RETHINKING THE DIVIDED WELFARE STATE: THE ROLE OF PRIVATE AND PUBLIC BENEFITS IN THE DEVELOPMENT OF PENSIONS AND HEALTH INSURANCE IN CANADA

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In recent years, academic attention has returned to an issue highlighted by Richard Titmuss half a century ago: the intersection of public and private social benefits (Titmuss 1958). This renewed interest in the public-private divide reflects an understanding that the extent and structure of private benefits can have a significant impact on the development of public programs. The dominant interpretation in the existing literature regarding the relationship between public and private benefits in the United States (especially work by Jacob Hacker) is that pre-existing private social benefits powerfully constrain the subsequent development of public benefits. Where public benefits emerge in the absence of such constraints, they are likely to be more comprehensive and universal with private benefits being relegated to a secondary role.

Given these expectations, the Canadian cases of pensions and health insurance presents a paradox. In Canada, the state was the first mover in the field of pensions and had the terrain largely to itself for at least four decades. Despite the fact that private benefits were not well-developed prior to the advent of public programs, the public benefit programs which did emerge were limited and left ample space into which private benefits eventually grew as a relatively equal pillar of the retirement income system. In contrast, despite the fact that private benefits were already well established before the state entered the health insurance field, the state simply displaced private benefits in two major steps, establishing a virtual public monopoly in core hospital and medical services, in some cases taking over private organizations to deliver the new public programs, and relegating private benefits to a supplementary role.

Does the Canadian case require a fundamental rethinking of the basic logic regarding the constraining effects of pre-existing private benefits and expansionary tendencies of public benefit programs where they emerge first? Answering this question requires looking beneath the outcomes to examine the political dynamics shaping these outcomes and doing so reveals a much more complex pattern in terms of the degree to which the predicted political dynamics, generated by conventional accounts of private and public benefits, emerged and were decisive to the resulting outcomes. In this regard, the central story is one of rich variation between pensions, hospital insurance and medical care insurance in terms of the political dynamics which emerged at both the federal and provincial levels and the degree to which they were determinative in shaping outcomes.

Public pensions did not generate expansionary dynamics sufficient to overcome the constraints posed – not by private benefits which were largely non-existent – but by the centrist political tendencies of the federal government as well as structural barriers to expansion posed by the constitutional assignment of jurisdictional responsibility for pensions in Canada. When the federal government did move to significantly expand its role in the 1960s, Canadian federal arrangements magnified the constraints posed by private benefits; however, these constraining dynamics would only partially counter-balance expansionary tendencies generated by federal-provincial politics centred around Québec nationalism. Thus, private benefits were not the main constraint on the expansion of public programs. To the degree that private benefits did pose constraints, this was primarily through their interaction with the institutional context of federalism in which they operated. Ultimately, these dynamics were overwhelmed by expansionary dynamics external to the politics of the private-public divide.

In hospital care insurance, in striking contrast to the existing literature, the existence of private benefits smoothed the way for the development of public benefits.

As in pensions, Canadian federal arrangements again magnified the effects associated with pre-existing private benefits but, this time, those dynamics operated in an expansionary direction. In the case of medical care insurance nearly a decade later, the constraining effects of private benefits were evident as had been in the case of pensions; however, as with pensions, they would be overwhelmed by expansionary dynamics generated by federal-provincial politics centred around Québec nationalism.

These cases suggest that expectations regarding the constraining effects of private benefits need to be tempered in a number of ways. First, pre-existing private benefits do not always act to constrain the development of public programs and these dynamics may operate in the reverse direction. Secondly, where constraining dynamics do emerge, they are highly mediated by the institutional context in which they operate. Thirdly, constraining dynamics, when they do emerge, may well be washed out by other, more powerful forces. Finally, there may be multiple constraints on the expansion of public programs and this suggests the need for caution in attributing too much causal weight to the constraining effects of private benefits.

To develop this analysis, the paper proceeds as follows. The second section provides a brief summary of the existing literature, especially that dealing with the United States, to identify key points for comparison. The third section turns to Canada, examining the public-private divide in pensions, both in the early decades and through its later evolution. The fourth section provides a similar analysis of the fields of hospital insurance and medical care insurance. Finally, the fifth section summarizes the findings about Canada, and reflects on their implications for comparative analysis.

THE LITERATURE ON THE PUBLIC-PRIVATE DIVIDE

Recent research on US experience has generated an interesting set of propositions regarding the relationship between private and public benefits at the inception of public programs.

In the United States, the scope of private benefits at the inception of public programs is argued to have had a strong role in determining whether public programs predominated or were relegated to a supplementary role. Hacker provides the fullest statement of this interpretation using pensions and health insurance to powerfully illustrate these different paths of development:

> *Divergence emerged between the two areas, however, because of the relative timing and sequence of public and private developments in the two areas. The passage of Social Security before private plans were widespread...created strong path-dependent processes in favor of the program... In contrast, the failure of health insurance during the New Deal and then after World War II created a path of policy development far less conducive to the eventual expansion of public authority. Subsidies for employment-based health benefits and for high-technology medicine created an expensive, fragmented system of health care finance and delivery that undercut the constituency for reform while raising the political and budgetary costs of policy change…* (Hacker 2002: 277-78).

Thus, public benefit programs implemented in the absence of a strong system of private benefits were more likely to be comprehensive and universal. Public programs introduced

after private benefits had come to play a core role in social protection were '...more likely to be limited to subsidizing private social provision and filling the gaps it creates' (Béland and Hacker 2004: 47).

Private benefits are argued to have constrained public programs in at least three ways: they fostered vested interests, they shaped public expectations, and they embedded institutions of private provision. Private benefits created vested interests both among providers (leading to the rise of organized interest groups) and beneficiaries (due to their habituation to private benefits). Private benefits shaped not only public expectations but also 'policy-makers' governing conceptions of the appropriate shape and scope of *public* social programmes' (Béland and Hacker 2004: 47). Finally, a direct challenge to private benefits, which have become a core source of social protection, 'entails large social dislocations and fiscal costs' (Béland and Hacker 2004: 47).

To examine these arguments about the interaction between public and private benefits at the time of the introduction of public programs, this paper considers pensions and health insurance in Canada in the period in which major public programs were first implemented.

