stepping stone to universal public health insurance. (For more than 20 years, the central challenge for federal policy-makers would be the struggle to bring costs under control.) In addition, the delays in passing Medicare due to southern intransigence pushed efforts at broader

public health insurance expansion into a period much less propitious for reform, marked as it was by the escalation of the Vietnam conflict, the Watergate scandal, and the oil crisis. The result was that another serious attempt at comprehensive health insurance reform was not to take place for several decades.

When debate turned to health insurance reform in the 1990s, dynamics related to race continued to powerfully shape the opportunities for health care reform. The initial Clinton health care reform package proposed mandating employer-provided health insurance coverage for all employees and providing public coverage for those not covered under employer-sponsored plans. The package was carefully sold as benefiting the "middle-class" and protecting middle-class health insurance coverage rather than as an effort to expand coverage to those who did not have it--a group disproportionately populated by racial minorities. As a result of dynamics created by the programs that emerged out of the 1960s, reforming health insurance by the 1990s, including the expansion of coverage to the uninsured, was a political strategy that was relatively highly inoculated against racial backlash. Popular images of the uninsured were not highly racialized in large part due to the perception that the very poor (a category of people which itself has a highly racialized image) already received coverage under existing government programs. Due to the peculiarities of their historical development, programs such as Medicaid were not perceived primarily in racial terms nor had political leaders tended to cast them in this light. These factors helped generated an opportunity for major reform.

At the same time, however, dynamics relating to race contributed to an overall context that was inhospitable to health insurance reform. First, the heightened racial charging of the American political system in the early 1990s – a context to which the Clinton administration's proposals for welfare reform and crime control contributed – helped undermine general public support for both expansion of federal programs and increases in taxes necessary to fund them. This greatly constrained the Clinton reformers' latitude in designing their package of health reforms. On the tax side, the lack of public support for higher taxes, which was also strongly conditioned by concerns about spending on minorities, created a context in which the Clinton administration felt bound to adopt an approach which was revenue-neutral. In turn, the failure of the plan to specify new revenue sources became an important element in the declining popularity of the Clinton proposals as important constituencies such as seniors became convinced that the expansion of coverage to the uninsured would be financed through cuts to their own coverage.[34]

Secondly, the heightened racial charging of the American political system in the early 1990s also contributed to lowering the public salience of health care relative to other issues which more directly played on racial dynamics such as welfare reform and crime control where reforms would ultimately be successful.

The politics of race helps explain the failure of national health insurance at crucial points in time, the timing and nature of successful public health insurance reforms, and the characteristics of these successful public programs that prevented them from paving the way for wider public coverage. This is not to argue that, in the absence of the dynamics generated by the politics of race, universal public health insurance would have been successfully adopted in the United States. However, the intertwining of the politics of public health insurance and the politics of race helped ensure that national public health insurance would not be successful.

Health Care as Statecraft: Territorial Politics in the Canadian Federation

For its part, public health insurance in Canada has been strongly shaped by the politics of territorial integration. On the one hand, federal intervention in various fields of social policy including health care offered the federal government the opportunity to create a direct connection with individual citizens in the disparate regions of Canada and foster a sense of attachment between them and the national polity. On the other hand, recognition of the potential role of social policy in nation-building has prompted strenuous resistance on the part of certain provinces--most notably Québec--to new federal health insurance programs or federal intrusions in the area of health.

In the immediate postwar period, an emergent vision for a comprehensive, national program of public health insurance foundered in the face of such resistance, and even a more limited federal cost-sharing plan collapsed in the face of resistance from Québec. Provincial plans for public hospital insurance, such as the one that developed in Saskatchewan, emerged out of this collapse largely as a matter of historical accident. The Saskatchewan government had proposed a system of universal hospital insurance coverage in the expectation of the announcement of a federal cost-sharing program although the federal-provincial negotiations over the plan (included in the broader postwar reconstruction package) broke down only months after the Saskatchewan announcement. The Saskatchewan government, which would almost certainly not have announced a program in the absence of the prospects of federal cost-sharing,

felt politically bound to proceed with the program and implemented universal hospital insurance in 1947 which would be followed by a similar program in British Columbia in 1949.

