DIVERGENT PASTS, CONVERGING FUTURES? THE POLITICS OF HEALTH CARE REFORM IN CANADA AND THE UNITED STATES

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On September 22 1993, President Clinton delivered an emotional plea before Congress about the urgent need for health care reform in the United States.[1] It was not the first time in history that an American president had sent such a message to Congress or shown a vivid interest in making health reform a prominent part of his administration's domestic policy agenda. But Clinton's address reflected the growing momentum of the health reform issue that had helped propel the Democratic party to the White House and signaled a significant shift in the future of government involvement in health care.

The absence of a universal, national health insurance program in the United States offers an intriguing policy puzzle in comparative politics. Although spiraling health costs, pressures for fiscal reform, and problems of access and quality are real concerns for many industrialized nations, in no other country has the basic legitimacy of the right to health care (and affordable health insurance)

been subject for so long to such fundamental scrutiny or attack as in the United States.

This policy puzzle is even more compelling if we compare the United States to Canada, its closest neighbor. While the legacies of the Canadian "loyalist" past and the American "revolutionary" experience may have led to different institutional settings and ideological baggage,[2] the two countries share more political, economic, and social characteristics than virtually any other pair in the industrialized world. Canada and the United States are often presented as similar nations in terms of their welfare state effort, reflecting a "liberal" model that emphasizes individual initiative and opportunity, in contrast to the more extensive welfare states of Europe, rooted in Catholic or "statist" traditions, or social-democratic principles.[3] Canada and the United States do tend to have lower social expenditures than western European nations, but they have experienced important differences in the timing, coverage and financing of their social programs.[4] Nowhere is this more evident than in the case of health insurance. Nation-wide, universal and comprehensive health insurance is publicly financed and administered in Canada, while in the United States, health insurance is concentrated in the private sector and is employment-based, with government involvement limited to coverage of the elderly, the poor, and the military.

Because Canada and the United States appear to have so much in common, and yet still have such different health insurance systems, the quest for health reform in the United States has invariably come to involve comparisons of the two neighboring countries. Canada's health insurance system has become a useful target and a political weapon in the reform debate, alternatively used as a model

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of what American health reform ought to aspire to, or as an ominous warning about the problems inherent in government involvement in a national health insurance program.

This paper provides an overview of Canadian and American health care systems and the evolution of health reform in the two countries. To what extent have these two neighbors experienced paths of divergence or convergence in their approach to health reform? Has there been a shift in the consensus around health reform? This paper also looks at the role that Canada has played in the debate over health reform in the United States, particularly the emergence of interest in the Canadian single-payer model for the United States. It focuses on the attempts to portray the Canadian health care model as undesirable because of the its perceived weaknesses in addressing problems of cost and access, and unsuitable because of the perceived incompatibility of the two countries' values and political institutions.

I. HEALTH REFORM IN HISTORICAL PERSPECTIVE

The recent surge of interest in *how* Canadian and American health insurance systems differ raises a more fundamental question that can inform the Canada-U.S. comparison; namely, *why* did these two countries develop such very different systems of government-funded health insurance? A brief overview of the development of health insurance in comparative perspective is useful to shed light on this question (see Table 1).

Although health reform had been on the Liberal party's platform since Mackenzie King became leader in 1919, there was no sustained federal interest in health insurance in Canada before the 1940s. Health insurance had been vaguely promised as part of the ill-fated Bennett New Deal in 1935. Several provinces had also studied health reform, but legislation was passed only in British Columbia in the midst of the Depression and was never implemented. In 1943, with growing public support for health insurance as part of a larger program of post-war social security, special Parliamentary hearings were held on health reform. In 1945 a national health insurance plan was presented as part of the Liberal government's postwar reconstruction package. This package, however, was blocked due to fiscal conflict with the provinces. A system of national health grants was eventually passed instead in 1948. Meanwhile, a social-democratic government in Saskatchewan initi-

ated its own hospital insurance program in 1947. Ten years later, under increasing pressure from the social-democratic third party, the Co-operative Commonwealth Federation (CCF, later New Democratic Party or NDP), provincial leaders, and public opinion, the federal Liberal government introduced a coordinated plan for hospi-

