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The Development of Health Insurance in Canada and the United States, 1940-1965

Antonia Maioni

Frequently raised in recent discussions about health care reform in the United States has been the model of the Canadian health insurance system. While debates about health insurance often turn into polemical battles over which country offers the “best” health care for its citizens, the issues at stake raise a fundamental question. Why did these two neighbors develop different forms of health insurance, a universal system of government-financed health care in Canada and a dual-tiered system of Medicare and Medicaid targeted at the elderly and poor in the United States? The contrast is even more significant when we consider that these two countries, generally classified as “liberal” welfare states, share many common economic, political, and social attributes and resemble one another in many of the features that influence welfare state expansion. Why, then, did Canada and the United States embark upon two very different paths to health reform, one of the most important pillars of the welfare state?

The extensive literature on the development of the welfare state provides us with at least three clues as to the types of factors that can explain divergent paths to health reform in Canada and the United States: the influence of social forces, the role of state actors, and the impact of state structures and political institutions. Social explanations concentrate on the role and influence of organized groups by examining the power of professional groups and business interests in shaping social reform. Neo-Marxist explanations focus on how social policy reflects the class struggle and demonstrate the correlation between higher social expenditures and the political strength of the working class mobilized into a social democratic party. The state-centered approach emphasizes the role of individual state actors, influential bureaucrats, and political leaders in setting the policy agenda and shaping legislation and the state’s administrative capacity to implement social reform. The recent application of neoinstitutionalism to the study of the welfare state has further enhanced our understanding of the interaction between social forces and the state in the development of social policy. This approach builds on the idea that the “rules of the game” of a political system impose certain constraints and opportunities conditioning legislative outcomes. These rules are derived from the constitutional settings that shape political institutions.
This article contributes to the theoretical debate by looking at how demand for health reform was conditioned by the political institutions shaping party systems in Canada and the United States. I argue that the federal structure and parliamentary institutions of the Canadian political system encouraged the formation of a social democratic third party and enhanced its efficacy in promoting health policy reform. The institutional constraints of the American political system, in contrast, impeded the emergence and consolidation of this type of policy “entrepreneur” and forced the proponents of health reform to restrain their strategies in order to appeal to a wider coalition within the Democratic party. The research methodology used in this article is based on comparative historical analysis, which involves examining the historical evidence for causal regularities and evaluating different explanatory factors that can account for divergent paths to social reform. Here, I trace the postwar development of health reform in Canada and the United States, concentrating on the quarter century between 1940 and 1965 when the two countries parted in their approach toward health reform. The significant difference, as the historical evidence suggests, is the presence of a social democratic third party in Canada able to influence the trajectory of health reform that resulted in the implementation of public, universal health insurance.

Institutions, Parties, and Health Reform

Institutional arrangements have been identified as among the most important constraints still faced by health reformers in the United States. Still, the linkages between institutions and policy outcomes remain quite complex. Recent neo-institutionalist research, both historical and comparative in nature, has tried to show the actual processes by which institutions have an impact on policy outcomes in the United States and other industrialized countries. One of the important linkages is the way formal institutions condition the crucial role of political parties in the policy process, particularly since parties serve an intermediary function between state and society in democratic political systems. In this analysis, I emphasize how formal rules led to the emergence of a third, left-wing party in Canada, but not in the United States, and how this third party was able to exert considerable influence in the development of health policy.

Parliamentary government and federalism are the two institutional attributes that stand out in explaining the differences between party systems in Canada and the United States. The first defines the rules of the game of legislative politics in the two countries. Both Canada and the United States have single member plurality electoral systems, which usually reinforce two party dominance and reduce the potential for third party representation. However, as cross-national studies of party systems have shown, the electoral system can not fully account for the differences
in the number of parties in Canada and the United States.\textsuperscript{14} While major party “failure” has often led to the emergence of political protest movements in the United States, such movements have not, at least in the twentieth century, been successful in consolidating electoral support.\textsuperscript{15} By comparison, several third parties have emerged and persisted at the federal level in Canadian politics.\textsuperscript{16}

The rules of Canadian parliamentary government offer certain opportunities for third party formation and efficacy that do not exist in the United States. One of these rules is parliamentary party discipline. Major parties in Canada are thus less capable of absorbing dissident factions, groups, and individuals either in or out of parliament. In the United States the broad coalitions represented under major party labels allow them to absorb protest movements more readily, especially given the structural barriers imposed on ballot access and the primary system of candidate selection.\textsuperscript{17} The presence of third party candidates in the United States has been influential in modifying major party platforms and realigning their political bases, but only rarely have these third parties functioned as autonomous political forces.\textsuperscript{18}