Following these early provincial plans, a national plan for hospital insurance emerged only as the haphazard result of a cycle of political one-upmanship between the federal government and the province of Ontario in the mid to latter half of the 1950s rather than by some overall design or inexorable logic. Federal conditions on cost-sharing for hospital insurance introduced a number of elements – including universality and public insurance as an entitlement unrestricted by payment of premiums or co-insurance fees -- which would contribute to the status of public health insurance as a symbol of national unity and identity despite never having been deliberately intended by policymakers. The requirement that insurance be universally available on uniform terms and conditions simply meant that federal cost-sharing funds could not be used to subsidize insurance provision through private plans -- thus effectively banning the transfer of public funds to private control. This provision reflected a desire to keep direct public control over public funds more than any egalitarian ideals.[35] A similarly unintended effect took place with regard to co-insurance (user fees) and premiums. The federal government simply wanted to ensure that increases in its own contributions would be directly tied to increases in the provincial financial contribution in order to provide incentives for provincial governments to exercise strong cost control. As a result, expenditures financed by payments from patients were not eligible for federal matching.[36] While the federal program did not proscribe premiums or user fees and had not envisioned a system free of these elements,[37] it inadvertently created significant disincentives to reliance on such funding mechanisms and they would fade, at least temporarily, from the public health insurance landscape. The shift away from the conception of health insurance as an entitlement earned through the payment of premiums or as benefits contingent on user fees helped set the stage for the growing perception of entitlement to public health insurance on a different basis – as a right of citizenship.

In the face of growing nationalist sentiment in Québec and a coherent overall strategy on the part of the Québec government to become "*maître chez nous*" ("master in our own house"), a national program for physician care insurance emerged in the 1960s as a potential federal initiative to counterbalance a series of developments that had tilted social policy dominance strongly toward the provincial government, including unemployment insurance (Québec initially opted out), university funding, and pensions (Québec was building its own pension scheme).

Implemented in the face of resistance from the Québec government, the addition of a national program for cost-sharing physician care insurance to the existing federal program of hospital care insurance laid the basis for the Canadian public health insurance system as it exists today.

This system would, however, begin to erode in the English-speaking provinces, especially in the late 1970s, with the increasingly widespread reliance on user fees and extra-billing, which had been, incidentally, banned by provincial legislation only in the province of Québec. This situation, in which the right to public health care was guaranteed at a higher standard in Québec than in the rest of Canada, became a serious political liability for the federal government in the context of the Québec referendum on sovereignty-association in 1980 in which the federal government aimed to portray itself as the guarantor of social rights and programs in Canada. In the absence of any provincial prodding and little cabinet or caucus support, the federal Liberal government would signal its intention, in the crucial weeks leading up to the referendum, to bring in legislation enforcing national principles for public health insurance (and banning extra-billing and user fees), thereby reasserting its claim to be the sole guarantor of the right of Canadian citizens to universal, comprehensive, first-dollar, public coverage for hospital and physician care insurance. The result was the *Canada Health Act, 1984* (CHA).

In terms of its broader symbolic appeal, the CHA was stunningly successful not only in Québec but on a pan-Canadian basis. In the context of debates regarding deepening economic integration with the United States (Canada-US Free Trade in 1987-88 and NAFTA in 1993), the Canadian health care system--symbolized by the CHA--gained iconic status. Over the 20-year period following its adoption, the centrality of health care to territorial politics and *vice versa* became increasingly evident. After the failure of the 1992 Charlottetown Accord, health care displaced constitutional issues as the single most important focus of federal-provincial relations in Canada, a situation that continued to prevail into the early 2000s. At the same time, the Canadian public health insurance system became increasingly gridlocked as a result of counter-pressures created by simultaneous federal and provincial strategies of credit-claiming and blame avoidance and strong public resistance to any reforms that might be considered an infringement on the principles enshrined in the CHA.