PENSIONS IN CANADA

When considered against the backdrop of existing interpretations of the relationship between the development of public and private benefits, the Canadian experience generates something of a puzzle. The political dynamics which shaped the development of pensions in Canada were, at least partly, consistent with existing theories, but the final outcome in terms of the balance between the public and private benefits was not.

When the state moved into the pensions field in the 1920s, it entered largely empty terrain. Private pensions were available to a tiny minority of employees, and those that did exist were 'top hat' benefits for senior executives. As a result, pressure for the protection of elderly Canadians generally flowed towards the public sector, and the state responded by taking three major steps, which came in 1927, 1951 and 1967. Despite being the first mover for almost half a century, however, the state did not dominate the sector in the long run. Rather, the state carefully left room for the private sector to grow, which eventually happened in the second half of the century. The limits to the expansion of the state were therefore not set by the existence of private benefits systems. Instead, the limits to state action were set by the centrist political ideology of the Liberal Party, which was in power when each of the critical steps was taken, and by the complexities of federal-provincial relations. Even in the later stages of state expansion, when political dynamics mirroring those predicted by the existing literature did emerge, objections from the nascent private industry would be trumped by other political forces.

The first step came in 1926-27 from a minority Liberal government dependent for its survival on a small number of labour representations in the House of Commons. Under pressure from this left flank, the government introduced the Old Age Pension (OAP), a means-tested pension of $20 per month for those 70 years of age and older (Bryden 1974; Orloff 1993). The OAP was a federal-provincial program and full provincial adoption took nine years, with many poorer provinces joining only after 1931 when Ottawa raised its contribution from 50 to 75 percent of the costs. By the late 1930s,

however, a national system was in place, with reasonably comparable benefits prevailing across the country as a whole (Banting 1987).

Despite the smallness of this first step, which targeted only the poorest and oldest, the expansion of private pensions remained slow. A survey in 1938 suggested that less than ten percent of the labor force enjoyed some form of private pension (Industrial Relations Centre 1938), and a follow-up survey conducted in 1947 found little had changed (Dominion Bureau of Statistics 1950). The terrain was thus still largely unoccupied in 1951 when the public sector took its second step. A constitutional amendment gave the federal government authority to provide old-age pensions directly, as long as federal programs did not conflict with provincial ones. The federal government introduced the Old Age Security program (OAS), a universal, flat-rate pension of $40 per month paid to all citizens aged 70 and above, funded through general tax revenues. As Table 1 indicates, public support for the program was overwhelming across the country, with the exception of tiny Prince Edward Island, and was highest in Ontario, the province likely to have had the highest level of private insurance coverage.

Old Age Security did not fully meet the needs of the postwar generation. The goal of retirement as a distinct phase of life when people did not have to be employed was becoming a common aspiration, and the central question was whether the state or the private sector would be the vehicle for meeting these rising expectations.[1] Coverage of the labour force by private pensions did expand during the 1950s and early 1960s, especially after changes in prevailing interpretations of tax regulations provided greater flexibility (Latimer 1964). The number of private pension plans grew by 50 percent between 1960 and 1965. But as a government survey noted, the trend was still largely driven by a "sharp rise in so called 'top hat' plans designed primarily for senior executives and other key personnel," and overall plan membership grew by only a quarter in first half of the 1960s (Dominion Bureau of Statistics 1967: 7). Figure 1 tracks coverage of various forms of private retirement savings over a twenty-year period. As many covered individuals had multiple forms of savings, it seems unlikely that the proportion of the labour force with some type of private benefit in 1965 was much greater than a quarter (Bryden 1974).

In this context of slow private expansion, the Liberal Party returned to power at the federal level in 1963 with a commitment to an expansionist social agenda, including the introduction of a contributory pension plan which would be layered on top of the universal OAS. While committed to expanding the role of public benefits, the Liberal Party also remained true to its centrist political ideology. They never wished to dominate the retirement income sector completely, and in their most ambitious moments they still anticipated a relatively modest plan replacing 30 percent of average earnings. Their proposal was supported by organized labour, a wide range of social groups, and the social-democratic New Democratic Party, whose support the government needed to maintain a majority in the House of Commons.

The federal proposal faced two challenges. Following the expectations of the conventional wisdom, the emerging private pension industry fought to protect room for its future expansion. Opposition to contributory public pensions was led by representatives of the financial and insurance industries, which managed private plans, with support from the representatives of the large business organizations which sponsored the plans (Banting 1985; Bryden 1974). Industry's most important ally

throughout this battle was the government of Ontario, which was governed at the time by the Conservatives. As Table 2 reveals, the private pension industry was heavily concentrated in Ontario; no other province came close as a base for the industry. Moreover, links between the financial industry and the Conservative government were strong, and industry representatives were deeply involved in the province's pension planning. In contrast to the federal Liberal's emphasis on a public program, Ontario advocated a private-sector strategy, which would require employers above a certain size to provide occupational pensions, massively expanding the role of the private sector in the retirement income system.

Because full contributory public pensions required an additional constitutional amendment for which Ontario's support was essential, the province was in a strong legal position. But the province was in a tricky political position. Although private pension coverage was higher in the province than in other parts of the country, a majority of Ontario workers still did not have such protection, as Table 3 shows.[2] Consistent with the conventional interpretation regarding the link between low levels of private coverage and public programs, the federal proposal was popular with Ontario voters and the provincial government, clearly recognizing this, accepted that contributory pensions of some sort were probably inevitable. But the province and the financial industry held out for a limited plan that left ample scope for private pensions and minimized redistribution by relating individual contributions and benefits closely.