Moreover, even though third parties in Canada have little immediate chance of forming a government, they can nevertheless influence federal policymaking. As issue “entrepreneurs” they can bring serious alternatives to the policymaking agenda and sustain them in a prominent national forum, the House of Commons. They can also pose a potential electoral threat, particularly if their support is regionally concentrated, and their platforms often serve as lightning rods for voter discontent. Under minority governments they hold the effective balance of power over the government and its policies. In the U.S. Congress, in contrast, third parties have limited potential as an independent political force because of the complex rules of the committee system and control by the two major party caucuses. The representation of ideological dissent is submerged within the broader exigencies of party representation, such as the absorption of labor and the left within the Democratic party.\textsuperscript{19}

Second, federalism has a significant institutional impact on the party system. The Canadian political system does not include a central institution that can effectively represent regions and provinces at the federal level, such as the U.S. Senate.\textsuperscript{20} Federal governments in Canada, while sensitive to regional concerns, do not necessarily have balanced representation from all regions in their party caucus or cabinet. Indeed, enduring regionalism has contributed to the rise of third parties and to their viability at both the federal and provincial levels. In the provinces, such parties have often supplanted one or both of the traditional major parties and reorganized the provincial party landscape.\textsuperscript{21} Because of the more decentralized nature of Canadian federalism, the many policy areas (including health policy) constitutionally considered to be under provincial responsibility, and the influential role of provincial governments in intergovernmental relations, the provinces exercise more independent power than American state governments.\textsuperscript{22}
the election of third party governments in the provinces can have significant implications for policy innovations.

The expression of regional differences by third parties is much more pronounced in Canada than in the U.S., where it can be channeled through regional blocs within the major parties. Where third parties have come to power at the state level, many used the machinery of existing major parties and usurped major party labels in their state organization. While “radical” state-level third parties, particularly in the American midwest in the first decades of the twentieth century, had some impact on the major parties, their influence was nevertheless limited by the encroachment of the federal government in the area of social policy and the ability of national parties to absorb their protest platforms.23

These two institutional attributes, parliamentary government and a distinctive form of federalism, provide opportunities for the rise of third parties in Canada and enhance their potential influence over the choice and elaboration of policy alternatives. In the case of health policy, the political expression of the left was pivotally important in shaping the divergent paths to health reform in Canada and the United States. The presence of a social democratic third party in Canada spurred universal health insurance to national prominence as a viable alternative in the health reform debate and focused powerful political pressure that led to the passage of legislation. By contrast, the absence of an independent voice for the left in the United States ensured that the agenda for national health reform would be set within the limits of the Democratic party coalition. The multiple veto points where opposition can be expressed in the American political system made it much more difficult to repel opposition to health reform than in Canada and further weakened attempts to achieve universal health insurance in the United States.

Health Reform in Canada: The Role of the CCF-NDP

Health Insurance and Postwar Social Security24 Prior to 1940, the Canadian government spent little effort addressing health reform. Partly, substantial jurisdictional uncertainty surrounded social policy, and federal initiatives were subject to confrontation with the provinces. This uncertainty was somewhat attenuated by the release of the report of the Royal Commission on Dominion-Provincial Relations in 1940 which suggested that the federal government had an important role in financing health insurance programs, even though health care was under provincial jurisdiction.25 In addition, both major parties displayed a fiscally prudent attitude toward social spending during the Great Depression. Although the booming wartime economy and the rhetoric of postwar security enforced the idea that the federal government had the responsibility to ensure the social protection of its citizens, the Liberal cabinet remained divided on the government’s role in social welfare.
During the 1940s the presence of a social democratic third party helped rouse the government’s interest in health reform. Originally a protest movement born of a long tradition of western agrarian protest and frustration with the failure of major parties to respond to the Great Depression, the Co-operative Commonwealth Federation (CCF) was formed in 1932 as a federation of independent labor representatives in the House of Commons, progressive farm and labor organizations in western Canada, and elements of the socialist left.26 With the rising interest in the postwar social order, heightened by the release of the Marsh Report (Canada’s own “Beveridge plan”), the CCF’s social reform platform, which included universal health insurance, captured the attention of Canadians.27 The party quickly gathered momentum in both federal and provincial politics: by 1944 it won a majority of the popular vote in British Columbia, became the official opposition in Ontario, and routed the Liberals and took office in Saskatchewan in an election dominated by the health reform issue.28

The spectacular rise of the federal CCF in public opinion polls — by late 1942 it was in a dead heat with the Liberals and Conservatives — combined with the popularity of health insurance — in April 1942, 75 percent of Canadians supported the idea of a contributory national health plan — may have convinced Prime Minister King that something had to be done.29 In addition, the Liberal government feared that the challenge of the CCF could undermine electoral support among the working class, particularly since organized labor also favored establishing a contributory health insurance program that would insure similar standards of care for workers across the country.

