

Evolution of Public Health Insurance Programs: A Tale of Two Countries

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“As was stated by Her Excellency, the Governor General of Canada, in the Speech from the Throne on September 30, 2002, ‘no issue touches Canadians more deeply than health care. Our health care system is a practical expression of the values that define us as a country.’ These values are fairness, equity and solidarity.” A. Anne McLellan, Minister of Health, Canada Health Act Annual Report, 2001-2002, December 2002¹.

“It has become something of a cliché to say that America’s healthcare system is in ‘crisis.’ But crisis is altogether the right word. We depend on coverage from what I would call a haphazard and piecemeal healthcare system of boxes where you get healthcare in this country depending on which box you happen to fit in.” Senator John Breaux (D-LA), Academy Health, National Health Policy Conference, Washington DC, January 23, 2003.

Introduction

These two statements reflect the outcomes of different public policy decisions resulting in the health care financing systems of Canada’s single payer national health insurance program (known as Medicare) and America’s complex multiple payer system of systems. What makes variations in health care financing policy, and the ensuing public perceptions, between Canada and the United States (U.S) even more significant is that the essential characteristics of these two health care systems matured through the same time frame. During the 1940s through the 1960s, both Canada and the U.S. exhibited fundamentally analogous social, economic, cultural, and to some extent political circumstances. Additionally, these two nations share commonalities that include a mutual heritage as former British colonies, shared medical training programs, comparable standards of health care, free exchange of health services, and similar systems of governance.² This paper will limit the discussion on similarities to the principles of federalism and its influence on health care policy.

Cultural similarities and comparable expectations for health care quality and access, combined with Canada's apparent rapid transition to universal health coverage during the late 1960s, have made Canada a focus for American health care reform initiatives during the early 1990s. Indeed, the single-payer Canadian model for health care financing continues to be a central theme in discussions for health care reform among American policy makers and health care analysts. For the most part, proposals to adopt a Canadian single-payer system as a means of expanding public health insurance coverage to the currently uninsured (or under insured) population have focused on expansion of the American Medicare program for the elderly.³ Using a line of reasoning based upon the ease of transition, reform advocates argue that the mechanisms—such as compulsory enrollment, payroll tax contributions, and provider payment schedules—needed to adopt a universal health insurance system mirroring Canada's single payer approach were already available through America's Medicare program.⁴ While this paper does not take a position on the relative merits of universal health care, it does argue that the parallels of institutional arrangements and governance tools used to implement Canada's Medicare program and America's Medicaid system for the "deserving poor" make Medicaid a much more compelling model for expansion of health care insurance.⁵ Both Canadian Medicare and U. S. Medicaid use one or more form of federalism; are primarily financed by federal grants, with co-shares paid by the state or province; are based upon a doctrine of partnerships between the federal and state or provincial governments; and encourage substantial regional variance by legislating management flexibility at the state or provincial level to oversee quality, access, and costs. The primary difference between these two finance systems is that Canadian Medicare provides universal coverage to all residents,

while Medicaid allocates substantial leverage to the states to set eligibility standards and covered benefits. This policy results in a complex and capricious eligibility system based upon income, family status, and the nature of an individual's disability. More importantly, this results in substantial interstate variation in health policy leading to inequitable access to public health insurance across the states in the United States.

A significant amount of research has been conducted to compare the U. S. and Canadian health care financing and delivery systems. Additionally, the literature is replete with comparative evaluations of the institutions of Canadian and U. S. systems of government. This paper will build on a “polity-centered” policy development theory by examining the influence of institutions and their ensuing legacies on the evolution of public policy for health care financing in both the U. S. and Canada⁶ By way of this analytical framework, this paper will address two of the many research questions resulting from comparative studies of the U.S. and Canada. The first question is why did Canada's reform efforts lead to universal coverage, while the U. S. developed an amalgam of various financing schemes that leaves approximately 16 percent of its citizens without health insurance?⁷ The second question is could aspects of the Canadian system be transported to publicly financed U. S. health care insurance programs (Medicare and Medicaid) as a means to expand health insurance coverage? To assist with answering these complex questions, this paper will begin with a brief overview of the germane aspects of the health care financing systems currently used in the United States and Canada to provide an understanding of the major variations between the two financial structures. Then, the paper will discuss the institutional, ideological, and political factors in place during Canadian and U. S. health policy formative years—between 1940 through the 1960s—to

offer theoretical reasons for the divergent health reform paths taken by these two nations. Finally, the paper will attempt to provide a theoretical rationale for the different policy outcomes in these two nations despite similarities in culture, intergovernmental relations, and tools of governance.

Health Care Financing in the United States—Current Outlook

A good number of health care policy analysts share Senator Breaux’s statement that the U. S. health care system is in “crisis.” Four intertwined elements support this opinion: rising health care costs, increasing numbers in the uninsured population, growing concern over health security for the middle class, and the effects of health spending on state and federal budgets.⁸ The relationship between these factors is primarily a result of the unique structure of health care financing in the United States. Unlike most industrialized nations, after the Second World War, America adopted policies based upon tax expenditures that promoted insurance coverage for the working age population through employment-based programs, thus hindering development of a centralized policy with government responsibility for providing health insurance to the population.⁹ These initial policy decisions set a series of path dependent health care finance policies into motion. As the “system” evolved, it became increasingly tied to the nuances of the labor market and dynamics within the overall economy, thus perpetuating the relationship between costs, numbers of uninsured, security, and impact on government budgets.

The U. S. health care financing system’s patchwork of private funds, employer-paid fringe benefits, federal grants, tax expenditures, and various other redistributive

methods has earned it the dubious status of being one of the “most complex systems in the world.”¹⁰ Moreover, the United States is “exceptional” in that it stands apart from other industrialized nations by spending more, while guaranteeing health insurance to a smaller percentage of its population.¹¹ Health insurance programs, both public and private, place individuals into categories to determine eligibility for health care insurance.¹² The following table presents the chief categories, their public funding mechanism, and eligible populations.

Program	Public Financing Mechanism	Eligible Population
Medicare	Directly funded from tax contributions, enrollee co-payments and enrollment fees	Citizens over the age of 65, must be enrolled in the program and pay enrollment fee. Provides coverage for approximately 13 percent of the insured population.
Medicaid and State Children’s Health Insurance Program (SCHIP)	Federal grants, with variable amount of state matching funds based upon Centers for Medicare and Medicaid (CMS) derived formula.	Poor or near poor families, children, severely disabled, people with certain renal conditions, and some categories of AIDS patients. Also covers long term care for needy Medicare enrollees. Provides coverage for approximately 10 percent of the insured population
Employer-based and private insurance	Forgone revenue in the form of income tax expenditures.	Working age population. Provides health insurance coverage for approximately 63 percent of the insured population.
Military, veteran’s health care	Direct appropriation of tax payer dollars.	Active duty military or retirees and their family members. Military veterans with service connected health conditions. Provides coverage for approximately 5 percent of the insured population

Health care insurance for the third of the insured population not covered by either employer-based or self insurance programs is based upon a disjointed system of federal and state programs—predominantly either Medicare or Medicaid. Federal and state

governments' decisions about what share the individual pays, what types of health care are covered, who is and who is not eligible to receive care, who can provide care and receive payment for their services, and so on, is an ambiguous and sometimes mystifying policy process.¹³ Further complicating the process, state and local governments bear the responsibility of budgeting for and defining "optional" levels of coverage for the poor and nearly poor not covered by Medicare or employer-based programs. As a result, there is significant regional variance regarding how, or if, health care should be provided to this category of the population.¹⁴

Since Medicare was established in 1965, as *Title XVIII of the Social Security Act (Health Insurance for the Aged and Disabled)*, it has been a centerpiece of American social welfare programs. Medicare's health insurance program covers all eligible beneficiaries without regard to income or medical history and is solely funded and managed by the federal government. Most individuals ages 65 and over are automatically entitled to Medicare Part A (*Hospital Insurance Benefits for the Aged and Disabled*) if they or their spouse are eligible for Social Security payments.¹⁵ Part B (*Supplementary Medical Insurance Benefits for the Aged and Disabled*) is voluntary, but covers 95 percent of all Part A beneficiaries. Part A is mainly financed by a 1.45 percent payroll tax paid by both employees and employers. Revenue from the payroll tax is held in the Hospital Insurance Trust Fund and is used to pay Part A benefits. Part B is financed by both beneficiary premiums (\$58.70 per month in 2003) and general tax revenues. One of Medicare's better attributes is the relatively low administrative costs, which accounts for less than 2 percent of total benefit spending.

Medicaid, established with Medicare under *Title XIX Grants to the States for Medical Assistance Programs* is a means-tested entitlement program that is jointly financed by the federal and state governments. Medicaid's benefits are limited to individuals whose income and "countable assets" fall below certain thresholds (set as a percentage of the Federal Poverty Level (FPL) equivalent to \$16,988 per individual or \$21,430 per couple). Eligible beneficiaries are entitled to have the government pay for basic and necessary medical care. In exchange for their participation, states are entitled to federal matching payments for the costs of covered services. The federal government matches states' spending for covered services on an indeterminate basis, using a formula known as the federal medical assistance percentage (FMAP). FMAP varies from state to state and is inversely related to state per capita income. Even though the matching rates range from 50 to 83 percent of the program costs, on average, the federal government pays 57 percent of total Medicaid costs.¹⁶ Medicaid is the largest grant-in-aid program to states and accounts for over 40 percent of all federal grant funds flowing to states. Furthermore, Medicaid represents each state's largest self-managed health care program.¹⁷

As a condition of participating in Medicaid, states are required by federal law to cover certain populations and services.¹⁸ However, states can choose to cover "optional" populations and to provide services that are not mandatory and to receive matching funds to help pay for the cost of this coverage. About 65 percent of Medicaid spending is for "optional" services.¹⁹ Because states have substantial flexibility in defining the benefits package, establishing eligibility criteria, and choosing how they reimburse providers, the Medicaid program varies extensively from state to state. Although nearly 75 percent of Medicaid beneficiaries are children and adults, these groups account for less than 30