The second major challenge came from the province of Quebec, which chose to invoke its constitutional paramountcy in the field and introduce its own plan. This step would not only protect the province's role in social policy. It was also a tool of nation-building for *québécois* nationalists. As Table 2 makes clear, few private pension plans were actually headquartered in the province, and a separate Quebec plan would enhance the province's role in the financial sector. By opting for a partially funded plan, the province planned to create a pool of public capital that could be invested in the economic development of the province. The government agency that manages the QPP fund, the *Caisse du dépôt and de placement du Québec*, emerged as the owner of the largest portfolio of stocks in Canada and a critical purchaser of bonds issues by the provincial government and public corporations engaged in major developments in the province, especially *Hydro Québec*. For Quebec nationalists, the *Caisse* symbolized a growing *québécois* presence in the world of finance, a training ground for French-speaking financial executives, and a key instrument of provincial industrial strategy (Banting 1985; Brooks and Tanguay 1985). As we shall see below, the symbolism of Quebec's decision to opt out of the Canada Pension Plan and operate its own plan was crucial in setting the stage for the politics of medical care insurance, which unfolded shortly afterwards.

Initially, federal officials assumed Ontario would be the major obstacle, and trimmed their sails accordingly. For example, they reduced the proposed replacement rate from 30 per cent to 20 per cent of average wages in the hopes of winning over the province. But during a 1963 federal-provincial conference, the Quebec government created a sensation by outlining its plan, which included more generous benefit levels and a more redistributive funding formula. Moreover, in contrast to the federal preference for a pay-as-you-go model, Quebec's model of a partially funded plan which would purchase provincial government bonds was attractive to other provinces as well. At that point, the federal proposal was dead. A final round of secret negotiations between the federal

government and Quebec produced a compromise plan: the federal government accepted partial funding; Quebec accepted an earlier phase-in of benefits; the replacement rate was set at 25 per cent of average monthly earnings, lower than the federal government's initial preference but higher than its Ontario-focused version; and the plan had broader benefits and a more redistributive structure than the federal government had originally anticipated.

The Ontario government and the insurance industry were not happy and, in the words of the leading federal negotiator, felt that the federal government "had used Quebec to turn the tables on them" (Kent 1988: 286). In the end, however, Ontario accepted the need for parallelism with Quebec. But it inserted on an important concession over the future development of the plan. To gain Ontario's agreement, changes to the CPP were to be subject to a complex joint-decision process. Changes would require the consent of the federal government and two-thirds of the provinces representing two-thirds of the population of the country, a requirement which is more demanding than the amending formula for most parts of the Canadian Constitution. Critically, the formula gives the province of Ontario a veto.

By 1965, the basic structure of public pensions in Canada had been established. Despite enjoying the first-mover status for four decades, the state has created a relatively 'liberal' regime of public pensions. The contributory plan was limited to 25 percent of average wages. In combination, the universal OAS and the maximum benefit from the C/QPP replace approximately 40 percent of earnings for the average wage earner, a modest amount by European and even US standards (Béland and Myles 2005). Consistent with this liberal ethos, the strength of the Canadian system is at the bottom of the income distribution. A Guaranteed Income Supplement, also introduced in 1965, provides an income-tested supplement for the elderly, which significantly enhancing the public replacement rate for low-income workers but left a modest replacement rate in the middle of the earnings range (Brown and Ip 2000).

The public sector had left room for the private sector to grow, and over the following decades growth did come, nurtured in part by generous tax treatment. By the 1980s, close to 40 percent of workers were covered by a private pension and a similar portion of Canadians invested in individual tax-assisted savings accounts known as Registered Retirement Savings Plans (RRSPs). As these plans matured, the sources of retirement income shifted. In 1960, private pensions provided about 10% of the income of elderly Canadians (Podoluk 1968: 230-37). By the new century, a new parity between public and private benefits had emerged. Figure 2 tracks the trends. By 2004, the C/QPP share had grown to about 20 percent of all retirement earnings; in combination with the OAS/GIS, the state was providing about 45 percent. But private retirement income from private pensions and RIFs (the name given to RRSPs when they pay out income) had risen to be the largest single source of income at almost 35 percent. When combined with other investment income, private instruments also represented about 45 percent of total income.

Summary: Despite the first mover status enjoyed by the public sector for almost half a century, the state chose not to fully dominate the retirement income sector in Canada. At each stage, significant space was left for private retirement savings instruments. The parameters of the development of public benefits were defined, not by the prior existence of private benefits, but by the centrist ideology of the Liberal Party

governments which led public sector expansion, and the complications inherent in the Canadian constitutional division of powers. When the federal government did move to occupy more of this policy space in the mid-1960s, the complexities of divided jurisdiction magnified the voices of those opposed to public pensions including vested interests associated with private pension benefits in the battle over contributory pensions. The advantages created by the Canadian system of federalism were not absolute, however, and were partially trumped by other more powerful political forces, such as Quebec nationalism. Conservatives only real victory was to build a fence around the new public plan to limit its growth and preserve space for the future growth of the private sector. It was not until the latter part of the century that private benefits grew to fill the space carefully preserved for them.

HEALTH INSURANCE IN CANADA

The outcomes of the process of development of private and public benefits in health insurance similarly generate a puzzle given existing interpretations of the relationship between the development of public and private benefits. While the expected dynamics emerged in the case of medical care insurance (though the final outcomes were quite different than expected), fundamentally different dynamics emerged in the case of hospital care insurance.

In terms of outcomes, the Canadian state simply displaced existing private benefits, introducing universal hospital and medical insurance in two major steps with the introduction of a federal cost-sharing program for universal hospital care insurance in 1957 and the introduction of a similar program for medical care insurance in 1966. During the introduction of hospital insurance in the 1950s, pre-existing private benefits in the crucial province of Ontario actually facilitated rather than constrained universal public insurance. In contrast, during the introduction of universal medical insurance in the 1960s, significant private medical benefits in that province posed a serious obstacle to the Saskatchewan governments attempts to introduce public medical insurance although the latter would ultimately prevail. While the opposition to a national program from the three provinces with the highest levels of private benefits follows the expectations of the conventional wisdom regarding the constraints posed by private benefits, this resistance was trumped by the federal government's desire to use medicare as a tool of nation-building.

Hospital Care Insurance

In some sense, outcomes in the area of hospital care conform with the conventional wisdom regarding the public private divide. Public hospital care insurance programs emerged first in provinces such as Saskatchewan and British Columbia where private benefit coverage was relatively low and only later, and with greater resistance, in other key provinces such as Ontario and at the federal level. However, government support for universal public health insurance in Ontario, where private benefits were widespread, runs contrary to existing interpretations regarding the constraining impact of private benefits. This expansionary dynamic, as it emerged in Ontario, reverberated at the federal level. The federal government, which faced a national constituency for which the incidence of private benefits was considerably more moderate than Ontario, was also

relatively moderate in both its support for – but also opposition to -- universal public hospital care benefits.