Seeking to assuage these pressures but cautious in his approach to health reform, King compromised by appointing a House of Commons special committee on social security in 1943. Senior officials within the department of pensions and national health had been drafting health insurance bills, and these drafts were submitted to the special committee. Although the Canadian Medical Association enjoyed cordial relations with these senior officials and contributed to the bills under review, it made clear that public funds should be used only to cover low wage and indigent patients.30 Labor representatives, in contrast, deplored the collusion between medical interests and the federal government in drawing up the bills.31

The committee’s report expressed doubts as to the “financial and constitutional questions” raised by health insurance, a view implicitly shared by King and most of his cabinet as well as by the Conservative opposition.32 Although the right in Canada differed significantly from the Republican party in the United States, due in part to its collectivist origins, Conservative party leaders shared the tenets of economic liberalism and took issue with the CCF’s vision of universal social reform, such as national health insurance.33

Both major parties had to react to the potential political challenge from the CCF in the next federal election, however. The Conservative party adopted the
“Progressive” label in order to widen its appeal in the western provinces against the CCF, while the Liberal party moved to usurp the left’s social reform platform. The Liberal government, meanwhile, released a blueprint for postwar social security that tied health and social insurance reforms to an overhaul of the federal-provincial fiscal relationship.34

The 1945 election results showed that the Liberal party’s fears about the CCF had been well founded. Although the CCF suffered the fall-out of concerted antisocialist rhetoric from its political opponents, the Liberal government won only a very narrow majority.35 While King and the provincial premiers were unable to agree upon the fiscal arrangements necessary for the proposed social security program, the federal government found it difficult to remain inactive on the health issue. The persistent demands of the CCF in Ottawa coupled with the new public hospital insurance plan implemented by the CCF government in Saskatchewan ensured that health reform would not disappear from the political agenda. In 1948 a program of national health grants, providing federal grants-in-aid to the provinces for public health and hospital construction, was inaugurated. Although declared a first step in the “ultimate goal of health insurance,” King and his government considered the measure a practical way of staving off more extensive health reform.36

Modifying Health Reform in Canada: The “Staging” Mechanism King’s successor, Louis St. Laurent, openly favored voluntary health insurance and encouraged provincial initiative in this area. Although the Liberal government was still divided on health reform, its margin for maneuver was becoming increasingly limited. In the House of Commons, the CCF continued to goad the government to act on its reform promises, reinforcing the popular success of the Saskatchewan hospital program.37 At the same time, the CCF was expanding its political base into central Canada and moving closer to the Canadian Labour Congress, another cause for potential concern among the major parties despite the CCF’s lackluster electoral performance during this period. The CCF’s health reform platform remained a major legislative aim of the newly united labor movement, and it insisted on federal involvement to provide adequate financing and ensure national standards for universal coverage.38

Despite the preference of the prime minister (and the medical lobby) for voluntary alternatives, the Liberal government was under increasing pressure to act. Public opinion polls showed a substantial majority of Canadians in favor of government-financed hospital insurance.39 Many provinces, beginning with the CCF government in Saskatchewan, experimented with various types of hospital insurance but found it difficult to finance such programs without assistance from the federal government. By 1955 the Conservative government in Ontario, under pressure from the CCF opposition and its allies in the labor movement, refused to “go it alone” as had Saskatchewan and insisted on federal cost-sharing guarantees before initiating a hospital insurance plan.40
The precedent set by Saskatchewan led to a consensus about the staging of health benefits, beginning with hospital insurance. Easier to administrate, this strategy also avoided direct confrontation with organized medicine. In early 1956 the federal government announced the possibility of a federal-provincial hospital insurance plan as soon as the provinces agreed. After obtaining the approval of Ontario and four other provinces, legislation was introduced the following year, and the Hospital Insurance and Diagnostic Services Act passed unanimously on April 10, 1957.41 Almost coinciding with the announcement of a federal election, the legislation proved to be of little help to the Liberal party. Parliament reconvened with a minority Conservative government led by John Diefenbaker. and federal participation in hospital insurance began July 1, 1958. By 1961 all ten provinces and two territories had introduced hospital insurance programs eligible for federal funds under the Hospital and Diagnostic Services Act.

The Consensus for Universal Health Insurance in Canada The federal Conservative government was not eager to reopen the health reform issue. Instead, the CCF government in Saskatchewan once again provided the initiative. A medical insurance program that combined private fee-for-service delivery with public administration and financing was introduced in 1961 despite vehement opposition to “socialized medicine” from the CCF’s political opponents.42 Saskatchewan’s doctors even attempted a last-ditch effort to scuttle its implementation through the withdrawal of medical services in July 1962. The unsuccessful strike contributed to a loss of prestige for the medical lobby and propelled medical insurance onto the national political agenda.