Through it all, the politics of territorial integration remained the animating spirit of Canadian health care debates. The federal government began to retreat from its role in health

care in the face of severe fiscal pressures in the early and mid-1990s. However, in the wake of the Québec referendum of 1995, the federal government undertook strenuous efforts to reinvigorate its role in health care as it had in the wake of the first referendum by positioning itself as the defender of the CHA and proposing new initiatives to extend the scope of public health insurance, especially in prescription drug and home care coverage, and later in proposing national wait time guarantees.[38] These efforts to expand the federal role in health care dominated health care debates (and, by extension, federal-provincial relations) for the decade following the Québec referendum.

There has been a strong historical link between the politics of health care and the politics of territorial integration. The first public commitment at the federal level to national health insurance (undertaken by the Liberal Party in 1919) occurred in the context of a serious disruption in relations between Québec and the rest of Canada--the first conscription crisis of 1917. National health insurance re-emerged on the federal political agenda with the federal announcement of a national health insurance plan in the same year as the second Québec conscription crisis in 1942. Proposals for a federal Medicare program resurfaced in the context of the Quiet Revolution in the 1960s. The federal government would renew its commitment to vigorous enforcement of Medicare principles in the context of the 1980 Québec referendum. In the immediate wake of the 1995 Québec referendum, the federal government again began a decade-long effort to renew its role in the health care field.

Path Dependence and Divergence in National-Level Reforms in the United States and Canada

The most influential contemporary analysis of the development of health insurance in the United States and Canada is provided by Hacker who argues that the passage of national health insurance faces virtually insurmountable obstacles in countries where private insurance coverage expands before the implementation of public insurance, public insurance plans are initially categorical, and efforts to expand the medical industry take place before the universalization of access The development of public health insurance in Canada challenges this interpretation on all three counts.

Differences in voluntary health insurance coverage do not provide a compelling explanation of divergent developments in the US and Canada. First, on a number of counts, the

data on voluntary insurance coverage do not support this conclusion. The difference in voluntary health insurance coverage in the two countries simply appears too slim to provide a compelling explanation of the large divergence in outcomes. Hacker compares voluntary health insurance coverage in Canada and the US in 1957 and, as a result, finds significant differences between the two countries with 70% coverage in the US in comparison with 45% coverage in Canada. (See Table 1.) However, if one compares coverage in Canada in 1957, when health insurance reform succeeded, with coverage in the US in 1950, when national health insurance was defeated, the relevant US coverage rate is nearer to 50% and much more comparable with Canadian coverage rates.

Table 1 Voluntary Private Health Insurance Coverage, United States (1950 and 1956) and Canada, 1956

	United States		Canada, 1956	Canada, 1956	Ontario
	1950	1956	Unadjusted	Adjusted	1956
Coverage (% of population)	50.5%	70.1%	44.7%	54.3%	74.4%

Source: Somers and Somers, 1961: 543, 547; National Health and Welfare, 1958: 4-5.

Furthermore, the coverage rates for Canada used in these comparisons do not take into account the fact that a number of provinces already had public hospital insurance thus depressing national levels of voluntary health insurance.[39] In 1956, the coverage rate in Canada (excluding provinces which already had public hospital insurance coverage -- e.g. Saskatchewan, British Columbia, Alberta and Newfoundland) was over 54% -- higher than US coverage rates in 1950 when national health insurance failed. In Ontario, where the adoption of hospital insurance was critical to the initiation of a federal plan, 74% of the population was covered by voluntary hospital insurance in 1956 when hospital insurance reform was successfully undertaken. This is higher than the national coverage rate in the US in 1957 and considerably higher than the roughly 50% coverage in the US in the early 1950s when health insurance reforms failed.