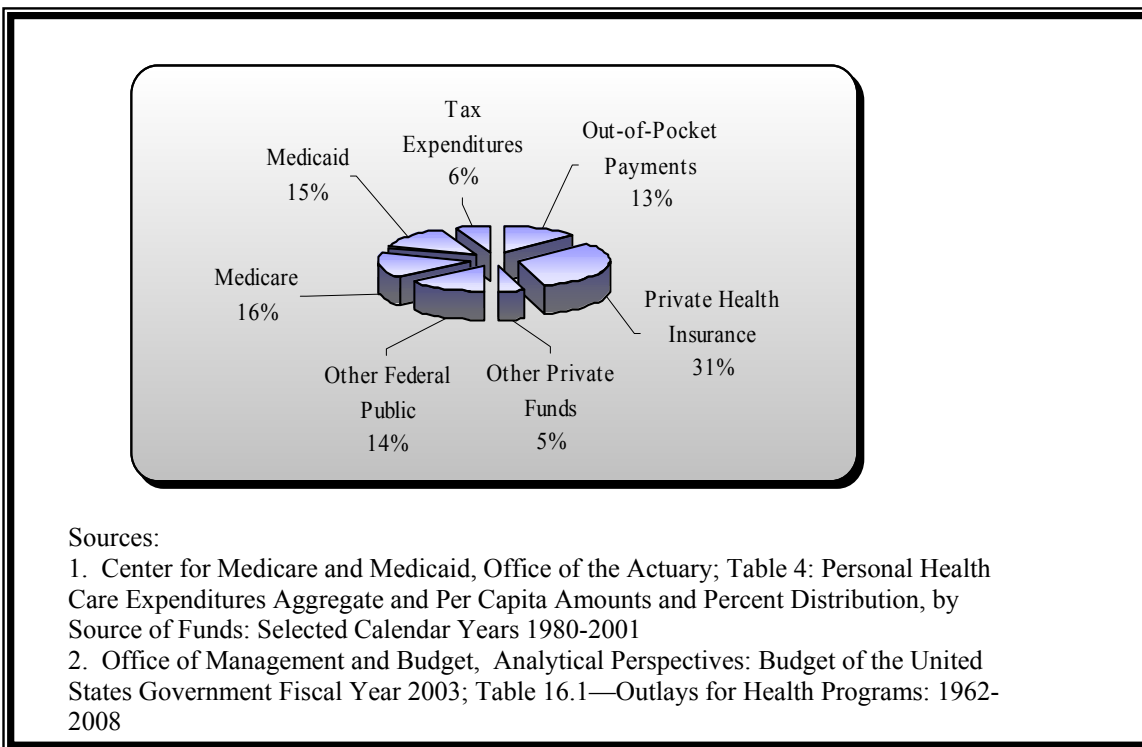
percent of spending on benefits. The remaining 70 percent of expenditures are made for services provided to the elderly and disabled, who make up only 25 percent of Medicaid beneficiaries. Costs associated with the elderly and disabled are primarily driven by long-term care, which accounts for 55 percent of all spending on benefits for the elderly and disabled. Overall, Medicaid is the nation's single largest purchaser of long-term care services, accounting for about 46 percent of all nursing home spending and 38 percent of all home health care spending.

In the determination of who gets what, when, and how, large groups of Americans are often left behind in the political and economic shuffle over health insurance policy. Federal, state and local governments continue to struggle with the problem of care for the poor and nearly poor. Even after considering all of the beneficent health care related legislation passed in this century, there is much about U. S. national health insurance policies that continue to be marked by inefficiency, limitation, inequality, and conflict.²⁰ Although legislators and analysts rarely agree on which course to take with health care finance reform, they generally agree that changes should be made to ensure equity and efficiency in the health care system.

Perhaps even more daunting than determining who is eligible for what type of care—and which program they are covered under—is the task of tracking national health care expenditures. The Centers for Medicare and Medicaid Services (CMS) reported that total national health expenditures for Fiscal Year 2001 was approximately \$1,236 billion, with public health expenditures accounting for \$537 billion or about 43.4 percent of the total costs.²¹ This accounting system fails to include tax expenditures, other publicly-

financed programs, and premiums that may have originated in the public sector.²² As presented in Figure 1, below, tax expenditures alone represented more than \$99 billion (or about 18 percent of total public health expenditures) in Fiscal Year 2001.²³ So, why would CMS fail to include such a significant expense in public health costs? Woolhandler and Himmelstein imply that the threat of tax increases has kept health reform in a fiscally constrained box. The further implication is that if the public were made aware that taxes pay for approximately 60 percent of all national health, rather than the 43.4 percent reported by CMS, public opinion could be moved to support a single payer or other form of universal health insurance.

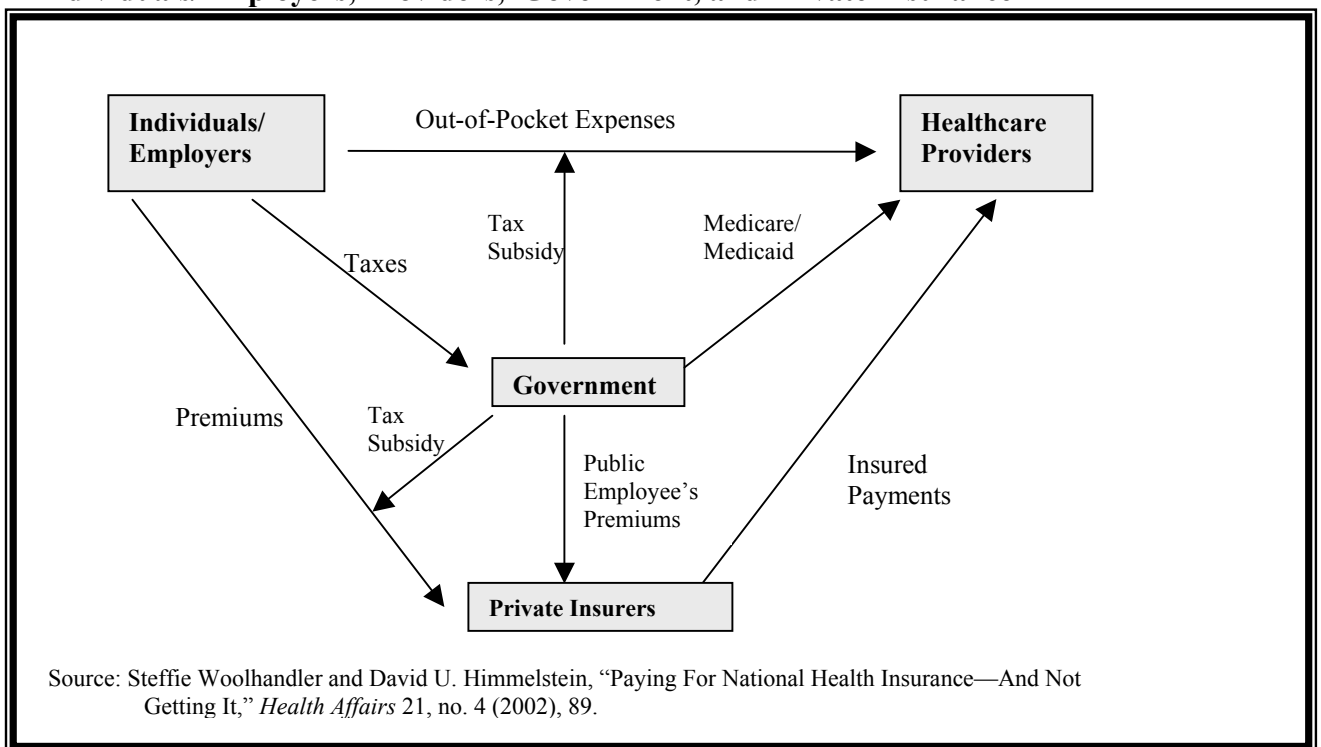
Figure 1. Health Care Expenditures as a Percentage of Total National Health Expenditures, 2001



Although Woolhandler and Himmelstein may be correct in their hypothesis, failure to count all health expenditures may be due to the sheer complexity of health care

financing in America. First of all, states use of creative means to extract maximum federal funding from disproportionate share hospital funds veils the true spending for Medicaid.²⁴ Most importantly, the data comes from numerous sources and is difficult to track. Figure 1, below is provided to demonstrate the complex relationship of health expenditures as money flows throughout the system.

Figure 1. Flow of Health Care Financing Funds among Individuals/Employers, Providers, Government, and Private Insurance



Canada's National Health Insurance System

The Canadian health insurance program is more than a mechanism to obtain care and to pay subsequent medical bills. It is also Canada's most successful and popular social welfare program. To Canadians, their health insurance system represents an important symbol of community and the government's commitment to mutual support and concern.²⁵

In this relatively heterogeneous nation, with deeply rooted divisions among the provinces, this program represents a unifying factor where all Canadians are fundamentally equal. Robert Evans makes this point succinctly in his statement, “There is no social program that we have that more defines “Canadianism” or that is more important to the people of our country.”²⁶ Moreover, Canadians take a great deal of pride in the fact that the economic burden for health care needs is shared, by the ability to pay, through the general tax system.²⁷

The thirteen Canadian provinces finance their health care through federal, provincial, and municipal taxes paid by individuals and corporations; employer payroll taxes or direct premiums paid by employers and individuals for services not covered by the provincial health plans; and out-of-pocket costs. Each province administers its own medical system, within the standard provisions and guidance of the country’s governing legislation, the *1984 Canadian Health Act*. As in most federal systems, financing and accountability for health services is divided among the provinces and the federal government. Given that the federal government helps fund the provincial health care systems—and withholds a portion of funds from those provinces that do not comply with federal standards—the federal government can, and does, influence the provincial systems.²⁸ Since the health insurance system is primarily financed through taxes, both sales and income taxes are higher in Canada than in the United States.²⁹

Although individuals may purchase insurance to provide access to benefits that are not listed as covered services under Canadian Medicare, all “medically necessary” hospital and physician services are provided regardless of the individual’s ability to pay for care, employment status, or age.³⁰ Only the provinces of Alberta and British Columbia charge a

small health premium, but this does not affect access to health care services. In recent years, the costs of non-publicly covered services has increased faster than other costs—in part due to budget cutting by the provinces—resulting in a decline in the proportion of total expenditures paid from public sources.

Despite the relative simplicity of the single payer system, the public financing mechanisms are complex to the point that it generates significant disagreement between the federal and provincial governments.³¹ To begin with, federal contributions for provincial health spending vis-à-vis the Canadian Health and Social Transfer (CHST) are combined into a single block grant for all social programs (health, education, and other social services).³² Since, there is not a specified share of federal transfers that is earmarked for health care, the provinces have full flexibility to spend all or any part of the CHST and equalization funds on health care.³³ Secondly, the Canadian federal government uses a variety of schemes—tax transfers, equalization funds, tax expenditures, tax credits, and transfer payments—to assist with health expenditures. Accordingly, a combination of the use of block grants as the governance tool to implement a health insurance program, combined with multiple sources of funding obfuscates the provincial and federal proportional shares of health care costs.