The events in Saskatchewan also influenced the Royal Commission on Health Services, set up in 1960 at the request of the Canadian Medical Association in an attempt to defuse pressure for health reform. Public hearings revealed the extent of polarization between groups across the political spectrum: from labor and farm groups who advocated complete public control of health services to the medical lobby, insurance, and business interests who recommended voluntary medical insurance and a means-tested public program for the medically indigent to purchase medical insurance.43 The commission’s 1964 report fell between the two poles but was clearly influenced by the Saskatchewan CCF’s medical insurance program. It recommended federal financial assistance to establish “comprehensive, universal, provincial programs of personal health services.”44

By this time the Liberal party had formed a minority government in Ottawa, with a new prime minister, Lester Pearson, receptive to a reform agenda that could revive the party’s fortunes and bolster its support on the left.45 This consideration was important because the newly reenergized social democratic third party was also attempting to attract disgruntled Liberal supporters. The New Democratic Party, formed in 1961 by the alliance of the CCF with the Canadian labor movement,
emphasized the public demand for action on medical insurance, the lack of Liberal response, and the success of the medical insurance program in Saskatchewan. Since the NDP now effectively held the balance of power in the House of Commons, the minority Liberal government was under pressure to formulate legislation that would satisfy the NDP.

The principles unveiled by Prime Minister Pearson in 1965 reflected this situation. In order to receive federal assistance, provincial medical plans would have to provide comprehensive, universal, publicly administered benefits for all citizens “under uniform terms and conditions” transferable between provinces. These principles were influenced by the recommendations of the royal commission, relying on the precedent set by federal-provincial hospital insurance arrangements and the Saskatchewan medical insurance program. Although the Canadian Medical Association made the medical profession’s objections clear, it was somewhat assuaged by the retention of fee-for-service delivery and, in several provinces, the ability to extra-bill patients or opt out of public programs. In any case, by this time its warnings about compulsory insurance “carried little weight with Lester Pearson’s minority government.” Now that the political agenda on national health insurance had been set, the medical lobby in Canada was restricted in its attempts to reroute the direction of health reform and could not influence individual political actors to the same extent as in the United States.

After the 1965 election again produced a minority Liberal government, the NDP focused its efforts on getting the legislation passed as quickly as possible before opposition forces both in and out of parliament could gather momentum. Some division remained within the Liberal government, particularly in attempts to delay implementation of the program. In the final analysis, however, medical insurance had become “politically potent: no one could afford to be seen as opposed.” The near unanimous passage of the bill in 1966 reflected the heightened political stakes surrounding the issue. Nevertheless, the prolonged and bitter debate over the legislation, the divisions within the government, and the significant concessions offered to the medical lobby indicate that the bill’s final passage was far from easy, even in a parliamentary system, and were profoundly influenced by the presence of a social democratic third party.

Health Reform in the United States: The Absence of a Third Party

National Health Insurance in the Truman Era As in Canada, no major health legislation was passed in the United States prior to the 1940s. Nevertheless, health reform had been under discussion since the turn of the century and figured prominently in the economic security debates of the 1930s. In contrast to the reluctant attitude of the Canadian government in the 1930s, the American federal
government was able to move into the social policy area and established important precedents for future reform.

Senior officials in the U.S. government displayed a generally more politicized attitude toward health reform than their Canadian counterparts. Together with progressive members of Congress, the Social Security Board drew up proposals for health and social reform such as the 1943 Wagner-Murray-Dingell bill, the “American answer to the Beveridge plan.”53 Despite favorable public support for social security measures, only limited legislative action ensued, in part because President Roosevelt refrained from endorsing these measures.54 Indeed, he did not promote an “Economic Bill of Rights,” including the right to medical care, until his fourth reelection bid. When Harry Truman became president, however, national health insurance became a primary domestic policy objective. Truman inaugurated the first presidential health message to Congress, in which he outlined a comprehensive plan for hospital construction, public health, medical education and research, cash disability, and compulsory prepaid medical care that included a far more centralized public system than the plan being considered in Canada.55

Although the opposition of organized medicine differed in both intensity and strategy, medical interests in Canada and the United States shared similar concerns about maintaining professional autonomy, preferring voluntary insurance and limited public programs for low income families and the medically indigent. Strengthened by its successful efforts in keeping health insurance out of the Social Security Act, the American Medical Association (AMA) was prepared to derail any renewed proposals for health reform. Its own national health plan, released in February 1946, emphasized individual responsibility, free enterprise, and limited local government involvement in public health.56

The American Federation of Labor had long resisted government involvement in social insurance but by the 1940s was reconciled to some extent with the Congress of Industrial Organizations on the issue of social reform. The two labor organizations became important lobbies for national health insurance during this period and enthusiastically endorsed the Truman plan. Indeed, American labor had more input into the administration’s health proposals than their Canadian counterparts, who maintained a wary distance from the major parties and leaned more toward the type of social reform advocated by the CCF platform. Faced with constraints on the formation of a labor party and under attack by the conservative Congress, labor leaders finally rejected the idea of independent political action once and for all and formally solidified their relationship with the Democratic party.57

Organized labor formed part of the broad Democratic coalition, but this coalition was far from harmonious. Southern Democrats ran under the Dixiecrat label in 1948, and although they returned to the Democratic fold in the new Republican Congress, they refused to support Truman in order to safeguard their states’ autonomy over
social policy and, more significantly, civil rights. The "conservative coalition" between southern Democrats and Republicans effectively blocked the Truman administration's social reform initiatives. Led by Senator Robert Taft, the ideologically charged opposition to health reform took on a vehemence that was relatively unmatched in the Canadian political landscape. Opponents of national health insurance made extensive use of the "socialized medicine" label and cold war rhetoric to link supporters of health reform to the dangers of communism and national security threats. This rhetoric was especially worrisome for Democratic legislators vulnerable to the AMA's electoral strategy, especially since polls showed growing opposition to Truman's plan and increasing support for the AMA's voluntary insurance alternatives.