Universal public hospital insurance benefits emerged earliest in Saskatchewan in 1947 and British Columbia in 1949 where private insurance benefits were only weakly developed. The Canadian federal system magnified the importance of the ideological trends developing in these provinces. In Maioni's classic statement of this argument, the federal system not only 'encouraged the formation of a social-democratic third party' (the Cooperative Commonwealth Federation which would later become the New Democratic Party) but also provided opportunities to innovate at the provincial level, and thereby 'enhanced its efficacy in promoting health policy reform.' (1998: 6) At the same time, in both provinces there was a very limited set of private hospital insurance benefits in existence (although somewhat higher in British Columbia than in Saskatchewan) such that the pre-existence of private benefits posed little resistance to the development of public hospital insurance benefits.

While much attention has rightly been paid to developments in Saskatchewan, the politics of the public-private divide in Ontario, Canada's largest province, were also critical. The federal government, which was lukewarm at best about implementing a federal program for public benefits, was only willing to implement a national plan if the program included a majority of the provinces representing a majority of the Canadian population – thus effectively requiring the participation of Ontario, which is by far the largest province. Here, both the political dynamics and the ultimate policy outcomes run contrary to existing interpretations regarding the constraining dynamics of private benefits.

While the scope of private benefits for health services was significant across Canada, this was especially the case in Ontario. On the eve of the advent of a national program in 1956, 70 percent of the population of Ontario had hospital insurance coverage (see Figure 3). In Ontario, private benefit plans contributed just under half of all hospital revenues (46 percent), making private benefits a much larger source of hospital revenue than either government funding (22 percent) or out-of-pocket payments (29 percent). (See Figure 4.) Despite widespread public benefits, Ontario in 1955 announced its support for a national public insurance program, and the federal government acted soon afterwards: "By assuming leadership of those pressing the federal government in 1955…, the Ontario government was clearly the determinative force that brought the nationwide system we now have" (Taylor 1978: 158).

Indeed, in several ways, the existence of a well-established set of private benefits in Ontario facilitated the adoption of a system of public benefits.[3] The growth of private benefits had certainly created commercial interests that were strongly opposed to universal public hospital benefits. While the Ontario government was not ideologically predisposed towards public benefits, Premier Leslie Frost, did not seem particularly concerned with the opposition of the industry and took several opportunities to publicly challenge the industry. In terms of the contribution of private benefits to the development of public benefits, first, they established public acceptance of the collective insurance principle. Second, private benefits created a ready-made revenue source as the Ontario government viewed private premiums as a pre-existing self-imposed tax. Third, the extent of private benefit coverage assuaged concerns on the part of policymakers about compliance and achievement of universal coverage. The Ontario government

proceeded in the belief that the large portion of the population that was already covered could be easily moved over to public coverage – helping to resolve the problem of adverse selection. Finally, private benefits helped address the critical issue of administrative capacity as the province simply converted the largest non-profit voluntary insurance plan (Blue Cross) into the public agency responsible for administering the new public program.

Private benefits did not simply ease the implementation of public benefits by increasing taxing and administrative capacity, pressure in favour of adopting hospital care insurance was generated by strong public support in the province for public hospital insurance benefits which existed in a context of extensive private benefits. Had Ontario faced a relatively clean slate in terms of private benefits as had Saskatchewan in 1947, the obstacles to moving ahead might have been much more difficult (Taylor 1978: 119-20).[4] This logic also helps explain why hospital insurance developed earlier than medical insurance for doctors' services, despite the fact that private hospital coverage was much higher than private medical coverage (see Figure 3).

Indicative of the challenges of moving ahead with public benefits in the absence of private benefits is the case of British Columbia. Private hospital insurance under the auspices of Blue Cross had been in existence for just under a decade when its physical equipment and staff were subsumed into the British Columbia Hospital Insurance Service (BCHIS). (Taylor, 1978: 167) However, the low administrative capacity of the private benefits system was insufficient to serve the needs of the new public program. The problems resulting from the lack of pre-existing administrative capacity brought the very existence of a universal public hospital insurance program into question. The results of this low level of administrative capacity were high levels of uninsurance, unpaid premiums, unpaid hospital bills – all of which led to increasing public, media and legislative criticism resulting in investigation, inquiries, resignations and, ultimately, the resignation of the minister. (Taylor, 1978: 167-8) Hospital insurance became "…the most bitterly emotional and controversial issue in the 1952 election campaign" and resulted in the defeat of the government. (Taylor, 1978: 168) By early 1954, premiums for hospital insurance were abolished and financing of the program was shifted to the social services retail sales tax. As Taylor notes, "British Columbia…paid part of the tuition costs in educating Canadian governments in the formulation of effective policies and administrative procedures in this most complex of the social insurances." (Taylor, 1978: 169) One of the lessons certainly related to the lack of pre-existing administrative capacity on which to base the provincial program.[5]

Physician Care Insurance

Despite having lower levels of private benefit coverage than was the case in hospital care (see Figure 3), a universal public program for medical care, including physician services, did not emerge until the 1960s -- by which time private benefit coverage had reached levels comparable to those for hospital care at the inception of national hospital insurance. (See Figure 5.) At the provincial level, the dynamics which emerged conform to the conventional wisdom regarding the constraining effects of private benefits and, with the exception of Saskatchewan, the outcomes also conform: each of the four largest Canadian provinces (with the highest levels of private insurance) adopted (or planned to adopt) non-universal public plans that would leave ample room

for private benefits. At the federal level, significant constraining effects resulting from private benefits emerged but were washed out by broader, much more powerful dynamics relating to Canadian federalism and the imperative of the Canadian government to ensure the territorial integrity of the Canadian state.