Although most of these mechanisms are used in the U. S., tax transfers and equalization stands out as uniquely Canadian. A federal tax transfer involves the federal government ceding some of its "tax room" to provincial governments. Specifically, a tax transfer occurs when the federal government reduces its tax rates to allow provinces to raise their tax rates by an equivalent amount. With a tax transfer, the changes in federal and

provincial tax rates offset one another and there is no net financial impact on the taxpayer. Tax transfers represent a growing source of revenue for provinces since they increase in value over time with growth in the economy. Equalization is a federal transfer program that allows all provinces, regardless of their ability to raise revenue, to provide comparable levels of services at comparable levels of taxation. Eligibility to receive equalization funding is determined by a formula measuring each province's revenue-raising capacity against a five-province standard. Currently, eight provinces receive equalization funds. When all of these financial mechanisms are taken into consideration, the federal government claims that it accounts for approximately 40 percent of national public health expenditures, while the provincial government claims that the federal government funds only 13 percent of all health care costs. This lack of consensus on the federal government's financial support for health care, and the reduction of services to contain costs has been a principal source of friction between the provincial and federal government for the past decade.

Like most nations, health care costs are on the rise in Canada. Provinces have responded to increased costs by “delisting” covered services driving private costs for “optional” services, such as cosmetic surgery and pharmaceuticals.³⁴ These trends indicate that aspects of the United States market-based, managed care system are migrating north to Canada. Further indicators of the influence of market structures, reform proposals in the past few years have increasingly called for the use of market competition internal to the government managed system.³⁵

Conceptual Framework

Despite the current differences of each of these financing systems, each process rose out of calls for reform and ensuing public policy reactions during the post World War II period of the 1940s through the 1960s. Neither nation had developed substantive public policies regarding health care prior to 1940; and each nation was firmly entrenched in their current methods of funding health care. In other words, absent a catastrophic catalyzing event, neither nation was likely to promote a policy agenda to transact a major overhaul of their respective health care systems. Analysts rarely agree on the specific reasons for agendas, public policy decisions, and their outcomes, but common themes reside in the influence of social forces and values, lack of cohesive governance and institutional structures, and pressures from special interest groups.³⁶ It is within the context of the last factor--institutions—that the analytical framework to evaluate the research questions identified in the introduction of this paper was conceived. First, why did Canada's reform efforts lead to universal coverage, while the U. S. pursued an employer-based health care financing system? Then, could aspects of the Canadian system be transported to publicly financed U. S. health care insurance programs as a means to expand health insurance coverage? Since this analysis uses a polity-centered approach, the primary contextual framework will be a review of the institutional legacy resulting from health financing policy formative years of the 1940s through 1960s. However, in order to complete the public policy development triad, the remaining two factors of ideology and interest groups will be briefly discussed to balance this analysis.

Ideology

Social scientists credit Tocqueville's *Democracy in America* with establishing the original insights into why American ideology is so vastly different from other nations. Louis Hartz draws upon Tocqueville's comparative observations on the exceptional nature of America's citizens and political structure to develop a compelling argument that links the absence of feudalism to the liberal tradition in America.³⁷ Hartz directed attention to basic American values of rugged individualism, a distrust of government, and a faith in liberalism.³⁸ Seymour M. Lipset effectively argues that the United States, born out of revolution, has always considered itself an exceptional country of citizens unified by an allegiance to a common set of ideals.³⁹ These ideals are identified as an "American Creed [that] can be described in five terms: liberty, egalitarianism, individualism, populism, and laissez-faire."⁴⁰ This ideology of "Americanism" and the resultant anti-statist views set the stage for political debates and shape the boundaries of the general public's tolerance for government managed social welfare programs. Samuel P. Huntington advances this argument to posit that Americans' intolerance of large central governments produces a wedge between political ideals, such as universal health care, and institutions.⁴¹ This divide, combined with a pro-market ideology has tremendous potential to dampen reform efforts.⁴² The arguments of these three social scientists clearly support the belief in American exceptionalism. As such America is ideologically distinct from Canada.

Canada and the U. S. emanated from the same British colonial tradition and both nations were created from revolutionary roots and share a common culture; however, these nations have fundamentally different ideological social-welfare values. These value differences are instructive when trying to explain the variations in politics, interest group influence, and institutional arrangements between these two sister nations. Lipset provides

the interesting assessment that the U. S. was born out of revolution, while Canada is borne out of the counter-revolution.⁴³ Lipset argues that the U. S. became totally independent from Britain while Canada remained British resulting in different cultural values. He then argues that the Tory tradition in Canada resulted in support for a strong state, group solidarity, and elitism. Lipset states:

Socialism is strong where Tory and monarchical statism have legitimated strong government, and where elitism has fostered organized counter reactions by the less privileged strata. A tradition of state paternalism fostered by national elites has served to legitimate efforts by the less privileged strata to mobilize resources to improve their position through government action.⁴⁴

Concisely stated, Canadian values of statism and elitism run counter to the values of the “American Creed.” As a result, they provide a cultural environment that is far more conducive to major social welfare reform efforts requiring governmental involvement. From a different perspective, Carolyn Tuohy argues that Canadian Toryism is a hybrid of British tory conservatism combined with socialism.⁴⁵ According to Tuohy this distinctive political philosophy of collectivism encourages “a collaboration between leadership of corporate groups and the state in pursuit of redistributive policies.”⁴⁶ Since collectivism runs counter to individualism, it is notably absent from the U.S. value system. In summary, fundamental dogmatic differences exist between the U. S. and Canada.

Interest groups

The influence of interest groups helps explain part of the reasons for the difficulty to enact major reforms in any nation. Business groups are generally opposed to additional mandates, as well as expansions of government. However, two specific industries traditionally stand out in opposition to national health insurance (NHI): insurance

companies and doctors. Insurance companies might lose business or be regulated under national health insurance; and doctors represented by the American Medical Association (AMA) and Canadian Medical Association (CMA) might feel that their freedom to conduct their practices would be limited by national health insurance.⁴⁷ Since interest groups are generally more numerous, better-organized, and both financially and politically stronger than ordinary citizens, they are generally viewed to have significant importance in the policy making process.⁴⁸

Interestingly, unpaid medical bills and reduced demand for services during the Depression years led both the AMA and the CMA to initially support government managed (and funded) health insurance for low-income citizens and the indigent.⁴⁹ However, in both the U. S. and Canada, suppliers of health services (AMA and CMA) were in opposition to the consumers of health care (represented by labor groups) regarding the appropriate level of government involvement in health care.

By the 1940s, the medical profession in Canada, in contrast to the U. S., was fundamentally supportive of state action to achieve universal health care coverage. Although they were internally divided over issues of medical remuneration, the CMA actively participated in discussions to shape the proposed systems. In contrast, the AMA refused to discuss reform efforts with legislators and waged a multi-million dollar campaign to discredit efforts, and successfully block NHI. Although the 1950s were remarkably quiet, each side continued to build coalitions. By the 1960s, the CMA became increasingly hostile to the notion of governmental health insurance, leading to a strike by Saskatchewan doctors in opposition to the introduction of Medicare in that province in

1962. This strike was ultimately unsuccessful. In fact, it diminished the prestige of the CMA and elevated the issue of NHI as a national political agenda.⁵⁰ Like the AMA, but with considerably less hostility, the CMA continued their fight against NHI by promoting a compromise of governmental subsidization of low-income subscribers to insurance plans offered by multiple carriers. By 1966, the NHI initiative had become “so politically potent; no one could afford to be seen as opposed.”⁵¹ With this political and social reality, CMA’s battle against NHI was apparently lost. The CMA wisely moved to work with the provincial governments to trade off entrepreneurial discretion for collective professional autonomy. Carolyn Tuohy surmises that it was a “red tory” response to accept some social responsibility for the mitigation of costs in return for the maintenance of a privileged position in the decision-making structure.”⁵²

Institutions and Partisanship

United States

Many policy analysts attribute the absence of a U. S. universal national health insurance program to the structure of government and institutions.⁵³ Their arguments have merit. The Founding Fathers took great care to ensure that sweeping changes would be difficult to accomplish. The delegates to the Constitutional Convention had experience with a government that was too strong (such as English rule during the colonial period after 1763) and government that was too weak to operate effectively under the first constitution, the Articles of Confederation . They wanted an effective government, but not one that was so strong as to infringe on liberties. The solution was to create a structure of government that would make radical change difficult, but not impossible. This was done through the related principles of separation of powers and checks and balances placed in three

government powers, legislative, executive, and the judicial. These powers that would be located in separate institutions: Congress, the president, and the courts, each with their own distinct power to check the other branch.⁵⁴ The combination of these two principles creates a situation that is described as "separated institutions *sharing* powers."⁵⁵

Although the United States' structure of governance provides a powerful institutional justification for the inability to enact major health reform initiatives, it is only one factor. Weaver and Rockman propose two additional two tiers: electoral rules and norms; and institutional forces emanating from the "constitutional architecture" such as judicial review, bicameralism, federalism, and the non-institutional factors of public opinion, values, and political divisions.⁵⁶ Even though each institutional factor has its own influence on policy formation, health care analysts place tremendous importance on partisanship and the role of divided government

The Constitutional Framers generally regarded parties as undesirable or even dangerous. Despite the Framers' intentions, the Constitution's plurality voting rules inadvertently provides powerful incentives for like-minded politicians to form permanent coalitions in government and the electorate.⁵⁷ Although the coalitions, characteristics, and even the strength of parties have changed over the years, they have become vital to the proper functioning of our system of government . In recent years, however, political scientists have questioned the efficacy of a government system divided along party lines. The implication is that the party allegiance interferes with the ability to enter into negotiated compromises that are critical to the legislation process. The literature indicates that divided government may hinder some legislative efforts, but that government is still is

able to legislate even when divided.⁵⁸ Changes in the electoral system have increased party homogeneity and given rise to conditional party government and increased majority party power; however, enacting legislation based upon majority membership alone is still difficult.⁵⁹

Legislation is an incredibly complex *institutional process* with a variety of players with distinct, yet sometimes intermingled, roles. Excluding partisanship, difficulty enacting legislation is due to a number of externalities, such as personalities, public opinion, the media, institutional context, ideological heterogeneity, party polarization, and budgetary situations. Majority parties may have difficulty executing their agenda when they misinterpret election to office as a mandate, are unwilling, or are unable to compromise, or overlook the power of the institutional relationships imposed by the Constitution. Partisanship may result in a modicum of inertia, but the key to controlling the legislative process involves an understanding of the rules of the game and institutional interactions. From a purely practical perspective, an issue has to get past the first step in the process and be placed on the agenda before a legislative proposal can even be considered. Secondly, compromises between competing ideologies of social agenda setting and pragmatic business approaches must be achieved. Partisanship may affect the civility of the Congress, but it does not always result in an adverse affect on the national government's ability to function or to be responsive to the electorate.⁶⁰

Canada

Parliamentary government and federalism are the two distinct institutional characteristics between the United States and Canada. Canada's parliamentary government defines the rules of the legislative process and provides enhanced

opportunities for third parties to develop into viable political forces. This is not true with the U. S. system that promotes a two party system to include dissident factions within the party at varying levels of conservatism (conservative, moderate, or liberal). Major parties in Canada are less likely to absorb nonconformist factions. As a result, even though third parties are not likely to control government, they have tremendous opportunity to frame the debates and influence policy outcomes.⁶¹

More importantly, although federalism has a significant impact on the party system in both countries it is more important in Canadian political outcomes. Unlike the balance provided by the U. S. Senate, the Canadian federal government does not necessarily embody regional representation. Consequently, provincial governments maintain significantly more control than states, resulting in a more decentralized form of federalism than the U. S.⁶² Because of this decentralization, the provincial governments have a more powerful role in intergovernmental relations than the American states. In a fairly symbiotic relationship, the parliamentary government and decentralized federalism make third party factions more important in the political framework. The combination of the development of effective third party factions, the distinctive nature of Canadian federalism, and the Parliamentary legislative process worked together to provide a smooth flowing policy stream for national health insurance.