Although Truman sent a third message to Congress on national health insurance in May 1949, his efforts suffered a decisive defeat at the hands of the AMA and the conservative coalition in Congress. The medical lobby was successful in limiting the scope of national health reform because it was able to capture public opinion and build up strategic alliances and support in Congress for its voluntary alternatives. The Democratic party, meanwhile, remained so deeply divided and polarized over this issue that compromise was virtually impossible at the time. Even though senior officials in key agencies displayed an even greater commitment to reform in the U.S. than in Canada, they were unable to bring the projects for national health insurance to term. These constraints forced frustrated reformers inside and outside government to rethink their approach and take the first steps toward a more limited program for social security recipients.

Modifying Health Reform in the U.S.: The "Targeting" Approach During the Eisenhower years health reformers in the Democratic party, sensing that national health insurance was beyond the realm of political feasibility, were open to alternative measures, even if they meant a partial rather than comprehensive approach. Their strategy was to build a palatable alternative to national health insurance by targeting a noncontroversial political constituency, the aged. Already the clientele of a widely popular federal program, the aged were also among the most vulnerable groups shut out of the growing private health insurance market.

The absence of this kind of targeting of the aged was one of the most important distinguishing features of the Canadian hospital insurance plan. The Social Security Act created a precedent for age-based cleavages in the American welfare state and reinforced the idea of deserving social groups, while no such precedent had been set in Canada. Rather, the debate in Canada centered around universal entitlements, reinforced by the demands of the CCF at the federal level, and by the precedent set by the CCF government in Saskatchewan. Hence, the agenda for health reform in Canada continued to include the CCF alternative, whereas in the United States national health insurance was effectively erased from the political landscape.
Despite the new moderate strategy, the Democratic party remained divided on health reform throughout the 1950s. With a Republican party in the White House, the impetus came primarily from outside government, most importantly from the AFL-CIO and former senior officials in the Truman administration. Together, they drafted the 1957 Forand bill, reintroduced in 1959, that proposed a limited plan for hospital insurance for Social Security recipients. The newly unified labor movement gave health reform a prominent place in its legislative agenda, but in contrast to their Canadian counterparts, labor leaders adopted a more pragmatic position on the issue. Accepting the idea that voluntary insurance could adequately cover the average American worker, labor turned its attention to filling the gaps in coverage for vulnerable groups. Following the social security model, it might, in time, set a precedent to extend this type of government program to other groups in the population.

Although careful not to alienate the aged and their political supporters, the AMA was visibly distressed at the idea of extending health coverage under Social Security as “the thin end of the ever-present wedge” toward a renewed effort for compulsory health insurance. The recurring themes of compulsion and “socialized medicine” again ensured the decisive defeat of the Forand bill in committee vote in March 1960, reflecting the enduring strength of the conservative coalition in Congress and the opposition of influential Democratic leaders. In the midst of a hotly contested presidential election, however, the potential political clout of the issue could not be ignored. The “right to adequate medical care” (defined as health insurance for the aged) was a prominent feature of the Democratic party’s national platform after Kennedy’s nomination, despite divisions among congressional Democrats. Pressured to launch an alternative, the Republican administration supported the Medicare for the Aged Act (MAA), which limited eligibility for federal aid to the medically indigent aged through a means test. The MAA represented the antithesis of the social insurance approach embodied in the Forand bill but also showed the effectiveness of legislative compromise in a measure designed to raise public support by helping the needy aged.

Medicare and the Politics of Compromise Health reform quickly emerged as a primary feature of the new Democratic administration’s domestic agenda due to mounting public support for health insurance for the aged. President Kennedy stressed this issue in his first state of the union address and shortly thereafter presented a special message to Congress on health and hospital care, repeated again in 1962 and 1963. The focal point of the legislative battles was the King-Anderson bill, first introduced in February 1961, specifically limiting hospital benefits to the aged and omitting physician services.