Secondly, the chronology of the extension of insurance coverage by type of health service in Canada runs contrary to the expectations generated by this strand of path dependent analysis. Public hospital insurance in Canada emerged earlier and with much less resistance than medical care insurance even though voluntary insurance coverage for hospital services was much more widespread than was voluntary medical care insurance.[40] Rather, the pattern of difference

between these two policy areas suggests that support for public health insurance was highest for service types in which voluntary coverage was highest. Voluntary private insurance in Canada had the reverse effect to that hypothesized by Hacker – the more successful that prepayment plans and private insurance were at demonstrating the advantages of insurance, the greater the public demand to extend coverage to everyone through public programs.[41]

Rather than differences in coverage rates leading to large-scale policy divergence, broad similarities in voluntary insurance coverage in both countries contributed to the *similar* characteristics of public insurance programs as they developed in each country. In both countries, voluntary health insurance contributed to the embeddedness of two central elements of the existing health services system – private physician practice and fee-for-service remuneration. In both systems, public insurance (whether universal or categorical) would not challenge these two central elements which had been locked in under the systems of voluntary health insurance in each country. This implies a very different mechanism of sequencing and lock-in than outlined in existing path dependent explanations.

Similarly, the evidence from the Canadian case does not support the contention that the existence of categorical programs undermines the subsequent development of universal programs. Prior to the federal proposal for comprehensive health insurance in 1945, all provinces provided for “grants to hospitals and for the hospitalization of indigent patients.”[42] Categorical health insurance programs existed in five of the ten provinces at the time that the federal hospital insurance program became a reality. Comprehensive categorical health insurance programs existed in both Saskatchewan and British Columbia prior to the advent of universal hospital insurance programs in those provinces. In Ontario, which was key to the inception of a federal hospital insurance program, a program of physician insurance for social assistance recipients, old age security recipients, and blind pension recipients had been in existence since the mid-1930s.

Neither does the Canadian case support the claim that the build up of the medical industry prior to the universalization of access created a serious barrier to public health insurance reform. Efforts to build up the medical industry had occurred at the same time in the United States and Canada and this build-up had proceeded to roughly the same degree in the two countries. Federal grants for hospital construction, similar to those in operation in the United States, had been in operation in Canada for roughly a decade at the time national hospital

insurance was implemented. As Tuohy notes, "The impact of the federal hospital grants programs on the hospital sector, moreover, was similar in the two countries. In each, the for-profit hospital sector, always small, declined further in significance."[43] In the Canadian example, there is no evidence that such grants undermined public programs of universal insurance and, according to Prime Minister Mackenzie King, the grants at the time were thought to represent "… the first stages in the development of a comprehensive health insurance plan for all Canada."[44] Thus, these similar sequences of development in the United States and Canada help to explain a number of the similarities in the contemporary systems of health care in the two countries rather than differences between them.

CONCLUSIONS

In arguing that racial and territorial politics were crucial in the development of distinctive approaches to health care in the United States and Canada, an important central point is that, although political culture, institutions, path dependence, and historical sequence all played an important role in shaping the development of health care in each country, the emergence of differences in their health care systems was ultimately rooted in the structure and nature of the two societies. Most critically, this interpretation emphasizes the need to be attuned to the effects of conjunctures between large scale processes of development and developments within particular policy fields. The positive feedback mechanisms associated with path dependence are evident at important points in the development of public health insurance in each country, *conjunctures* between the development of public health insurance and other large-scale process unfolding simultaneously – especially the extension of civil rights in the United States and the process of nation-building in Canada – were critical in shaping the path of development of public health insurance. The sequence of events – the timing and stage of each of these processes at the point at which they intersected – was also critical in determining their impact on the development of public health insurance in each country. However, to gain an adequate understanding of the divergent paths taken by each country in regard to the development of public health insurance, one *must* look, among other things, to the role played by the politic of race in the United States and the politics of territorial integration in Canada.