Rocky Road to U. S. Health Reform

In 1933, President Franklin Roosevelt created a task force, the Committee for Economic Security, to consider possibilities for a system of economic pensions for retired persons and insurance for health care. The committee developed the plan that eventually

became Social Security, but reluctantly concluded that national health insurance could not be passed, largely because of the opposition of the American Medical Association.

Moreover, although Congress was controlled by the Democrats, the power lay in the hands of southern conservatives who did not support NHI.⁶³ As a result though, the *1935 Social Security Act* was passed creating the Social Security, welfare, and unemployment compensation programs we know today. Unlike other Western industrialized nations; however, health care was not a part of the program.

Private health insurance emerged concurrent to Roosevelt's efforts to enact social insurance legislation. During World War II, when wage and price controls were in effect, businesses found that they could increase compensation to their employees by offering non-wage fringe benefits, such as health insurance. Health insurance interests and physicians responded to this demand and materialized as powerful political and economic forces. More importantly, private health insurance attained an institutional foothold in business practices and was viewed in a positive light by both employers and employees. The Internal Revenue Service allowed the costs of health insurance to businesses to be deducted as a business expense. The Internal Revenue Code of 1954 codified this practice was by including a regulation that made this deduction permanent.⁶⁴

Harry Truman was the first President to make health care a formal agenda item. Unfortunately he was never able to get the support for health care reform in the ideologically fractionalized Congress.⁶⁵ Although the Democrats regained control of Congress after the 1948 elections, southern conservative Democrats, known as "Dixiecrats," regained key positions of power. This faction of democratic conservatives

joined forces with Republicans to form a conservative coalition that frustrated efforts at passage of NHI.

By the 1950s, advocates of national health insurance decided to pursue smaller, incremental changes, focusing on two groups that might win public sympathy, the elderly and the young.⁶⁶ Ultimately some success was achieved and Congress passed the non-mandatory *1960 Kerr-Mills Act* that provided states with matching funds (grants) to pay providers to help elderly poor. In 1960, John F. Kennedy advocated federally funded universal medical assistance for the elderly and was unsuccessful. When Lyndon Johnson became president in 1963, following Kennedy's assassination, he successfully pursued health care for the young, elderly, and poor along with other social programs under the rubrics of the War on Poverty and the Great Society. President Johnson's 1964 "landslide" election with the largest popular vote in American presidential election history provided him with an electoral mandate to pursue his Great Society agenda. More importantly, Democrats who were ideologically compatible with the President won large majorities in both houses of Congress. Given the popular mandate and the galvanizing force emanating from President Kennedy's assassination, Congress was able to overcome opposition from the AMA and combined the elderly program and the *Kerr-Mills Act* and created two new programs—Medicare for the elderly and Medicaid for the poor.⁶⁷ Both programs remain the foundation of governmental efforts to provide health insurance today.

National Health Insurance "Success" in Canada

Canada's publicly financed national health insurance program has its roots in the *British North America Act of 1867* that defined the roles and responsibilities in the

intergovernmental dealings of the health care system. All aspects of the hospital sector—including construction and maintenance of facilities to all medical care provided in the hospitals—were under the control of the provincial governments. The federal government was responsible for the military, disenfranchised groups, such as Native Indians and Eskimos and for regulation of all food and drugs. This early empowerment of the provinces gave them influence in future program changes.

Both American and Canadian interest in public welfare programs, including national health insurance, grew out of the adverse social and economic conditions of the Great Depression. By the mid-1940s, public support for NHI was strong in both of these nations. However, unlike the U. S., Canadians not only believed that health care was a public good, they were willing to pay for national health insurance using taxpayer dollars.⁶⁸ As previously discussed, the notion had the support of the CMA—provided that their interests were represented in policy decisions. Citizen pressure for the government to take action was strong and organized in their efforts.

By 1947, the province of Saskatchewan had introduced a hospital insurance program funded by provincial tax dollars. In 1949 British Columbia adopted a similar program, followed by Alberta in 1950. Also in 1949, when Newfoundland became part of Canada, half of population was already covered by health insurance. As a result, despite attempts at NHI, the four provinces had functional hospital insurance plans. The demonstration effect of these four provincial plans proved to be instrumental in the health policy debate. The *1957 Hospital Insurance and Diagnostic Services Act* was enacted in response to pressure from the provincial governments for assistance.⁶⁹ The 1957 act

provided each province with federal grants that were to cover approximately half the program's cost as long as they complied with four conditions: comprehensive care that provided all medically necessary services without benefit limitations; plans were to be publicly administered on a non-profit basis by a public agency accountable to the provincial government; benefits had to be universal (available to all citizens) and provided on uniform terms and conditions; and plans had to be portable among provinces. Although this was a major step toward cost-sharing of services, it was a rocky start that took almost a decade to implement.

As a result of the hospital program, in the early 1960s, public support increased for expansion of services to include physician services that were outside the hospital. This idea was met with opposition from the CMA, the private insurance industry, and some provinces. To win support from these groups, the federal government met with the industry (physicians and insurance) to compromise over payment schedules and covered benefits. As the ultimate compromise to the private insurance, the federal government bought the major hospital provider (Blue Shield) and transferred the resources to the provinces. As a result of these governmental concessions, when the *1968 Medical Care Act* was implemented, physicians received windfall gains as demands for care increased, combined with significant reductions to overhead costs.⁷⁰ Furthermore, since the insurance plans were primarily purchased in total, the transition was relatively transparent to the average citizen.

This timeline belies the claims that Canada was able to implement major health care reform almost overnight. In fact, the process started in the late 1800s and took almost

70 years to develop a national health insurance program that provided both inpatient (hospital) care and ambulatory (physician-office based) care. Moreover, the program is not truly a national program. The national government does not have the authority to set up and manage a national health care system. Canada's national system is actually a patchwork of provincial and territorial programs. In spite of general federal regulations that tie the plans together, each province has tremendous latitude to manage their programs, as they deem necessary.

Conclusions

While neither the U. S. nor the Canadian health care financing systems are without controversy, two fundamental differences emerge when comparing the two. First, unlike American states, the Canadian provinces began experimenting with provincial health programs early in the policy development process. These early provincial experiments provided a road map for the Canadian national health insurance system—known as Medicare. Second and more importantly, unlike Americans, Canadians placed a higher value—backed with the willingness to pay—on insuring that all citizens have equal access to health services.⁷¹ To ensure that market forces would not interfere with this policy, the federal government took dramatic regulatory steps to prohibit private insurance for services covered under Medicare.⁷² As a result, unlike the U. S., incentives for developing a robust market-driven private insurance system were substantially weakened.⁷³

Review of the ideology, interest groups, and institutional arrangements helps to address the primary research question as to why two essentially different health care financing systems evolved in these two “sister” nations. Indisputable ideological

differences regarding the role of the state in any social policy are present; Americans are decidedly more anti-statist. Furthermore, Canada is clearly more communitarian in their philosophy and willingness to pay for social reform efforts that take care of the nation's citizens, while the U.S. is more individualistic.⁷⁴ In Canada, the interest groups—represented by the health insurance industry and the medical profession—were coerced into collaborating with the government to develop a mutually agreeable health care financing system. In contrast, internal debate within all key U. S. factions of the national health insurance, combined with government actions that strengthened the interest groups made compromise impossible. In fact, when serious discussion on social reform began in the United States, the government chose to refrain from adding health insurance to the *1935 Social Security Act*, rather than face the opposition from special interest groups. By avoiding this conflict, President Roosevelt may have missed a prime opportunity to resolve issues and, at a minimum, strengthened the determination and ability of the AMA and the nascent health insurance to fight national health insurance. Finally, institutional arrangements and partisanship differences hindered any major policy changes. Within the United States, state governments are not provided with the same level of interaction or consideration in the policy development and implementation as Canadian provinces. Canada uses a substantially more collaborative form of federalism than the United States that was institutionalized during the immediate post World War II period by adopting a practice of codetermination for wide-ranging national policies.⁷⁵ Under this premise, provincial governments work together with the federal government as equal partners in policy development. Provincial governments are also empowered to take the initiative on their own—acting collectively in the absence of the federal government—to formulate

national policy. Similar action among the U. S. states is prohibited and it is unlikely that consensus among the 50 states could be obtained to engage in any serious development of national policy.

Conceivably a more important consideration is the political philosophy adopted by President Franklin Roosevelt, during the most active period of U. S. social reform (the New Deal). The New Deal restructured partisan politics and it shifted the institutional arrangements of intergovernmental relations to form a powerful federal government stance, weakening reform efforts at the state level. As pointed out by Timothy Conlan, “Put simply, Roosevelt’s platform—and certainly his rhetoric—boiled down to two elements: that government can help solve society’s economic problems and that the federal government should take the lead in doing so.”⁷⁶ The effect of centralized government authority was to stifle state involvement in formation of U. S. social reforms. In contrast, during this same time frame, a relatively more robust cooperative form of federalism stimulated innovation in the Canadian provinces.