Nevertheless, the AMA and its new political action committee (AMPAC) tried to link these proposals to compulsory health insurance, just as organized labor’s
energetic campaign carefully avoided making any linkages between hospital insurance for the aged and universal health insurance. This approach broadened the potential coalition in favor of health reform to include elements of the broader medical community, such as the American Nurses Association and the American Hospital Association.70

While interest groups waged the public battle over Medicare, the bill faced a divided Congress. As in the 1940s, the Democratic administration faced overt hostility from southern Democrats, even though the proposed reform was but a shadow of Truman’s plan for comprehensive health insurance. Despite the high level of support from the administration, House Speaker Sam Rayburn “lacked formal means to enforce party discipline on recalcitrant Democrats,” and the bill was still in the thrall of the Ways and Means committee controlled by chairman Wilbur Mills, six southern Democrats, and the Republican opposition.71

By the time Medicare finally passed in 1965, several changes had buffeted the policy playing field. As part of his commitment to the Kennedy program, President Johnson highlighted health reform in his “Great Society” initiative; he stressed continuity not only with Kennedy’s New Frontier but also with the New Deal and the Fair Deal.72 Voters responded overwhelmingly to these messages in the 1964 elections. When Congress reconvened in January 1965 with a newly energized Democratic caucus, health reform was accordingly the first order of business. Nevertheless, the measure still faced institutional constraints and significant challenges from alternative proposals, such as the AMA’s “Eldercare” expansion of Kerr-Mills to include medical insurance for the aged and the Republican “Bettercare” to provide voluntary hospital and medical insurance. Wilbur Mills considered these alternatives as ways to assuage conservative resistance to Medicare, respond to Republican and AMA criticisms, and foil inevitable future demands for expansion of the hospitalization plan.73 Mills’ strategy combined the competing proposals into what became known as Medicare Part A and Part B. Part A would include benefits for compulsory hospital insurance coverage, financed by the Social Security payroll tax; the new Part B would incorporate the proposals for supplementary voluntary insurance for medical and diagnostic services financed by monthly premiums. After extensive hearings the Medicare compromise bill passed both the House and the Senate with substantial majorities.

The protracted legislative battle and passage of Medicare shows that incremental health reform is possible in the United States but at the same time highlights the institutional constraints that limit such reform. Throughout this period the compromises on the health issue reflected the way in which the Democratic party had to appeal to the right, in contrast to Canada, where the Liberal party was forced to consider the left as a political force in the federal legislature. President Johnson’s careful political maneuvering of the Democrats in Congress shows the realm of the possible when a concerted effort is made to simulate party discipline, while the
brokerage between proponents of Medicare and the congressional leadership revealed that, no matter how popular or limited in scope the proposed health legislation, it was still subject to compromise and change before final passage.

**Parting at the Crossroads**

As this historical overview shows, the period from 1940 to 1965 represents a crucial crossroads in the development of health insurance in Canada and the United States. In 1940 Canada and the United States shared many similarities in the delivery, financing, and administration of their health care systems, but by the end of the 1960s they had fundamentally parted ways. In the immediate postwar era the decisive failure of the Truman plan seemed to preclude further attempts at introducing national health insurance, while in Canada the door remained open to such reform. In the 1950s and 1960s the two countries diverged even further. The United States embarked on a modified reform strategy in which government programs were targeted at specific clienteles. In Canada universal access and public administration were the prerequisites to federal involvement in provincial health insurance programs.

What explains this parting at the crossroads? This comparative historical analysis has emphasized how divergent policy outputs in the two countries reflected the different institutional attributes of their political systems. The legislative battles over health reform in Canada were clearly influenced by the presence of a social democratic third party whose emergence and influence were shaped by parliamentary rules and by the expression of regional protest through the federal system. The idea of government involvement in health insurance had some support within the major parties in Canada, but successive Liberal governments were obliged to make reactive political decisions influenced by the presence of a social democratic third party in the House of Commons. As an independent voice for the left, the CCF-NDP acted as a policy “entrepreneur” for a universal health insurance alternative that reflected social democratic principles of comprehensive care, equitable access, and public administration. Its ability to shape the parameters of health reform in Canada derived from the potential electoral threat it represented as a regionally based political movement and a release valve for voter discontent, particularly among the working class. The third party also profited from the institutional leverage it could expend within the House of Commons, keeping health reform on the political agenda and helping to facilitate its final passage. In addition, the CCF-NDP’s innovations at the provincial level displayed to a wider national audience how government intervention in the health care sector could be successfully implemented. This demonstration effect helped create a momentum toward a consensus around the idea of a universally available system of public health insurance in Canada.
In the United States, the constraints on third party formation and success channeled demands for health reform through the deeply divided Democratic party. Health reformers necessarily had to strike political compromises. Since labor and the left were effectively captured by the Democratic party, these compromises had to appeal to a broader coalition within the party, including influential southern conservatives who controlled powerful institutional levers in the Congress. In the absence of party discipline, it was difficult to create a coherent campaign for health reform and sustain the necessary support for the passage of national health insurance. In addition, the opponents of health reform, particularly professional groups who perceived concentrated costs related to universal health insurance, were able to take advantage of multiple veto points in the American legislative system.