TABLE 1: CHRONOLOGY OF MAJOR LEGISLATIVE DEVELOPMENTS

	Canada	United States
1916		AALL Model Bill
1935	*Employment and Social Insurance Act*	*Social Security Act*
1936	BC: *Health Insurance Act*	
1943		Wagner-Murray-Dingell bill
1943	Special Committee on Social Security	
1945	Dominion-Provincial Conference on Reconstruction	
1946		Truman bill *Hospital Construction Act*
1947	Sask.: *Hospital Services Plan*	
1948	*National Health Grants Program*	
1949	BC: *Hospital Insurance Service* Alberta: *Hospital Services Plan*	Truman bill
1955	Ontario: *Hospital Insurance Plan*	
1957	*Hospital Insurance and Diagnostic Services Act*	
1960		*Medical Assistance for the Aged*
1961	Sask.: *Medical Care Insurance Act*	King-Anderson bill
1964	Hall Commission Report	
1965		*Health Insurance for Aged (Medicare)* Medical Assistance for the Poor (Medicaid)
1966	*National Medical Care Insurance Act*	
1972		Nixon Health Insurance Partnership
1973		*Health Maintenance Organization Act*
1974		Hawaii: *Prepaid Health Act*
1975		Kennedy-Corman bill
1977	*Established Programs Financing Act*	
1982		Medicare Prospective Payment System
1984	*Canada Health Act*	
1986	*Act to Amend Federal-Provincial Fiscal Arrangements*	
1988		*Medicare Catastrophic Coverage Act*
1989		MA: *Universal Health Care Act* MN: *HealthRight Act*
1990		Pepper Comm. on Comprehensive Health Care
1991	*Government Expenditures Restraint Act*	
1992		Bush health reform proposals OR: *Universal Health Care Act* CA: *Health Insurance Plan of California*
1993		Clinton Task Force on Health Reform FL: *Health Care and Insurance Reform Act*
1994	National Forum on Health	Debating health bills in Congress

tal insurance for the provinces. In 1961 the CCF in Saskatchewan again took the initiative and passed medical insurance, although its implementation was delayed by a doctors' strike in 1962. By 1966 the minority federal Liberal government, under pressure from the labor-affiliated New Democratic Party and its own Liberal left wing, introduced a federal-provincial program of universal medical insurance that adopted the broad outlines of the Saskatchewan model and the recommendations of the 1964 Hall Report. By 1971 universal health insurance had been implemented in every province, although not without confrontation, such as the 1970 doctor's strike in Quebec. Conflict with doctors in Ontario also marked the implementation of the 1984 Canada Health Act that banned extra-billing and other practices considered inimical to the principles of access and affordability of health care.[5]

In the United States there was considerable interest in health insurance in the early decades of the century during the Progressive era, but the first attempts to promote government involvement were denounced as "foreign" infiltration and did not survive the First World War. Federal interest in health care surfaced during the preparation of the economic security bill in 1934. But health insurance was eventually left out of the 1935 Social Security Act because of the controversy associated with the issue, fostered in large part by the opposition of business and the medical profession allied with conservative interests in Congress. In the 1940s health insurance remained the most important "unfinished business" of the New Deal for reformers inside and outside of government. President Truman's proposals for national health insurance were endorsed by many groups, including labor, and for a time enjoyed substantial public support. These initiatives were stalled, however, by the conservative coalition in Congress (Republicans and southern Democrats) and the campaigns against "socialized medicine" launched by the medical lobby, particularly successful in the context of the nascent Cold War. In the 1950s these political constraints, including the frustration engendered by anti-health insurance campaigns and the growing hostility in Congress, forced health reformers to retreat from national health insurance in favor of offering coverage to a limited group, namely hospital insurance for the elderly under social security. But President Kennedy's attempts to implement this program after 1961 were also thwarted by Congress and the medical lobby. It was only after the breakthrough 1964 election that the publicly-financed health

insurance programs under Medicare and Medicaid were passed in the United States. These compromise measures included a social-insurance program for hospital insurance for the elderly, a voluntary medical insurance plan, and a means-tested addition to cover the medically indigent. Since then proposals for national health insurance have continued to resurface on the political agenda in the United States, most notably in the 1970s, through efforts by both a Republican administration and Congressional Democrats, and with growing intensity in the 1990s.[6]