In contrast to 1947 when Saskatchewan was basically facing a clean slate in the construction of its hospital insurance benefits program, in the 1960s in medical care insurance, Saskatchewan faced a powerful obstacle in physician-controlled private physician care benefits.[6] Moving forward with public physician care benefits required the province to confront the medical profession and expropriate its major revenue source – its near monopoly control of private medical care benefits, which in 1960 extended coverage to just under 40 percent of the Saskatchewan population through plans directly controlled by the Saskatchewan College of Physicians and Surgeons (Taylor 1978: 328). Nevertheless, after an intensely bitter confrontation and strike by doctors, Saskatchewan established a universal public medical care plan. The constraining dynamics of private benefits emerged but were not sufficiently powerful to prevail in the face of the ideological commitment of the Saskatchewan government. It was the strong ideological commitment on the part of the Saskatchewan government in the face of significant resistance that allowed for the emergence of universal public physician-care benefits.

Similar dynamics emerged in other provinces but, in these cases, the constraining dynamics, consistent with the ideological predispositions of the various provincial governments, would prevail. While private hospital insurance coverage rates had only exceeded 50% in two provinces and 70% in one province in 1956, medical care coverage by 1965 was higher than 50% in six provinces and in excess of 70% in the three most populous English-speaking provinces. As the standard interpretation would predict given these higher levels of coverage, the constraining dynamics posed by pre-existing private benefits were much more clearly in evidence in regard to physician care insurance than had been the case for hospital care insurance.

The three largest English Canadian provinces (Ontario, BC, Alberta) with the highest levels of surgical and medical care coverage in Canada almost immediately introduced plans that would rely primarily on employer-provided medical care insurance and subsidized (or government offered) insurance for those with low incomes – thus incorporating a very strong role for private benefits in conformity with the positions of both the medical profession and insurance industry (Taylor 1978: 328).[7] (See Figure 5.) In the case of Alberta, the provincial program was a highly explicit and deliberate attempt to provide a counter-example to the universal program adopted in Saskatchewan. With this level of provincial support, it appeared that the private benefit model would dominate: 'With three of the four most powerful provincial governments adopting CMA-CHIA policy, the odds in favour of the market economy approach and against the political economy philosophy...had shifted most favourably' (Taylor 1978: 348).

Similar constraining dynamics resulting from private benefits emerged at the federal level. Clearly, the federal government was certainly sensitive to the powerful opposition of the insurance industry. In the end, however, the federal government opted for universal public insurance, and that choice predominated. A variety of factors tipped the federal choice. The interaction between developments in pensions and health insurance was crucial, with the province of Québec playing a catalytic role. Québec, home to the vast majority of Canada's French-speaking minority population, had

embarked on an aggressive program of asserting provincial dominance in social policy. As discussed in the previous section, Québec announced its intention to build a separate provincial pension program at a federal-provincial conference of September 1963. This decision was perceived as a major loss for the federal government and raised serious concerns about the integrative capacity of national social policy. When combined with related decisions on other programs, Québec was effectively opting out of all major national universal social programs including youth allowances, pensions, and hospital insurance.[8] However, opting-out need not necessarily apply to new programs, and a national system of public medical care insurance provided a new opportunity to help redress the perceived imbalance between provincial and federal predominance in social policy. Under a federal shared-cost program, the link with individual citizens would be indirect but, nevertheless, a universal program certainly reflected the idea of pan-Canadian social rights of which the federal government could cast itself as guarantor. It was in this context that the federal government announced its intention to move forward with medical care insurance in the Speech from the Throne in April 1965. Legislation was to be passed in 1967 and came into effect in 1968. By 1971, all provinces had opted in to the universal program.

In this case, the province of Québec was key and public support in that province for universal medical care insurance was the highest of all provinces. In keeping with the expectations in the literature, support for the proposed universal medical care insurance programs was highest in Québec and Atlantic Canada – where private benefit coverage was lowest -- and lowest in Ontario where private benefit coverage most widespread. (See Table 4.) Following the inception of programs for both hospital and medical care services, public programs would come to dominate both areas – predominance that would remain unchallenged even into the next century. (See Figure 6.)

Summary

In hospital care insurance, there was little drive at the federal level to implement a program of public benefits – perhaps reflecting the moderate level of private benefits across the country which neither resulted in a strong imperative to fill a vacuum nor created a set of insurmountable obstacles to public benefits. In Saskatchewan, facing relatively particular conditions, public hospital insurance benefits had moved ahead in the relative absence of private benefits. However, in British Columbia, moving ahead in the absence of private benefits almost proved disastrous for the public health insurance benefit program. Following this logic, in Ontario, it appeared that the existence of private benefits was a precursor to public benefits in terms of providing administrative capacity, public habituation to premiums, and public support for the collective insurance principle.

In the second round of health insurance reforms relating to physician care insurance, the pre-existence of private benefits did not contribute to easing the introduction of public benefits as it had earlier.[9] Rather, the political dynamics which emerged at both the federal and provincial levels conform with the expectations generated by the existing literature: the constraints posed by vested interests – both among the business sector and the public – appeared poised to predominate. At the federal level, existing private benefits created strong resistance on the part of vested interests to a universal public program and national public opinion on a federal program

of universal public physician care insurance appeared mixed. Similarly, at the provincial level, public opinion in provinces with highest private coverage rates demonstrated less support for universal public benefits than provinces with lower levels of private benefits. Among the former provinces, the three most-populous English-speaking provinces brought in plans for voluntary public insurance which would leave scope for private benefits to predominate in physician care insurance. Nevertheless, in response to concerns related to territorial integration, the federal government implemented a universal physician care insurance program based on the level of public support for universal public benefits in Québec – where private benefits were less pervasive and popular support for public benefits higher. Thus, in the case of physician care insurance, conventional political dynamics generated by the presence or absence of pre-existing private benefits were clearly evident but the outcomes generated by these dynamics were significantly transformed by the territorial politics of federalism.

DISCUSSION

Canadian experience in health insurance and pensions presents a paradox. In the case of pensions, the state had the field largely to itself for at least four decades. Yet private pensions eventually expanded to become an equal pillar in the retirement income sector. In the field of health insurance, private benefits were well-developed before public benefits emerged. Nevertheless, the state simply displaced private benefits, establishing a virtual public monopoly in core hospital and medical services, in some cases taking over private organizations to deliver the new public programs, and relegating private benefits to a supplementary role. Hence the Canadian paradox: public benefits came to dominate in the field where private benefits had already emerged strongly before the state entered; and private benefits expanded most in the field in which the public sector was unrivalled for close to half a century. At least in terms of outcomes, Canadian experience stands in contrast to that of the United States where the development of private benefits in the areas of pensions and health insurance fits with the argument that pre-existing private benefits powerfully constrain the expansion of public benefits.