NOTES

[1] Gunnar Myrdal, *An American Dilemma: The Negro Problem and Modern Democracy* (New York: Harper and Brothers, 1944).
[2] Richard Iton, *Solidarity Blues: Race, Culture, and the American Left* (Chapel Hill, NC: University of North Carolina Press, 2000). The reference to racial politics is not to imply that races exist in some objective sense. As Iton notes (p. 20): "While empirically races do not 'really' exist, the obsession with the implications of racial differences has affected the political activities of all Americans, in some manner, regardless of their background. As these categories have been imbued with significance, the behavior and perceptions of Americans have been affected so as to give even greater life to an essentially artificial realm."
[3] See, for example, Michael K. Brown, *Race, Money and the American Welfare State* (Ithaca, NY: Cornell, 1999); Martin Gilens, *Why Americans Hate Welfare: Race, Media, and the Politics of Antipoverty Policy* (Chicago: University of Chicago Press, 1999); Robert C. Lieberman, *Shifting the Color Line: Race and the American Welfare State* (Cambridge, MA: Harvard University Press, 1998); Gwendolyn Mink, *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942* (Ithaca, NY: Cornell University Press, 1995); Gwendolyn Mink, *Welfare's End* (Ithaca, NY: Cornell University Press, 1998); Jill S. Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (New York: Oxford University Press, 1994); and Linda F. Williams, *The Constraint of Race: Legacies of White Skin Privilege in America* (University Park, PA: Pennsylvania State University Press, 2003).
[4] See Iton and Jill Quadagno, *Transformation of Old Age Security: Class and Politics in the American Welfare State* (Chicago: University of Chicago Press, 1988), 191-4.
[5] See Iton 181; and Quadagno, 1988: 194-96.
[6] Iton 237, 150.
[7] Quadagno, 1988: 10. This view has more recently come under serious challenge. See Daniel Béland and Jacob S. Hacker, "Ideas, Private Institutions and American Welfare State 'Exceptionalism': The Case of Health and Old-Age Insurance, 1915-1965," *International Journal of Social Welfare* 13 (2004): 42-54.
[8] Quadagno, 1988: v.
[9] Keith Banting, "The Welfare State as Statecraft: Territorial Politics and Canadian Social Policy," in Stephan Leibfried and Paul Pierson, eds., *European Social Policy: Between Fragmentation and Integration* (Washington, DC: Brookings Institution, 1995) 270-72.
[10] Banting 284.
[11] Daniel Béland and André Lecours, "The Politics of Territorial Solidarity," *Comparative Political Studies* 38, 6 (2005): 87.
[12] Seymour Martin Lipset, *Continental Divide: The Values and Institutions of the United States and Canada* (New York: Routledge, 1990), 8.
[13] Ibid., 138. In regards to Lipset's claims, Marmor aptly notes that "[n]ever has so much been claimed with so little evidence." Theodore R. Marmor, "Canada's Health Care System: A Model for the United States?" *Current History* 90 (December 1991): 423.
[14] Robert T. Kudrle and Theodore R. Marmor. 1981. "The Development of Welfare States in North America," 81-121 in Peter Flora and Arnold J. Heidenheimer, ed., *The Development of Welfare States in Europe and North America* (New Brunswick: Transaction, 1981), 111.