Definite patterns of political discourse and policy formation emerge in the historical comparison of the evolution of health insurance in Canada and the United States.[7] The strength and impact of the demand for health reform were conditioned by the presence of very different political institutions and party politics. In the Canadian case, parliamentary government and decentralized federal arrangements encouraged both the formation of a social-democratic third party that shaped the direction of health reform, and the sub-national innovations that led to a nation-wide program of universal health insurance. The constraints of party discipline and the regional nature of protest movements contributed to the formation of an independent third party on the left that was able to influence the development of health insurance at both the federal and provincial levels. The CCF-NDP acted as a lightning rod for groups that supported national health insurance and was able to translate this pressure through the political system by pressuring the dominant party of the center, the Liberal party.

In the American case the consensus around health reform was more difficult to build because of the institutional features of the American political system. In the highly fragmented arena of American politics, competition between the executive and legislature precluded the development of a coherent reform agenda. The absence of party discipline necessitated partisan coalition building and compromise that restricted the scope of eventual reform outcomes. Because labor and the left were constrained within the confines of the Democratic party, their reform proposals had to appeal to a broader cross-section of political actors. In addition, the permeable nature of Congressional politics, with its multiple veto points, allowed opponents of universal health insurance a greater voice in the political process. While decentralized federalism encouraged policy innovation in the Canadian province, American states were less autono-

mous in the development of social policy initiatives. The sheer number of sub-national governments and their competitive relationship with one another also impeded consensus-building on the issue of national health insurance.

II. HEALTH CARE IN CANADA AND THE UNITED STATES

Although health care systems vary greatly across different countries, a common feature is the extent to which the public sector has come to play a dominant role in the delivery and financing of health care.[8] Despite differences in political culture or in the timing of welfare state development among the advanced industrialized countries, there seems to be a widespread consensus about the "right" to health care, and the need for compulsion and regulation by government to guarantee this right. As John Iglehart points out, Canadians "long ago overcame any reluctance they may once have had about delegating to the government the central role of establishing the appropriate level of resources devoted to health care."[9] Governments in Canada and other industrialized countries have sought to do so by openly confronting health care providers through the political process and treating health care as a public good. The principles of universality, public financing and administration, and expenditure controls are widely accepted with the notable exception of the United States.

Canada and the United States developed similar health care delivery systems.[10] Solo practice, private fee-for-service care, the dominance of voluntary hospitals, charity care based on philanthropic, religious or community care, and direct government involvement limited to public health services were essential characteristics of both countries until mid-century. In both Canada and the United States, medical associations developed out of a desire to strengthen the monopoly of professional physicians and to regulate the practice of medicine.[11] Since the 1910s medical education on both sides of the border has retained important linkages, accreditation of medical schools falls under the same agencies, and licensing of physicians remains reciprocal across states and provinces. Even today the delivery of health care in the two countries retains striking similarities. Voluntary, nonprofit hospitals dominate the health sector in both countries. The majority of physician services are still based on private practice and fee-for-service remuneration. There are, however, major differences in the costs and financing of health

benefits, and in the structure of, and coverage provided by, government-funded health insurance.