Despite the diversity of the U. S. and Canadian health care systems as they are currently structured, there are similarities in the U. S. Medicaid program and the Canadian provincially-based health insurance program. As previously discussed, both the U.S. Medicaid and Canadian Medicare are heavily mired in the use of categorical matching grants and fiscal federalism.⁷⁷ Moreover, both U.S. Medicaid and Canadian Medicare use equalization formulas based upon demographic factors, such as state (or provincial) per capita income and fiscal need. As pointed out by David Beam and Timothy Conlan, even though fiscal federalism provides a powerful theoretical basis for the use of grants to

provide benefit spillover effect and equalize fiscal capacity, this is seldom an outcome of intergovernmental grants.⁷⁸ The use of needs-based funding formulas in these two health care programs indicates that the theory of fiscal federalism applies to both insurance schemes. Regardless of the influence of fiscal federalism as a factor in the political philosophy behind U.S. Medicaid and Canadian Medicare, Beam and Conlan also identify the strong political attraction that grants have to obtain cooperation of the state governments to engage in controversial programs. This is certainly the case with both programs. States have embraced Medicaid so avidly that it has evolved into the largest federal aid grant to the states. In Canada, the use of federal matching funds is the only means by which the federal government is able to exert any control over health care delivery in the provinces.

Passage of Medicaid in 1965—approximately the same time that Canada passed national health insurance legislation—has empowered the states to become innovators and policy entrepreneurs in health care finance policy.⁷⁹ The same key circumstances that led to the creation of national health insurance in Canada are currently in place in the United States. Health care financing in the U. S. is becoming increasingly unstable, driving calls for reform from businesses, which are no longer happy with the economic burden of the status quo. States are natural laboratories of democracy for what can and what should work in the United States. Also, like post World War II Canada, judicious application of the theories of federalism and intergovernmental cooperation provides an opportunity to engage the states with serious dialogue regarding health care finance reform. Regardless, health policy analysts and legislators should be cognizant of history and institutional

differences between Canada and the U.S. as future dialogue to reform the American health care financing system emerges from the political and policy streams.

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Appendix A

Tables

TABLE 1. COMPARATIVE DATA (CALENDAR YEAR 2000) FOR EXPENDITURES AND BENEFITS AMONG ORGANIZATION OF ECONOMIC COOPERATION AND DEVELOPMENT (OECD) NATIONS; SORTED BY PER CAPITA NATIONAL HEALTH EXPENDITURE							
Country	Total expenditure on health - Per capita, US\$ PPP	Total expenditure on health - % GDP	Public expenditure on health - % Total expenditure on health	Private insurance - % Total expenditure on health	Out-of-pocket payments - % Total expenditure on health	Public expenditure on health - % GDP	Percentage of Population Covered by Public Health Programs
Australia	\$2,211	8.3	72.4	--	--	6	100
Austria	\$2,162	8	69.7	7.1	19	5.6	99
Belgium	\$2,269	8.7	71.2	--	--	6.2	98
Canada	\$2,535	9.1	72	11.2	15	6.5	100
Czech Republic	\$1,031	7.2	91.4	--	9	6.6	100
Denmark	\$2,420	8.3	82.1	1.6	16	6.8	100
Finland	\$1,664	6.6	75.1	2.5	21	5	100
France	\$2,349	9.5	76	12.6	10	7.2	99
Germany	\$2,748	10.6	75.1	12.5	11	8	99.5
Greece	\$1,399	8.3	55.5	--	--	4.6	100
Hungary	\$841	6.8	75.7	0.1	21	5.1	100
Iceland	\$2,608	8.9	84.4	--	--	7.5	100
Ireland	\$1,953	6.7	75.8	7.5	11	5.1	100
Italy	\$2,032	8.1	73.7	0.9	23	5.9	100
Japan	\$2,012	7.8	76.7	0.3	--	5.9	100
Korea	\$893	5.9	44.4	7.2	--	2.6	100
Mexico	\$490	5.4	46.4	--	--	2.5	100
Netherlands	\$2,246	8.1	67.5	--	--	5.5	74.2
New Zealand	\$1,623	8	78	6.2	14	6.2	100
Norway	\$2,362	7.8	85.2	--	14	6.7	100
Portugal	\$1,441	8.2	71.2	--	--	5.8	100
Slovak Republic	\$690	5.9	89.6	--	10	5.3	98
Spain	\$1,556	7.7	69.9	3.4	--	5.4	100
Switzerland	\$3,222	10.7	55.6	--	--	6	98
United Kingdom	\$1,763	7.3	81	--	--	5.9	100
United States	\$4,631	13	44.3	34.3	15	5.8	45

Source: OECD HEALTH DATA 2002 4th ed.

TABLE 2. UNITED STATES CORPORATE AND INDIVIDUAL INCOME TAX ESTIMATES OF TAX EXPENDITURES (IN MILLIONS OF DOLLARS)

	Corporations	Individuals
Exclusion of employer contributions for medical insurance premiums and medical care		82,800
Self-employed medical insurance premiums		1,520
Workers' compensation insurance premiums		4,730
Medical Savings Accounts		20
Deductibility of medical expenses		499
Exclusion of interest on hospital construction bonds	280	820
Deductibility of charitable contributions (health)	710	3,300
Tax credit for orphan drug research	140	
Special Blue Cross/Blue Shield deduction	270	

Source: U. S. Office of Management and Budget. *Analytical Perspectives: Budget of the United States Government Fiscal Year 2003*. Washington, DC: Government Printing Office, 2002: 105.

TABLE 3. MARGINAL PERSONAL INCOME TAX AND SOCIAL SECURITY CONTRIBUTION RATES ON GROSS LABOUR INCOME (2001)¹

		% APW			
		67%	100%	133%	167%
Canada	Central government	15.0%	21.0%	22.0%	26.0%
	Sub-central	7.3%	10.3%	10.8%	12.7%
	Combined	22.3%	31.2%	32.8%	38.7%
	Employee SSC	6.5%	6.6%	0.0%	0.0%
	'All-in'	28.8%	37.8%	32.8%	38.7%
	Employer SSC	7.5%	7.5%	0.0%	0.0%
	Total tax wedge	33.8%	42.1%	32.8%	38.7%
United States	Central government	15.0%	15.0%	27.5%	27.5%
	Sub-central	6.8%	6.8%	6.8%	6.8%
	Combined	21.8%	21.8%	34.3%	34.3%
	Employee SSC	7.7%	7.7%	7.7%	7.7%
	'All-in'	29.5%	29.5%	42.0%	42.0%
	Employer SSC	7.7%	7.7%	7.7%	7.7%
	Total tax wedge	34.5%	34.5%	46.1%	46.1%

Key to abbreviations:

APW=average production wage (in national currency), meaning the average annual gross wage earnings of adult, full-time workers in the manufacturing sector.

All-in=the all-in tax rate, calculated as the combined central and sub-central government income tax plus employee social security contribution, as a percentage of gross wage earnings.

Total tax wedge=the combined central and sub-central government income tax plus employee and employer social security contribution tax, as a percentage of labor costs defined as gross wage earnings plus employer social security contributions. The tax wedge excludes cash transfers (see footnote 1).

Footnotes:

1. This table reports marginal personal income tax and social security contribution rates for a single person without dependent, at various multiples (67%, 100%, 133%, and 167%) of the APW. The results, derived from the OECD Taxing Wages framework (elaborated in the annual publication *Taxing Wages*), use tax rates applicable to the tax year beginning in calendar year 2001. The results take into account basic/standard income tax allowances and tax credits, but exclude universal family cash transfers (included in *Taxing Wages*). The marginal tax rates are derived on the basis of a unit increase in gross wages, with the exception of the marginal total tax wedge calculation, which considers an increase in gross labor costs (gross wages + employer SSC) resulting from a unit increase in gross wage earnings. The sub-central personal tax rates used in this table correspond to those used in *Taxing Wages* (rates applicable in a typical manufacturing area or a weighted average of sub-central rates for the country as a whole).
 2. Table extracted from *Taxing Wages: 2000-2001*. [database on-line] (Organization for Economic Cooperation and Development, February 2002), accessed 15 March 2003; available from www.SourceOECD.org
-

References

- Aaron, Henry J. and Barry P. Bosworth. *Economic Issues in Reform of Health Care Financing*. Washington, DC: The Brookings Institution, 1994.
- Anderson, Gerard. *Multinational Comparisons of Health Care: Expenditures, Coverage, and Outcomes*. Baltimore, MD: The Commonwealth Fund, 1998.
- Barer, Morris L., Robert G. Evans, Matthew Holt, and J. Ian Morrison. "It Ain't Necessarily So: The Cost Implications of Health Care Reform." *Health Affairs* 13, no. 4 (1994): 88-99.
- Beaudan, Eric. "Canadian Model of Healthcare Ails." *Christian Science Monitor*, 28 August 2002, A1.
- Berwick, Donald. "Implementing the 21st Century Health Care Chasis." In *Academy for Health Services Research and Health Policy Annual Research Meeting*. Washington DC, 2002.
- Binder, Sarah. "The Dynamics of Legislative Gridlock, 1947-1996." *American Journal of Political Science* 93, no. 3 (1999): 519-533.
- Blendon, Robert J., Cathy Schoen, Catherine M. DesRoches, Robin Osborn, Kimberly L. Scoles, and Kinga Zapert. "Inequities in Health Care: A Five Country Survey." *Health Affairs* 21, no. 3 (2002): 182-191.
- Boyd, Donald J. "Medicaid Devolution: A Fiscal Perspective." In *Medicaid and Devolution: A View from the States*, ed. Frank J. and John J. Dilulio Thompson, Jr., 56-105. Washington, DC: Brookings Institution Press, 1998.
- Brady, D. W., & Volden, C. *Revolving Gridlock: Politics and Policy from Carter to Clinton*. Boulder, CO: Westview Press, 1998.
- Brown, Lawrence D. and Michael S. Sparer. "Poor Program's Progress: The Unanticipated Politics of Medicaid Policy." *Health Affairs* 22, no. 1 (2003): 31-45.
- Cameron, David and Richard Simeon. "Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism." *Publius* 32, no. 2 (2002): 49-65.
- Canada Health Act Division. *Canada Health Act Annual Report, 2001-2002*. Ottawa, Canada: Health Canada Publications Centre, 2002.
- Conlan, Timothy. *From New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform*. Washington, DC: The Brookings Institution, 1998.
-