A consideration of the dynamics underpinning these paradoxical outcomes generates a more nuanced picture which is less discordant with the conventional expectations regarding the constraining effects of private benefits albeit which suggests that such expectations need to be significantly tempered. First, strong pre-existing private benefits do not always constrain public benefits. The case of hospital care insurance demonstrates that pre-existing private benefits may actually facilitate rather than limit the introduction of public programs. Secondly, Canadian experience reminds us that there are multiple constraints on the expansion of public benefits, and we should be careful about over-emphasizing the role of private benefits. In the case of pensions, it was the federal state itself that, for a long period of time and in the absence of pre-existing private benefits, carefully preserved space for private benefits as a result of the centrist political ideology of the governing party. Thirdly, even where the expected constraining dynamics do emerge, external political dynamics can decisively trump the constraining dynamics of private benefits. In the case of both pensions and physician care insurance, constraining dynamics did powerfully emerge but were, nevertheless, overwhelmed by broader political realities. Finally, expansionist and constraining dynamics do not operate independently of the larger political and institutional context in

which they operate. In pensions, the Canadian federal system, due to the geographical concentration of the private insurance industry, magnified the constraining effects generated by pre-existing benefits – without which the state would have been likely to expand public benefits more significantly. In hospital care insurance, expansionist dynamics generated by the pre-existence of private benefits in Ontario were similarly magnified.

In each of these cases, the political dynamics resulting from the particular sequencing of the establishment of public and private benefits are important; however, they are but one set of various dynamics which interact within particular institutional contexts to produce outcomes that are anything but predetermined.

ENDNOTES

[1] The concept of retirement from employment, especially as early as age 65, was some distance off at this point. The 1961 census revealed that income from employment was still the largest source of income for families whose head was aged 65-69 and as important as government transfers for families whose head was aged 70 and above (Podoluk 1968: 230-31).

[2] The data in the table are for 1970, when a new survey was initiated. However, private coverage had not changed much by 1970, and the table is undoubtedly broadly relevant to the mid-1960s as well.

[3] The following draws from Taylor 1978: 110-24.

[4] These factors mattered less in Saskatchewan because of its small size and strong municipal system which could be used to collect premiums.

[5] Not surprisingly, when the neighbouring province of Alberta introduced its hospital insurance program in mid-1950 (at which point, the administrative problems of the BC program would have been very evident), it opted against a provincially-administered program in favour of providing provincial subsidization to municipally-administered and financed programs.

[6] Because Saskatchewan already had its own hospital insurance program, the advent of federal cost-sharing for hospital insurance provided Saskatchewan with a large financial windfall which allowed the province to move ahead on public medical care insurance.

[7] In the 1960s, Ontario's position in regard to both pensions and physician care insurance was highly consistent – revealing a strong preference for allowing private benefits to predominate while public benefits would be relegated to a secondary role. This preference was consistent with the approach of the previous Conservative administration under Premier Leslie Frost. This raises the question of why pre-existing private benefits appear to have contributed to conventional effects in the case of pensions and physician care insurance where they had not in hospital care insurance a decade earlier.

[8] 'Opting-out' of established federal programs and running separate provincially-defined programs was an option which the federal Liberal Party had espoused while in opposition in the early 1960s.

[9] Once administrative capacity was established in provinces through their hospital insurance programs and public support for the collective insurance principle (whether public or private) became embedded, the pre-existence of private benefits in the area of physician care insurance was probably much less critical in the establishment of public benefit programs.

Table 1 Public Attitudes towards the Introduction of Old Age Security, 1951

Province	Approve	Disapprove
Newfoundland	90.0	10.0
PEI	42.9	57.1
Nova Scotia	69.5	30.5
New Brunswick	80.0	20.0
Quebec	84.2	15.8
Ontario	87.8	12.2
Manitoba	86.4	13.6
Saskatchewan	83.8	16.2
Alberta	75.4	24.6
British Columbia	76.7	23.3
Canada	83.1	16.9

Note: The question asked was: "Next year, every Canadian 70 years of age and over will start getting a pension of $40 per month, regardless of their financial position. Do you approve of this?"

Source: Canadian Gallup Poll, August 1951, Question 212

Table 2 Distribution of pension plans, by province, 1960

Province	Proportion of all pension plans headquartered in province
Newfoundland	0.5
PEI	0.4
Nova Scotia	2.4
New Brunswick	1.8
Quebec	16.0
Ontario	50.7
Manitoba	7.1
Saskatchewan	3.8
Alberta	7.2
British Columbia	9.5

Source: Dominion Bureau of Statistics

Table 3, Private pension membership by region, 1970

Region	Plan Members	Regional labour force	% coverage
Atlantic	205,482	658,000	31.2
Quebec	740,471	2,328,000	31.8
Ontario	1,222,116	3,130,000	39.0
Prairie	385,793	1,380,000	28.0
British Columbia	241,511	878,000	27.5

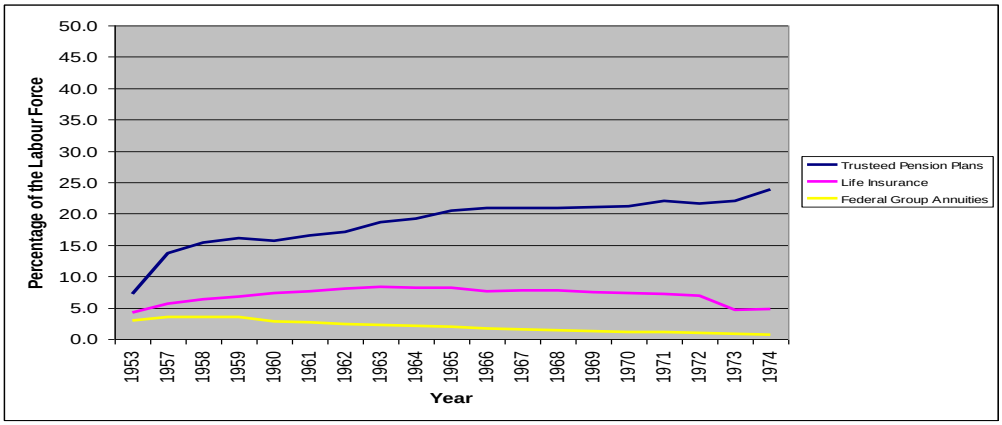
Sources: Pension membership data from Statistics Canada 1970, Table 3; data on labour force from Statistics Canada 1983