The American health insurance system can be described as a complex maze of different programs. The majority of Americans rely on employer-based benefits or private insurance coverage. Over forty percent of Americans, veterans and military personnel, the elderly, disabled, and poor, enjoy some form of public coverage. The major government involvement is a dual-tiered system of federal and state programs under Medicare and Medicaid. The latter is a social assistance program based on the means-test that reimburses hospitals and physicians that care for the 25 million persons eligible for welfare benefits. Administered by the states, Medicaid plans are jointly financed by federal and state governments. Medicare enrolls 35 million elderly or disabled Americans eligible for social security benefits.[12] The social insurance portion of Medicare (Part A) covers hospital benefits directly paid by the federal government and financed by compulsory payroll contributions. Medicare Part B offers supplementary medical insurance for physician care, with the federal government reimbursing users through privately contracted insurance carriers. The plan is financed through monthly premiums and income tax payments. Much like the private insurance system, Medicare beneficiaries are responsible for paying substantial deductibles and coinsurance charges. Hospital care under Part A is limited to 90 days of inpatient and 100 days of nursing home care per illness, after deductibles. Part B covers 80 percent of approved charges; patients are responsible for the remaining 20 percent plus deductibles. Many opt for supplementary medi-gap policies to cover the high costs of out-of-pocket expenditures. Because of the complexity and permeability of the employer-based American health insurance system, it has been estimated that between 30 and 40 million Americans are not covered by any form of insurance, either private or public.[13] Millions more are "underinsured," that is, insured for only part of their potential total health bill.[14]

Compared to the patchwork of insurance mechanisms in the United States, national health insurance in Canada seems relatively simple, resembling more a harmonious mosaic of ten provincial systems. Under the terms of the 1966 Medicare Act and the 1984 Canada Health Act, each provincial health program must adhere to five basic principles: accessibility, comprehensiveness, universality, portability and public administration. All Canadians, regardless of

age, income or employment status, are eligible for government-funded hospital and medical benefits. Each province administers a health insurance program that covers practically all diagnostic services, hospital care and physician fees. Patients are covered for standard room care in the hospital, all drugs, diagnostic and laboratory tests; medical care includes all general, surgical and specialist care in and out of the hospital. Any remaining costs, such as private hospital rooms, prescription drugs, and dental care, can usually be covered by supplemental private insurance.

These health insurance programs are jointly financed by provincial revenues and block grants from the federal government. While the majority of hospitals are independently administered, they rely on annual global budgets imposed by provincial governments. The majority of physicians, meanwhile, remain in private practice but are reimbursed for their services according to fee schedules negotiated with the provincial government. They are not permitted to bill above these amounts, and any services rendered in private clinics or hospitals may not be charged to the government.

Prior to the introduction of government-funded hospital and medical insurance, Canada and the United States had similar patterns of health care expenditures. The implementation of health insurance did not fundamentally change the delivery of care in the two systems, but it did significantly alter the growth of health expenditures and the nature of health insurance financing (see Table 2). In 1960, for example, health expenditures represented just over 5 percent of GDP in both countries. By 1975, after the full implementation of hospital and medical insurance in Canada, health expenditures rose to 7 percent of GDP in Canada and over 8 percent in the United States. Fifteen years later the gap had considerably widened: in 1990, Canada spent 9.5 percent of GDP on health, while the United States spent over 12 percent. Government spending now accounts for about three-quarters of Canada's total health bill, while in the United States government spending covers less than half of all health expenditures. Both Canada and the United States spend considerably more on health care than other industrialized countries. In 1991, U.S. expenditures rose to over 13 percent of GDP and Canada's to 10 percent of GDP. By comparison, the average for the OECD countries as a whole was only 8 percent (Table 3).

The changes in expenditure patterns over time are especially noteworthy since both countries started out at relatively similar

TABLE 2:
HEALTH CARE IN CANADA AND THE UNITED STATES[1]