-
- Coughlin, Teresa A. and Stephen Zuckerman. "States' Strategies for Tapping Federal Revenues: Implications and Consequences of Medicaid Maximization." In *Federalism and Health Policy*, ed. Alan Weil John Holahan, and Joshua M. Weiner, 145-175. Washington, DC: The Urban Institute Press, 2003.
- Cunningham, Peter J. *Pressures on the Safety Net: Differences in Access to Care for Uninsured Persons By the Level of Managed Care Penetration and Uninsurance Rates in a Community*. Washington, DC: Center for Studying Health System Change, 1998.
- Donelan, Karen, Robert J. Blendon, Cathy Schoen, Karen Davis, and Katherine Binns. "The Cost of Health System Change: Public Discontent in Five Nations." *Health Affairs* 18, no. 3 (1999): 206-216.
- Edwards III, George C. "The Legislative Impact of Divided Government." *American Journal of Political Science* 41, no. 2 (1997): 545-563.
- Evans, C. Lawrence. "Committees and Health Jurisdictions in Congress." In *Intensive Care: How Congress Shapes Health Policy*, ed. Thomas E. Mann and Norman J. Ornstein, 25-52. Washington, DC: American Enterprise Institute for Public Policy Research and The Brookings Institution, 1995.
- Evans, Robert G. "Canada: The Real Issues." *Journal of Health Politics, Policy and Law* 17, no. 4 (1992): 738-762.
- _____. "Canada." *Journal of Health Politics, Policy and Law* 25, no. 5 (2000): 888-897.
- Federal Support for Health Care: The Facts* [database on-line] (Canadian Department of Finance, February 2003, accessed 15 March 2003); available from http://www.fin.gc.ca/factsheets/fshc4_e.html#Back6.
- Ginsberg, Eli and Robert M. Solow, ed. *The Great Society: Lessons for the Future*. New York, NY: Basic Books, 1974.
- Ginzberg, Eli, ed. *Medical Gridlock and Health Reform*. Boulder, CO: Westview Press, 1994.
- Glied, Sherry. *Chronic Condition: Why Health Reform Fails*. Cambridge MA, 1997.
- Goldfield, Norbert. "'Truman and the Medical Profession: Replay or Lesson for the Nineties.'" *Physician Executive* 19, no. 2 (1993): 3-7.
- Graig, Laurene A. *Health of Nations: An International Perspective on U.S. Health Care Reform*. 3rd. Washington, DC: Congressional Quarterly Press, 1999.
-

-
- Greenberg, Jonathan. "Give 'em Health, Harry." *The New Republic* 209, no. 15 (1993): 20-25.
- Hacker, Jacob S. *The Divided Welfare State*. Cambridge, UK: Cambridge University Press, 2002.
- Hartmann, Susan M. *Truman and the 80th Congress*. Columbia MO: University of Missouri Press, 1971.
- Hartz, Louis. *The Liberal Tradition in America*. New York, NY: Harcourt, Brace & Co, 1955.
- Hecl, Hugh. "The Clinton Health Plan: Historical Perspective." *Health Affairs* 14, no. 1 (1995): 86-98.
- Henderson, James W. *Health Economics and Policy*. Second. Cincinnati, OH: South-Western, 2002.
- Holahan, John. *Variations Among States in Health Insurance Coverage and Medical Expenditures: How Much is Too Much?* Washington, DC: The Urban Institute, 2002.
- Holahan, John and Mary Beth Pohl. *States as Innovators in Low-Income Health Coverage*. Washington DC: The Urban Institute, 2002.
- Huntington, Samuel. "The Gap: American Creed Versus Political Authority." In *Governance and American Politics*, ed. James P. Pfiffner, 46-53. Fort Worth, TX: Harcourt Brace & Company, 1995.
- Hurley, Robert and Stephen Zuckerman. *Medicaid Managed Care: State Flexibility in Action*. Washington, DC: The Urban Institute, 2002.
- Iglehart, John K. "Medicare." In *Contemporary Health Policy*, ed. Beaufort B. Longest, Jr., 539-552. Chicago, IL: Health Administration Press, 1999.
- Jameison, Kathleen and Erika Falk. "Continuity and Change in Civility in the House." In *Polarized Politics: Congress and the President in a Partisan Era*, ed. Jon R. Bond and Richard Fleisher, 96-108. Washington, DC: Congressional Quarterly Press, 2000.
- Johnson, Haynes and David S. Broder. *The System: The American Way of Politics at the Breaking Point*. Boston, MA: Little, Brown and Company, 1997.
- Key, V.O. "The Nature and Function of Political Parties." In *Governance and American Politics*, ed. James P. Pfiffner, 383-390. Fort Worth, TX: Harcourt Brace College Publishers, 1995.
-

-
- Kingdon, John W. *Agendas, Alternatives, and Public Policies*. 2d ed. New York, NY: Addison-Wesley Educational Publishers Inc, 1995.
- Levit, Katharine, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin. "Trends in U.S. Health Care Spending, 2001." *Health Affairs* 22, no. 1 (2003): 154-164.
- Lipset, Seymour Martin. *American Exceptionalism: A Double-Edged Sword*. New York, NY: W. W. Norton, 1996.
- Longest, Beaufort B., Jr., ed. *Contemporary Health Policy*. Chicago, IL: Health Administration Press, 2001.
- Madison, James. "The Union As A Safeguard Against Domestic Faction And Insurrection (Federalist Papers No. 51)." In *The Federalist Papers*, ed. Clinton Rossiter, 45-52. New York, NY: New American Library, 1999.
- Maioni, Antonia. "Nothing Succeeds Like the Right Kind of Failure: Postwar National Health Insurance Initiatives in Canada and the United States." *Journal of Health Politics, Policy and Law* 20 (1995): 6-30.
- _____. "Parting at the Crossroads: The Development of Health Insurance in Canada and the United States, 1940-1965." *Comparative Politics* 29, no. 4 (1997): 411-431.
- Mann, Cindy. "The Flexibility Factor: Finding the Right Balance." *Health Affairs* 22, no. 1 (2003): 62-76.
- Mansfield, Harvey C. and Delba Winthrop, eds. *Democracy in America*. Chicago, IL: University of Chicago Press, 2000.
- Marmor, Theodore R. "The Politics of Universal Health Insurance: Lessons from Past Administrations?" *PS: Political Science and Politics* 27, no. 2 (1994): 194-198.
- _____. *The Politics of Medicare*. Second edition. Hawthorne, NY: Aldine De Gruyter, 2000.
- Mayhew, David R. *Divided We Govern: Party Control, Lawmaking, and Investigations, 1946-1990*. New Haven, CT: Yale University Press, 1993.
- Mongan, James J. "Anatomy and Physiology of Health Reform's Failure." *Health Affairs* Spring (1995): 99-102.
- Morone, James A. "The Bureaucracy Empowered." In *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. and Gary S. Belkin Morone, 148-164. Durham, NC: Duke University Press, 1994.
-

-
- Neustadt, Richard. "The Power to Persuade." In *Governance and American Politics*, ed. James P. Pfiffner, 142-150. Fort Worth, TX: Harcourt Brace & Company, 1995.
- "Passing Round the Medicine Hat." *The Economist*, 12 February 2003, 35-37.
- Peterson, Mark A. "Congress in the 1990s: From Iron Triangles to Policy Networks." In *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. and Gary S. Belkin Morone, 103-147. Durham, NC: Duke University Press, 1994.
- Poen, Monte M. *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare*. Columbia, MO: University of Missouri Press, 1979.
- Reinhardt, Uwe. "International Perspectives on Health Policy Reform." In *Social Security and Medicare: Individual vs. Collective Risk and Responsibility*, ed. Sheila Burke, Eric Kingson, and Uwe Reinhardt. Washington, DC: National Academy of Social Insurance, 2000.
- _____. "The Imperative of Universal Coverage." In "*Health Action 2003: National Grassroots Meeting*". Washington DC: Mayflower Hotel: Families USA, 2003.
- Reinhardt, Uwe, Peter S. Hussey, and Gerard F. Anderson. "Cross-National Comparisons of Health Systems Using OECD Data, 1999." *Health Affairs* 21, no. 3 (2002): 169-191.
- Rushefsky, Mark E. and Kant Patel. *Politics, Power & Policy Making: The Case of Health Care Reform in the 1990s*. Armonk, NY: M. E. Sharpe, 1998.
- Schlesinger, Arthur, Jr. *The Politics of Hope*. Boston, MA: Riverside Press, 1962.
- Schlesinger, Arthur M. Jr. *The Cycles of American History*. New York, NY: Mariner Books, 1999.
- Shelton, Michael W. *Talk of Power, Power of Talk: The 1994 Health Care Reform Debate and Beyond*. Westport, CT: Praeger Publishers, 2000.
- Skocpol, Theda. *Protecting Soldiers and Mothers: The Political Origin of Social Policy in the United States*. Cambridge, MA: Harvard University Press, 1992.
- _____. *Boomerang: Health Care Reform and the Turn Against Government*. New York, NY: W. W. Norton & Company, 1997.
- Starr, Paul. *The Social Transformation of American Medicine*. New York, NY: Basic Books, 1982.
-

State Health Facts Online (Kaiser Family Foundation, 1 August 2003, accessed 18 August 2003); available from <http://statehealthfacts.kff.org>.

Steinmo, Sven and Jon Watts. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Politics, Policy and Law* 20, no. 2 (1995): 329-372.

Stiglitz, Joseph E. *Economics of the Public Sector*. New York, NY: W. W. Norton & Company, 2000.

Stone, Deborah. *Policy Paradox: The Art of Political Decision Making*. Revised. New York, NY: W. W. Norton & Co., 2002.

Sundquist, James L. "Needed: A Political Theory for the New Era of Coalition Government in the United States." *American Political Science Quarterly* 103, no. 4 (1988-1989): 614-616.

Tax Expenditures and Evaluations, 2002 [database on-line] (Canadian Department of Finance, February 2003, accessed 15 April 2003); available from www.fin.gc.ca.

Taxing Wages: 2000-2001 [database on-line] (Organization for Economic Cooperation and Development, February 2002, accessed 15 March 2003); available from www.SourceOECD.org.

The Institute for the Future. *Health and Health Care 2010: The Forecast, The Challenge*. San Francisco, CA: Jossey-Bass Publishers, 2000.

Thompson, Frank J. . "The Faces of Devolution." In *Medicaid and Devolution: A View from the States*, ed. Frank J. Thompson and John J. Dilulio Jr., 14-55. Washington, DC: Brookings Institution Press, 1998.

Tsebelis, George. *Veto Players: How Political Institutions Work*. Princeton, NJ: Princeton University Press, 2002.

Tuohy, Carolyn Hughes. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*: Oxford University Press, 1999.

_____. "The Costs of Constraint and Prospects for Health Care Reform in Canada." *Health Affairs* 21, no. 3 (2002): 32-46.