The comparative analysis shows that it is difficult to evaluate the impact of federalism without taking into account other political actors and institutions. In the United States there were few state-level initiatives in health insurance and few instances of social democratic state or local governments during this period. With regional agrarian movements and the left captured by major parties and social policy secured by the federal government, states were not under the same pressure to undertake bold innovations. The institutional features that hindered the formation of coherent policy at the national level were also present in each of the fifty states. The tendency in American federalism for regions to express their interests in the national political arena also worked against universal health insurance, as the southern Democrats demonstrated so effectively in congressional politics.

Federalism seems to have had a more amenable influence on the expansion of national health insurance in Canada. Although jurisdictional conflicts checked federal interference in the health area, provincial pressure eventually prodded federal involvement in hospital insurance. In addition, provincial innovations became constructive models for federal participation. The Saskatchewan experiments established the principles of universal health insurance, tested the limits of reform opponents, and ultimately demonstrated the success and shortcomings of such programs.

In the Canadian parliamentary system the executive had greater leverage over health legislation, but in both Canada and the United States political leaders were influenced by partisan politics. Democratic administrations were forced to compromise with the right, while Liberal governments were pulled increasingly by the left. Legislators enjoyed different types of flexibility that allowed them to shape health reform. In the Canadian system third party representatives had considerable exposure in national politics, while government caucus members could rouse their leaders from complacency. At the same time, however, party discipline assured the passage of legislation without the divisive infighting and the pervasive influence of outside groups that characterized the American political system.

Institutions also had an impact on organized labor. Both the Canadian and
American labor movements supported a national program of universal health insurance. The crucial difference was their ability to translate this goal into actual legislation. Their ability was conditioned by the nature of labor’s political alliances in the party system and the boundaries imposed on political action. Given the structural constraints facing an independent labor-based third party in the American political system, organized labor was forced into the Democratic party coalition, which included not only labor and health reform allies but also the conservative coalition and its allies. In the U.S. organized labor was forced to retreat from national health insurance to a politically feasible alternative in order to overcome Congressional resistance and AMA opposition and recapture the public agenda on health reform. The presence of a social democratic third party was crucial for the labor movement in Canada. Although the CCF-NDP never came to power (or had cabinet representation) at the federal level and thus does not correspond exactly to the social democratic model described by the literature on the welfare state, the presence of a third party of the left nevertheless gave Canadian labor significant leverage in health reform.

To summarize, this article has argued that Canada and the United States parted at the crossroads of health reform due to their different institutional configurations and, more precisely, the way these configurations shaped partisan politics in the two countries. The establishment of the public sector in health insurance in Canada and the United States has also had lasting effects on future reform. Universal health insurance in Canada has been institutionalized in a long process of change and experimentation, accomplished through a series of leaps in the dark by provincial innovations and then bolstered and extended through federal involvement. The favorable public consensus that now exists about the role of government in the health care system was built up over time as a result of the success of the public sector in assuring the basic health needs of Canadians. While confrontation between government and medical interests persists, these disputes have not yet called into question the fundamental precepts of government-financed health care. This consensus has remained viable not simply because the system is perceived as successful, but also because it is difficult to challenge such a consensus in the Canadian political system. Despite a decade of Conservative government in Canada and increasing fiscal pressures on the provinces, changes in the fundamental principles underlying universal health insurance have been limited by the extent to which this consensus has become “embedded” in the Canadian political culture.

Such a consensus has yet to be realized in the United States. The limited programs of the 1960s, based on social security precedents, reflect the tendency toward compromise inherent in American political institutions and the American party system. These compromises have in turn become embedded in the American health care system and in perceptions of the government’s role in health and social reform. The institutionalization of Medicare and Medicaid, while widening the role
of government involvement in the health sector, has also set limits on the feasibility of further reform. Health reform continues to be embroiled in political hassles involving powerful interest groups, a divided Democratic party, and the confines of bipartisan compromise. But the recurrent resurfacing of national health insurance on the political agenda indicates that the enduring demand for reform still persists and will continue until a satisfactory compromise on health policy is reached in the United States.

NOTES

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3. Canada and the United States experienced comparable timing of industrialization and levels of economic development, have federal structures of government, and are generally considered to have similar political cultures relative to European nations; neither has developed fully corporatist policy-making arrangements or strong national social democratic or labor parties, and the organized labor movement in both countries has been historically weak and fragmented. See Antonia Maioni, “Explaining Differences in Welfare State Development: A Comparative Study of Health Insurance Legislation in Canada and the United States” (Ph.D. diss., Northwestern University, 1992); Robert T. Kudrle and Theodore R. Marmor, “The Development of Welfare States in North America,” in Peter Flora and Arnold J. Heidenheimer, eds., The Development of Welfare States in Europe and America (New Brunswick: Transaction Books, 1991).


State Back In," in Peter B. Evans, Dietrich Rueschemeyer, and Theda Skocpol, eds., Bringing the State Back In (New York: Cambridge University Press, 1985).