Table 4: Support for Medicare, Canada, by Region, 1968

	National	Atlantic Canada	Québec	Ontario	West
Support for Medicare	55%	58%	64%	49%	55%
Medicare should be dropped	19%	20%	12%	23%	19%

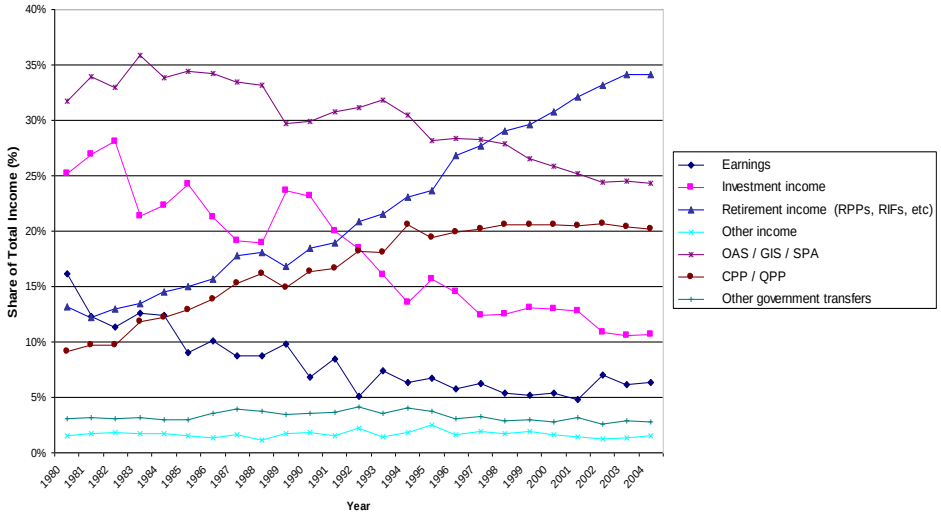
*Figures for Atlantic Canada are not reported in Taylor, 1998: 391 are extrapolated by author using national figures.

Figure 1: Members of Private Pension Plans as Percent of Labor Force, 1953, 1957-77



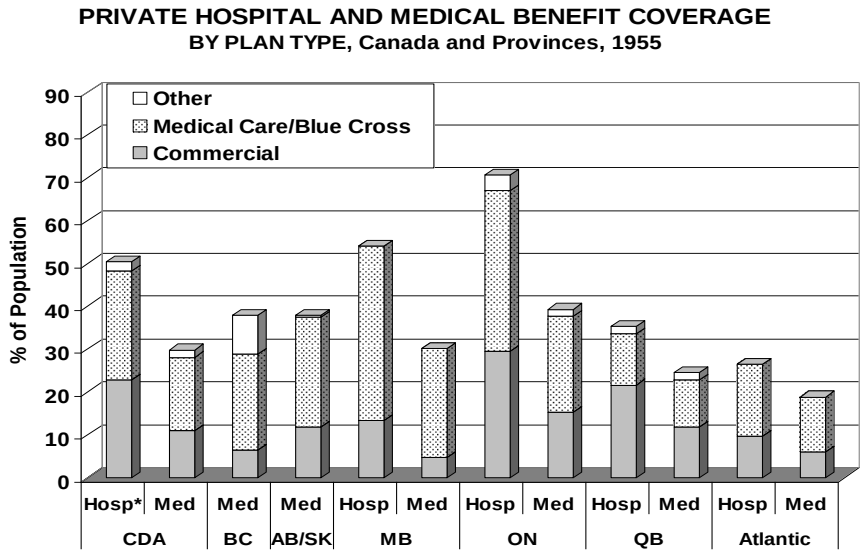
Source: Data on memberships in private plans from Dominion Bureau of Statistics (1952-1974); data on the labor force from Urqhart 1965 and Statistics Canada 1980.

Figure 2: Income Sources of the Elderly, as a Percent of Total Income, 1980-2004



Source: Data from Statistics Canada CANSIM, Table 202-0407.

Figure 3: Private Hospital Benefit Coverage, By Plan Type, 1955



*Average hospital coverage for Canada includes the six provinces without an existing public hospital insurance plan – Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia and Prince Edward Island.