U. S. Census Bureau. *Health Insurance Coverage in the United States: 2002*. Washington, DC, 2003, P60-223.

U. S. Office of Management and Budget. *Analytical Perspectives: Budget of the United States Government Fiscal Year 2003*. Washington, DC: Government Printing Office, 2002.

Ullrich, Dierk. "Concurring Visions: Human Dignity in the Canadian Charter of Rights and Freedoms and the Basic Law of the Federal Republic of Germany." *Global Jurist Frontiers* 3, no. 1 (2003): Article 1.

Weaver, R. Kent and Bert A. Rockman. "Institutional Reform and Constitutional Design." In *Do Institutions Matter? Government Capabilities in the United States and Abroad*, ed. R. Kent Weaver and Bert A. Rockman, 462-482. Washington, DC: The Brookings Institution, 1993.

_____. "Assessing the Effects of Institutions." In *Do Institutions Matter? Government Capabilities in the United States and Abroad*, ed. R. Kent Weaver and Bert A. Rockman, 1-41. Washington, DC: The Brookings Institution, 1993.

Weir, Margaret. "Institutional and Political Obstacles to Reform." *Health Affairs* Spring (1995): 102-105.

Weir, Margaret, Ann Shola Orloff, and Theda Skocpol, eds. *The Politics of Social Policy in the United States*. Princeton, NJ: Princeton University Press, 1988.

White, Joseph. *Competing Solutions: American Health Care Proposals and International Experience*. Washington, DC: The Brookings Institution, 1995.

Woolhandler, Steffie and David U. Himmelstein. "Paying for National Health Insurance-- And Not Getting It." *Health Affairs* 21, no. 4 (2002): 88-99.

Endnotes:

¹ Although the Queen or sovereign is the head of state in Canada, the powers and authority of the sovereign have been delegated to the Governor General of Canada, and the Governor General is in effect the Canadian head of state.

² One of the primary differences between the United States and Canada resides within their systems of governance. The United States uses a system of separation of powers with a president as the head of state. The Canadian government uses a parliamentary system. However, both countries have constitution and employ a system of federalism to balance power and responsibility between the federal and state/provincial governments.

³ Although the numbers of uninsured Americans shift with changes in unemployment and other economic indicators, on average approximately 16 percent of all Americans were uninsured over the past decade.

⁴ Although economists argued that expanding the Medicare to accomplish universal health care was technically feasible, they admitted that it would require careful consideration of the nuances involved with a complex weave of health care, labor compensation packages, and prices. Henry J. and Barry P. Bosworth Aaron, *Economic Issues in Reform of Health Care Financing* (Washington, DC: The Brookings Institution, 1994); Morris L. Barer and others, "It Ain't Necessarily So: The Cost Implications of Health Care Reform," *Health Affairs* 13, no. 4 (1994): 88-99; Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* (Washington, DC: The Brookings Institution, 1995), 267-269.

⁵Scholars have argued that the U.S. system of Medicare and Medicaid are patterned after the British “poor laws.” Lawrence D. Brown and Michael S. Sparer, "Poor Program's Progress: The Unanticipated Politics of Medicaid Policy," *Health Affairs* 22, no. 1 (2003): 31-45.

⁶ The polity-centered, or “institutionalist,” approach emphasizes the importance of institutional features of government, the rules of electoral competition organization, and structure of state institutions in shaping policy outcomes. For additional information on this premise, see the introductory chapter of Margaret Weir, Ann Shola Orloff, and Theda Skocpol, eds., *The Politics of Social Policy in the United States*, Pages. (Princeton, NJ: Princeton University Press, 1988).

⁷ Census Bureau data estimates that in 2001 the number of uninsured Americans increased by about 1.4 millions people to over 41 million, or about 16 percent of all Americans. U.S. Bureau of the Census, *Health Insurance Coverage: 2001* [database on-line] (U.S. Bureau of the Census, September 30 2002, accessed 12 February 2002); available from <http://www.census.gov/hhes/hlthins/hlthin01/hi01t4.html>.

⁸ Sherry Glied, *Chronic Condition: Why Health Reform Fails* (Cambridge MA: 1997), 3-16.

⁹ Jacob S. Hacker, *The Divided Welfare State* (Cambridge, UK: Cambridge University Press, 2002), 231-236.

¹⁰ Joseph E. Stiglitz, *Economics of the Public Sector* (New York, NY: W. W. Norton & Company, 2000), 304.

¹¹ Table 1 of Appendix A provides comparative data from 27 OECD nations to illustrate this point. Laurene A. Graig, *Health of Nations: An International Perspective on U.S. Health Care Reform*, 3rd. (Washington, DC: Congressional Quarterly Press, 1999); Uwe Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs* 21, no. 3 (2002): 169-191.

¹² Cindy Mann, "The Flexibility Factor: Finding the Right Balance," *Health Affairs* 22, no. 1 (2003): 62-76; Uwe Reinhardt, "The Imperative of Universal Coverage," in "*Health Action 2003: National Grassroots Meeting*" (Washington DC: Mayflower Hotel: Families USA, 2003).

¹³ For example, Medicare is targeted towards the non-working population over the age of 65. Medicaid covers most non-elderly who are low-income or unemployed adults, including special categories of pregnant women, children under the age of 18 (under the State Children Health Insurance Program (SCHIP)); some disabled, patients diagnosed with HIV/AIDS; and any person with renal disease regardless of income. Childless adults who are not elderly, disabled, or pregnant cannot be covered by Medicaid regardless of their income level or need for coverage.

¹⁴ Peter J. Cunningham, *Pressures on the Safety Net: Differences in Access to Care for Uninsured Persons By the Level of Managed Care Penetration and Uninsurance Rates in a Community* (Washington, DC: Center for Studying Health System Change, 1998); John Holahan, *Variations Among States in Health Insurance Coverage and Medical Expenditures: How Much is Too Much?* (Washington, DC: The Urban Institute, 2002).

¹⁵ People under 65 who receive Social Security cash payments due to a disability generally become eligible for Medicare after a two-year waiting period. Also, individuals with end-stage renal disease (ESRD) are also entitled to Part A regardless of their age.

¹⁶ FMAP for Medicaid ranges from 50 to 77 percent. FMAP for SCHIP ranges from 65 to 83 percent. *State Health Facts Online*, (Kaiser Family Foundation, 1 August 2003, accessed 18 August 2003); available from <http://statehealthfacts.kff.org>.

¹⁷ In 1999, states spent about 15 percent of their own general fund dollars on Medicaid.

¹⁸ The federal government may waive the general rules regarding populations and services covered by Medicaid.

¹⁹ Over half of Medicaid spending is for optional services, such as prescription drugs. Katharine Levit and others, "Trends in U.S. Health Care Spending, 2001," *Health Affairs* 22, no. 1 (2003): 154-164.

²⁰ The Institute for the Future, *Health and Health Care 2010: The Forecast, The Challenge* (San Francisco, CA: Jossey-Bass Publishers, 2000).

²¹ CMS employs a simple accounting method that counts payments based upon "who wrote the last check in the sequence" from consumer (patient) to provider. Steffie Woolhandler and David U. Himmelstein, "Paying for National Health Insurance--And Not Getting It," *Health Affairs* 21, no. 4 (2002): 88-99.

²² Table 2 in Appendix A provides a more detailed breakdown of the FY 2001 tax expenditure data reported by the Office of Management and Budget.

²³ Tax expenditures include line items for exclusion of employer contributions for insurance programs and medical care (largest share of the total at \$82.8 billion), medical savings accounts, deductions for worker's compensation and self-employed medical premiums, charitable contributions, special Blue Cross/Blue Shield deductions, tax credit for orphan drug research, and exclusion of interest on hospital construction bonds. *Analytical Perspectives: Budget of the United States Government Fiscal Year 2004* (Washington, DC: U. S. Office of Management and Budget, 2003).

²⁴ Payments for disproportionate share hospitals (DSH) have come under increased scrutiny over the past few years. Not only does this result in some states receiving more Medicaid funding, it results in under, or over, reporting the expense of the Medicaid program. Teresa A. Coughlin and Stephen Zuckerman, "States' Strategies for Tapping Federal Revenues: Implications and Consequences of Medicaid Maximization," in *Federalism and Health Policy*, ed. Alan Weil John Holahan, and Joshua M. Weiner (Washington, DC: The Urban Institute Press, 2003).

²⁵ Robert G. Evans, "Canada: The Real Issues," *Journal of Health Politics, Policy and Law* 17, no. 4 (1992): 738-762.

²⁶ *Ibid.*, 740.

²⁷ The Canadian federal government's fiscal constraints in the late 1990s led to decreased health care benefits that resulted in public dissatisfaction with national health insurance. Recognizing the importance of the health care system, the Canadian government promptly addressed concerns to deal with shortcomings. In comparison, little or no action has been taken to resolve ongoing concerns voiced by U.S. citizens on issues regarding financial health security, gaps in insurance coverage (including increased numbers of uninsured) and increased access problems. Robert J. Blendon and others, "Inequities in Health Care: A Five Country Survey," *Health Affairs* 21, no. 3 (2002): 182-191; Karen Donelan and others, "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* 18, no. 3 (1999): 206-216.

²⁸ On average, the federal government historically funded 40 percent of health care costs. This dropped to 23 percent in 1999, but was recently increased in response to complaints from provinces. Eric Beaudan, "Canadian Model of Healthcare Ails," *Christian Science Monitor*, 28 August 2002, A1; "Passing Round the Medicine Hat," *The Economist*, 12 February 2003.

²⁹ In fact, Canadian income tax rates are only higher for certain categories. Higher taxes should be considered within the context of average wages. OECD reports that Canadian average production wages (APW) for 2001 were approximately 13 percent higher in Canada than the United States (\$37,052 USD in Canada versus \$32,371 USD). For additional detail see Table 3 of Appendix A.

³⁰ Similar to the U. S. system, many of these supplemental insurance services are provided as a fringe benefit of employment. Unlike the U. S. system, this practice is not subsidized by tax expenditures. For the most part, supplemental insurance provides services such as cosmetic surgery, private hospital rooms, and outpatient medications. Provinces do pay for outpatient medications for selected population groups, such as those individuals that receive social welfare assistance. Some provinces pay for outpatient medications for the general population, but require substantial co-payments. Robert G. Evans, "Canada," *Journal of Health Politics, Policy and Law* 25, no. 5 (2000): 888-897.

³¹ For instance in February 2003, the provincial government alleged that the federal health care spending was only roughly 14 cents on the dollar, down from 50 cents in the 1960s. The federal government of course disputes this account and points to a failure of the provincial government's ability to interpret the governing legislation and to properly track the federal co-shares. *Federal Support for Health Care: The Facts*, [database on-line] (Canadian Department of Finance, February 2003, accessed 15 March 2003); available from http://www.fin.gc.ca/factsheets/fshc4_e.html#Back6.