8. Here, I am referring to James Q. Wilson’s typology of entrepreneurial politics and the way in which certain political actors can produce policies with concentrated costs but widely distributed benefits. James Q. Wilson, Political Organizations (New York: Basic Books, 1973), ch. 16. I am indebted to my colleague Christopher Manfredi, for bringing this useful analogy to my attention.


25. The Royal Commission was set up in 1937, after the Employment and Social Insurance Act of 1935 was found to be a federal infringement of provincial jurisdiction in the area of social welfare, on health care. see Government of Canada, Report of the Royal Commission on Dominion-Provincial Relations, Book II: Recommendations (Ottawa: King’s Printer, 1940), pp. 4–35, 42–43.

26. On the formation of the national CCF, see Young, chs. 2, 3.

27. Leonard Marsh, a student of Beveridge closely associated with the CCF’s intellectual wing, drew heavily on social democratic principles in drawing up his report commissioned by the federal government’s Advisory Committee on Reconstruction. Leonard Marsh, Report on Social Security for Canada, 1943 (Toronto: University of Toronto Press, 1975).

28. The CCF won forty-seven seats to the Liberal’s five and formed its first provincial government in Saskatchewan after the 1944 election; Ivan Avakumovic, Socialism in Canada: A Study of the CCF-NDP in Federal and Provincial Politics (Toronto: McClelland and Stewart, 1977), ch. 6.

29. CCF support was estimated at 29 percent, the Liberals and Conservatives at 28 percent each. Gerald L. Caplan, The Dilemma of Canadian Socialism: The C.C.F. in Ontario (Toronto: McClelland and Stewart, 1973). pp. 110–11; Canadian Institute of Public Opinion, Apr. 8, 1942.


31. House of Commons, Special Committee on Social Security, Minutes of the Proceedings (Ottawa: May 18, 1943).

32. House of Commons, Special Committee on Social Security, Fourth Report of the Special Committee on Social Security (Ottawa: July 23, 1943).

34. The federal government would contribute to the costs of such plans in the provinces, in return for control in the collection of personal and corporate taxation; on the development and demise of those proposals see Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System and Their Outcomes* (Montreal: McGill-Queen’s University Press, 1987), ch. 1.

35. The 1945 federal election was part of the “contest for labour” between the CCF and the Liberal Party. Janine Brodie and Jane Jenson, *Crisis, Challenge and Change: Party and Class in Canada Revisited* (Ottawa: Carleton University Press, 1988), ch. 7.


37. Stanley Knowles, the CCF party whip, was particularly effective in this area; see, for example, House of Commons, *Debates*, Dec. 1, 1952, 339; and Nov. 23, 1953, 258.


40. Taylor, p. 105.

41. On the development and passage of the legislation, see Taylor, pp. 211–34.

42. On the conflict over medical insurance in Saskatchewan, see Robin F. Badgley and Samuel Wolfe, *Doctors’ Strike: Medical Care and Conflict in Saskatchewan* (Toronto: Macmillan, 1967).

43. National Archives of Canada, RG 33, volumes 6 to 24 and 44 to 60.


51. See note 23.


53. Quoted in Monte M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979), p. 32. Senators Robert Wagner and James Murray had sponsored health insurance bills in the 1930s; the 1943 bill, cosponsored by Representative John Dingell, was supported by organized labor. Influential bureaucrats in the Social Security Board included Arthur.
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59. The AMA’s two million dollar “national education campaign,” directed by Whitaker and Baxter, the California public relations agency that was also hired to campaign against Governor Earl Warren’s health reform proposals in California earlier in the decade, proclaimed “the voluntary way is the American way.” Frank Kennedy, “The American Medical Association: Power, Purpose, and Politics in Organized Medicine,” The Yale Law Journal, 63 (May 1954), 938–1022.

60. Although 58 percent of Americans supported Truman’s health initiatives in 1945, by the end of 1949 support dropped to 36 percent. The Gallup Poll, vol. 2, pp. 801–03, 886. Several pro-health insurance Democrats targeted by the AMA eventually were defeated in 1950 and 1952. Kennedy, pp. 1015–17.

61. Memo from Cornelius A. Wood to Oscar Ewing, Jan. 20, 1950, National Archives file 011.4, box 7, FSA.

62. In the 1950s over 60 percent of Americans were covered by hospital insurance, while a third had some form of medical insurance, but less than a quarter of total private health expenditures were covered by insurance. Louis Reed, “Private Medical Care Expenditures and Voluntary Health Insurance, 1948–60,” Social Security Bulletin, 24 (December 1961), 3–11.


66. The vote was seventeen to eight. Led by Ways and Means chairman Wilbur Mills. seven southern Democrats joined the Republicans, Congressional Quarterly Almanac (1960), 154.

67. Sundquist, pp. 311–18.

68. For an analysis of the role of public opinion in the 1960s health reform debate, see Lawrence R.


71. Ibid., p. 46.