[15] Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada* (New York: Oxford University Press, 1999), 117.
[16] See Theodore R. Marmor, *The Politics of Medicare* (Chicago: Aldine, 1973); James Morone, *The Democratic Wish: Popular Participation and the Limits of American Government* (New York: Basic Books, 1990), 255-6; Jill S. Quadagno, *One Nation Uninsured: Why the US has No National Health Insurance* (New York: Oxford University Press, 2005); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass.: Belknap Press, 1992); 536-9; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).
[17] Primary jurisdiction over health care was granted to the provinces by virtue of S.92 of the British North America Act, 1867 (later to become the Constitution Act, 1982) which assigned the provinces jurisdiction over the "Establishment, Maintenance, and Management of Hospitals..."
[18] See esp. Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (Princeton, NJ: Princeton University Press, 1998).
[19] See Jacob Hacker, "The Historical Logic of National Health Insurance: Structure and Development of British, Canadian, and US Medical Policy." *Studies in American Political Development* 12 (Spring 1998): 57-130; Jacob Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (Cambridge: Cambridge University Press, 2002); Tuohy, 1999; Maioni, 1998.
[20] In order to avoid confusion, I use 'path dependence' to refer to the ensemble of concepts – critical junctures, sequencing, and positive feedback. The dynamics by which a particular policy direction becomes self-reinforcing, sometimes referred to elsewhere as 'path dependence,' is referred to here as positive feedback.
[21] In Kingdon's conception, these windows of opportunity open when there is a confluence of the distinct problem, policy and political streams which contribute to policy-making. See John W. Kingdon, *Agendas, Alternatives and Public Policies* (Boston: Little Brown, 1984).
[22] Paul Pierson, *Politics in Time: History, Institutions and Social Analysis* (Princeton, NJ: Princeton University Press, 2004), 18, 66, 68.
[23] Orren and Skowronek refer to these collisions or abrasions among distinct realms as "intercurrence." Karen Orren, Karen and Stephen Skowronek, *The Search for American Political Development* (Cambridge, UK: Cambridge University Press, 2004), 113-8. See Paul Pierson, *Politics in Time: History, Institutions and Social Analysis* (Princeton, NJ: Princeton University Press, 2004), 55-8.
[24] Tuohy, 1999: 47, 48.
[25] Ibid., 118-20.
[26] Hacker, 1998: 128.
[27] Hacker, 1998: 82; Maioni, 1998: esp. Chpt. 8; Tuohy, 1999.
[28] Hacker, 1998: 128; Maioni, 1998: 165.
[29] Maioni, 1998: 7.
[30] Tuohy, 1999: 124.
[31] For an excellent overview, see Ira Katznelson, *When Affirmative Action was White: An Untold History of Racial Inequality in Twentieth-Century America* (New York: Norton, 2005).

[32] Although this continued to the case when the Medicare proposal was first discussed within the administration, by the time that Medicare was proposed in Congress in the late 1950s, eligibility for Social Security had been expanded to include these groups.
[33] Lieberman 37.
[34] Theda Skocpol, *Boomerang: Health Care Reform and the Turn Against Government*. New York: Norton, 1996.
[35] David C. Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Kingston and Montreal: McGill-Queen's University Press, 1986), 166.
[36] The provinces, of course, argued that co-insurance payments should be considered a provincial contribution and thus eligible for federal matching. Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes*. Kingston and Montreal: McGill-Queen's University Press, 1978), 153.
[37] The federal position was only that provincial hospital plans should limit co-insurance fees so that they did not place an "excessive" financial burden on patients. Taylor, 1978: 135.
[38] See Gerard W. Boychuk, "Federal Spending in Health…Why Here? Why Now?" in G. Bruce Doern, ed., *How Ottawa Spends 2002-2003: The Security Aftermath and National Priorities*, (Don Mills, ON: Oxford University Press, 2002) 121-36.
[39] Thus, Taylor adjusts the data to include only those provinces without a public health insurance program. As a result, hospital benefit coverage in Canada in 1952 increases from 37.6% to 43.7%. Taylor, 1978: 65.
[40] Taylor, 1978: 199.
[41] Malcolm G. Taylor, *Insuring National Health Care: The Canadian Experience* (Chapel Hill: University of North Carolina Press, 1990), 66.
[42] A.E. Grauer, *Public Assistance and Social Insurance: A Study Prepared for the Royal Commission on Dominion-Provincial Relations* (Ottawa: King's Printer, 1939), 47.
[43] Tuohy, 1999: 47
[44] Taylor, 1990: 81.