Figure 4: Provincial Hospital Revenues, By Source, Available Provinces, 1956

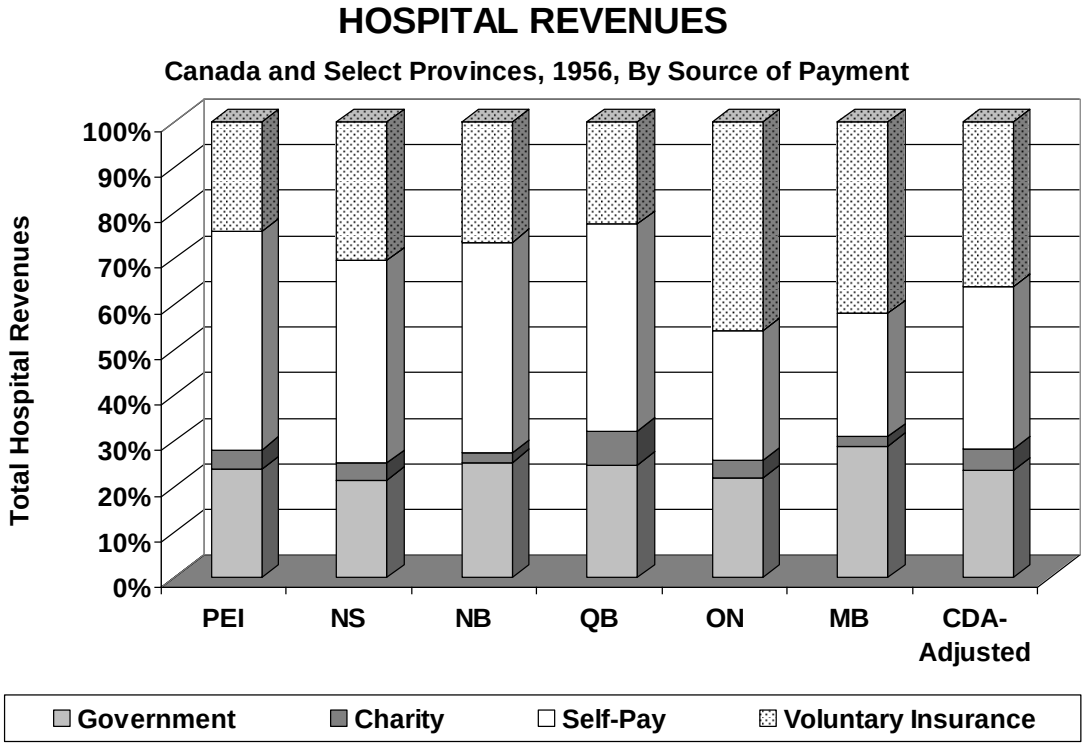


Figure 5: Private Surgical and Medical Benefit Coverage, By Plan Type, 1965

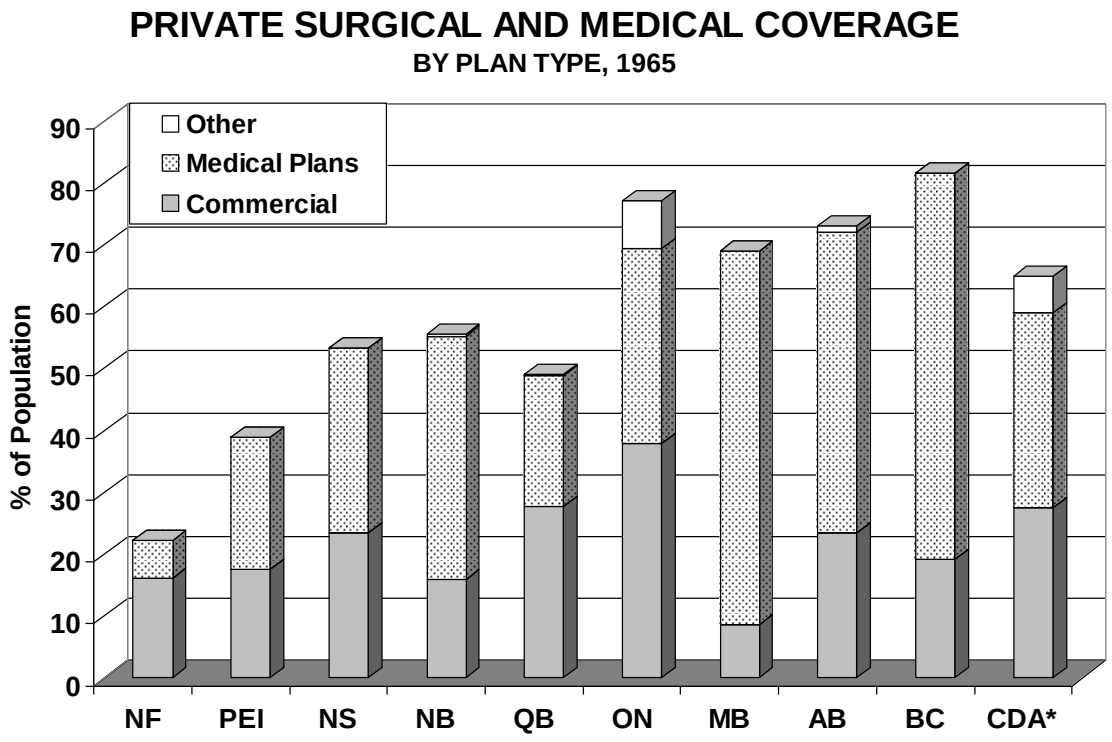
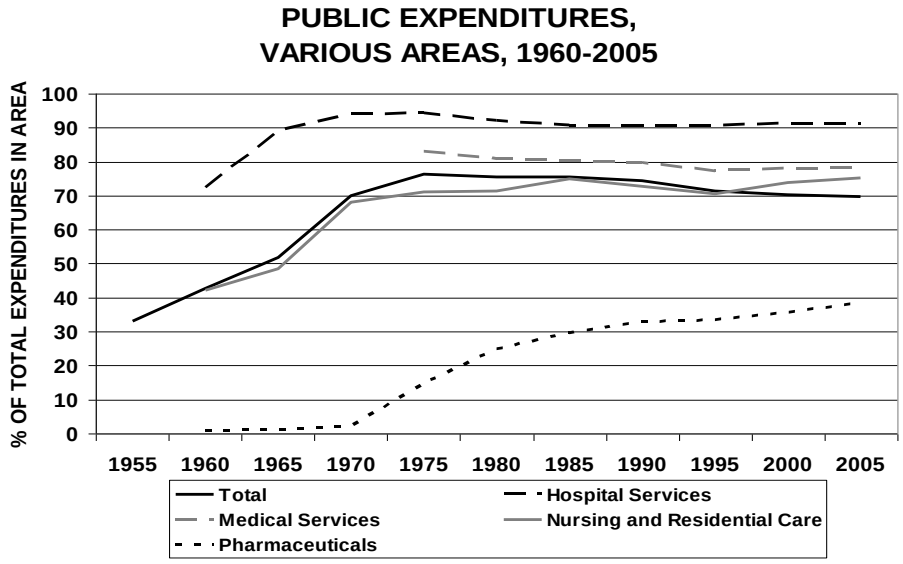


Figure 6: Public Health Expenditure as Proportion of Total Expenditure, By Area of Provision, 1955-2005



Source: Canada, National Health and Welfare, 1955; OECD, 2006. Pharmaceuticals include prescription drugs as well as other personal health non-durables. A breakdown in public-private funds for medical services is not available prior to 1975.

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