³² In 1977, the provincial and federal governments mutually agreed to change specified provincial expenditures on health and post-secondary education block funding to give provinces much greater flexibility in how they allocate federal transfers. This action was taken in response to provincial complaints that cost sharing distorted provincial spending decisions and favored better-off provinces since they could afford to spend more as a means to attract more federal dollars than less well-off provinces. In response to complaints that the federal government reduced their share of health spending without consulting the provinces, the federal government has agreed to create a new Canada Health Transfer to improve transparency and accountability of federal transfer support for health. The changes are projected to take effect in April 2004.

³³ For this reason attempts to derive comparative data, such as that provided in Figure 2 were unsuccessful.

³⁴ Despite these inconveniences and reports of long waits for non-urgent specialty care, Canadians report high levels of satisfaction with their access to, and quality of, health care. Blendon and others, "Inequities in Health Care."; Donelan and others, "The Cost of Health System Change: Public Discontent in Five Nations."

³⁵ For instance, recent reform proposals recommended that provinces use gatekeepers to specialty care and capitated budgeting, similar to policies used by the United States since the 1970s. Graig, *Health of Nations: An International Perspective on U.S. Health Care Reform*, 143-144.

³⁶ It is important to note that these factors apply to all forms of legislative agendas, alternatives, and policy development. John W. Kingdon, *Agendas, Alternatives, and Public Policies*, 2d ed. (New York, NY: Addison-Wesley Educational Publishers Inc, 1995); Deborah Stone, *Policy Paradox: The Art of Political Decision Making*, Revised (New York, NY: W. W. Norton & Co., 2002).

³⁷ Louis Hartz, *The Liberal Tradition in America* (New York, NY: Harcourt, Brace & Co, 1955).

³⁸ For the purposes of this paper, the term "liberalism" is used in terms of the classic definition. In this sense, American liberalism represents a disdain of socialism counterbalanced with a belief in the rule of law and the free market system. Arthur Schlesinger, Jr., *The Politics of Hope* (Boston, MA: Riverside Press, 1962).

³⁹ Seymour Martin Lipset, *American Exceptionalism: A Double-Edged Sword* (New York, NY: W. W. Norton, 1996).

⁴⁰ *Ibid.*, 19.

⁴¹ Samuel Huntington, "The Gap: American Creed Versus Political Authority," in *Governance and American Politics*, ed. James P. Pfiffner (Fort Worth, TX: Harcourt Brace & Company, 1995).

⁴² Americans are less welfare-oriented; Most other industrialized nations are more moralistic Lipset, *American Exceptionalism: A Double-Edged Sword*. Correspondingly, American citizens do not agree that access to health care is a right Graig, *Health of Nations: An International Perspective on U.S. Health Care Reform*, 184.. These considerations provide a convincing justification for universal health coverage failure in the United States.

⁴³ Lipset, *American Exceptionalism: A Double-Edged Sword*, 91-92.

⁴⁴ *Ibid.*, 95.

⁴⁵ Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford University Press, 1999).

⁴⁶ *Ibid.*, 115.

⁴⁷ Physicians' qualms have some merit, as evidenced by attempts to contain Medicare costs by regulating hospital lengths of stays and fee schedules instituted in the 1980s.

⁴⁸ Mark E. Rushefsky and Kant Patel, *Politics, Power & Policy Making: The Case of Health Care Reform in the 1990s* (Armonk, NY: M. E. Sharpe, 1998)

⁴⁹ Antonia Maioni, "Nothing Succeeds Like the Right Kind of Failure: Postwar National Health Insurance Initiatives in Canada and the United States," *Journal of Health Politics, Policy and Law* 20 (1995): 6-30; Monte M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia, MO: University of Missouri Press, 1979).

⁵⁰ Antonia Maioni, "Parting at the Crossroads: The Development of Health Insurance in Canada and the United States, 1940-1965," *Comparative Politics* 29, no. 4 (1997): 411-431.

⁵¹ *Ibid.*

⁵² Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*, 117.

⁵³ Much credit is given to the notion of divided government, but this argument is disputed by the fact that Democratic presidents Roosevelt, Truman, and Clinton failed in their reform attempts with unified government.

⁵⁴ Presidents can either sign or reject legislation, legislatures can approve or reject executive and judicial appointments, courts could declare actions of the president and Congress as unconstitutional, legislatures could, to a certain extent, limit the actions of the judiciary, and so forth. Furthermore, jurisdiction over health care matters is fragmented among numerous Congressional committees and bureaucratic agencies. C. Lawrence Evans, "Committees and Health Jurisdictions in Congress," in *Intensive Care: How Congress Shapes Health Policy*, ed. Thomas E. Mann and Norman J. Ornstein (Washington, DC: American Enterprise Institute for Public Policy Research and The Brookings Institution, 1995).

⁵⁵ George Tsebelis presents an interesting argument that the real institutional factor is the extent to which they provide political players with veto power over policy choices. Using concepts of game theory, demonstrates why an increase in the number of "veto players," or an increase in their ideological distance from each other, increases policy stability, hindering reforms. George Tsebelis, *Veto Players: How Political Institutions Work* (Princeton, NJ: Princeton University Press, 2002).

⁵⁶ R. Kent and Bert A. Rockman Weaver, "Institutional Reform and Constitutional Design," in *Do Institutions Matter? Government Capabilities in the United States and Abroad*, ed. R. Kent Weaver and Bert A. Rockman (Washington, DC: The Brookings Institution, 1993), 446.

⁵⁷ By the election of 1800, a two party system mirroring the ideological division between property owners and the landless and between debtors and creditors was firmly in place. James L. Sundquist, "Needed: A Political Theory for the New Era of Coalition Government in the United States," *American Political Science Quarterly* 103, no. 4 (1988-1989): 614-616.

⁵⁸ Sarah Binder, "The Dynamics of Legislative Gridlock, 1947-1996," *American Journal of Political Science* 93, no. 3 (1999): 519-533; David R. Mayhew, *Divided We Govern: Party Control, Lawmaking, and Investigations, 1946-1990* (New Haven, CT: Yale University Press, 1993).

⁵⁹ Mayhew, *Divided We Govern: Party Control, Lawmaking, and Investigations, 1946-1990*.

⁶⁰ Kathleen Hall Jamieson and Erika Falk, "Continuity and Change in Civility in the House," in *Polarized Politics: Congress and the President in a Partisan Era*, ed. Jon R. Bond and Richard Fleisher (Washington, DC: Congressional Quarterly Press, 2000).

⁶¹ Maioni, "Parting at the Crossroads: The Development of Health Insurance in Canada and the United States, 1940-1965."

⁶² R. Kent Weaver and Bert A. Rockman, "Assessing the Effects of Institutions," in *Do Institutions Matter? Government Capabilities in the United States and Abroad*, ed. R. Kent Weaver and Bert A. Rockman (Washington, DC: The Brookings Institution, 1993).

⁶³ Although government appeared to be unified and controlled by the Democratic Party, they were ideologically separated until President Johnson's remarkable landslide election in 1964. Hugh Heclo, "The Clinton Health Plan: Historical Perspective," *Health Affairs* 14, no. 1 (1995): 86-98.

⁶⁴ James W. Henderson, *Health Economics and Policy*, Second (Cincinnati, OH: South-Western, 2002), 107-109.

⁶⁵ Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare*.

⁶⁶ Despite the continued debate in Congress, a lack of activist's enthusiasm resulted in a dearth of health policy proposals during the Eisenhower administration. Interestingly, it was during the Eisenhower administration that the word "medicare" was first introduced. President Eisenhower sponsored "medicare" legislation to provide civilian hospital and physician health care to certain dependents of military personnel Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origin of Social Policy in the United States* (Cambridge, MA: Harvard University Press, 1992).

⁶⁷ Theodore R. Marmor, *The Politics of Medicare*, Second edition (Hawthorne, NY: Aldine De Gruyter, 2000).

⁶⁸ Robert J. Blendon and John M. Benson, "Americans' Views On Health Policy: A Fifty-Year Historical Perspective," *Health Affairs* 20, no. 2 (2001): 33-47

⁶⁹ The 1957 *Hospital Insurance and Diagnostic Services Act* would serve as the basis for what would become the 1968 *Medical Care Act*, which would transition into the current legislation of the 1984 *Canadian Health Act*.

⁷⁰ Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*.

⁷¹ Dierk Ullrich, "Concurring Visions: Human Dignity in the Canadian Charter of Rights and Freedoms and the Basic Law of the Federal Republic of Germany," *Global Jurist Frontiers* 3, no. 1 (2003): Article 1.

⁷² Carolyn Hughes Tuohy, "The Costs of Constraint and Prospects for Health Care Reform in Canada," *Health Affairs* 21, no. 3 (2002): 32-46.

⁷³ Indicative of the effect of ideological differences on policy objectives, the same economic circumstances that drove the 1973 *Health Maintenance Organization (HMO) Act* and other market-focused regulations to contain costs in the United States prompted Canada to move in the opposite direction to a mandatory, government-controlled system.

⁷⁴ Recent U.S. public opinion poll data indicate that three-quarters of the public think that increasing the number of Americans covered by health insurance is a very important issue, requiring action from the President and Congress. Unfortunately, there is little agreement on solutions to the problem of the uninsured. Furthermore, willingness to pay remains one of the toughest obstacles to providing insurance coverage for the uninsured; only about half of the adults surveyed say they would be willing to pay more in higher insurance premiums or taxes in order to increase the number of insured Americans. Kaiser Health Poll Report January/February Edition <http://www.kff.org/healthpollreport/feature3/media/feature.pdf>.

⁷⁵ David Cameron and Richard Simeon, "Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism," *Publius* 32, no. 2 (2002): 49-65.

⁷⁶ Timothy Conlan, *From New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform* (Washington, DC: The Brookings Institution, 1998), 8.

⁷⁷ Although the Canadian system uses block grants, funds still must be used within a category of health, education, or social welfare. In fact 60 percent of the funds are used for health-related programs.

⁷⁸ David R. Beam and Timothy Conlan, "Grants," in *The Tools Of Government: A Guide To The New Governance*, ed. Lester Salamon (Oxford, NY: Oxford University Press, 2002).

⁷⁹ John Holahan and Mary Beth Pohl, *States as Innovators in Low-Income Health Coverage* (Washington DC: The Urban Institute, 2002); Robert Hurley and Stephen Zuckerman, *Medicaid Managed Care: State Flexibility in Action* (Washington, DC: The Urban Institute, 2002).