	Canada			United States		
	1960	1975	1990	1960	1975	1990
Health care expenditures						
Total exp. on health (% GDP)	5.5	7.2	9.5	5.3	8.4	12.4
Public exp. on health (% GDP)	2.3	5.5	6.8	1.3	3.5	5.2
Public exp. as % of total exp.	43	76	72	25	42	42
Per capita health exp.	109	435	1811	143	592	2600
Per capita exp. on health administration	3	7	23	6	23	150
Average income of physicians	14,304	36,580	89,923	25,050	55,300	155,800
Percent of total health exp. spent on						
Hospital costs	44	53	49	38	49	46
Medical costs	24	22	22	29	26	29
Pharmaceuticals	13	10	13	16	10	8
Percent of population eligible for public coverage of						
hospital benefits (in-patient)	68	100	100	20	40	44
medical benefits (ambulatory)	2	100	100	20	40	44
pharmaceutical costs	5	19	34	3	10	12
Physician supply						
Physicians per capita	1.2	1.7	2.2	1.4	1.7	2.3
Doctors' consultations per person	--	4.9	6.9	--	5.1	5.5
Hospital use						
In-patient hospital stay (average number of days)	11	11	14	21	11	14
In-patient care admission rates (per capita)	15	17	14	14	17	14

[1] *OECD Health Systems,* Volume I: *Facts and Trends 1960-1991*; Volume II: *The Socio-economic Environment Statistical References* (Paris: OECD), 1993. All dollar figures in $US; Canadian conversions reflect purchasing power parity at current dollar values.

levels. The introduction of national health insurance in one country and the institutionalization of a mixed public-private system in the other have led to significant differences in cost escalation. There has been a much more rapid increase in health costs in the U.S., both in absolute and relative terms, despite the presence of millions of uninsured and underinsured Americans. Cost containment in Canada is facilitated to some extent by the setting of annual global budgets for hospitals by the provinces, the centralization of diagnostic services,

TABLE 3:
HEALTH EXPENDITURES IN OECD COUNTRIES, 1991[2]

total	Total Exp as % GDP	Public Exp as % GDP	Per Capita Exp in $US	Public Exp as %
United States	13.4	5.9	2,867	44
Canada	9.9	7.5	1,915	72
France	9.1	6.7	1,650	74
Sweden	8.6	6.7	1,443	78
Australia	8.6	5.8	1,407	68
Germany	8.5	6.1	1,659	72
Netherlands	8.3	6.1	1,360	73
Italy	8.3	6.5	1,408	78
Japan	6.8	4.7	1,267	71
United Kingdom	6.6	5.5	1,043	83
OECD average:	8.1	6.1	1,395	76

[2] *OECD Health Systems,* 1993; OECD averages calculated for 22 OECD countries (excludes Greece and Turkey).

uniform fee schedules negotiated between the provinces and medical associations, and considerably lower administration costs (see Table 2).

Despite the higher cost of health care in the United States, more Americans seem dissatisfied with the system as a whole than are Canadians (see Table 4). In recent cross-national comparisons of public opinion on health care, Canadians have expressed the highest overall satisfaction with their health care system. Americans, on the other hand, have indicated the greatest dissatisfaction and interest in rebuilding their health care system. Some of this interest is directed at their Canadian neighbors (61 percent of Americans expressed a favorable interest in the Canadian model) although this is not widely reciprocated north of the border (95 percent of Canadians preferred their own system of health care to the American alternative).[15]

Although Americans have yet to reach a consensus as to the type of reform they want, some patterns are clear. Even though the majority of Americans are satisfied with their personal experience with physician and hospital care, they are nevertheless concerned about the soundness of the health system as a whole, particularly the

TABLE 4:
SATISFACTION WITH HEALTH SYSTEMS[3]

	United States	Canada
Public attitudes about system as a whole (percentage)		
Minor changes needed	10	56
Fundamental changes needed	60	38
Rebuild System	29	5
Prefer own system		95
Would prefer other's system	61	
Public attitudes about personal health care		
	U.S.	**Canada**
Very satisfied	56	72
Somewhat satisfied	30	20
Dissatisfied	14	8
Not able to receive care	13	4

[3] Robert J. Blendon *et al.* Satisfaction with Health Systems in Ten Nations. *Health Quarterly*, 11 (1): 2-10, 1990; Robert J. Blendon, "Three Systems: A Comparative Survey" in *Health Management Quarterly*, Vol. 9, No. 1, (Spring 1989): 2-10.

problems of access to care and the soaring costs of health. Historical polling data shows sustained support for government intervention in the area of health care since the 1940s. Recent polls reflect sustained support for legislation to regulate the cost of health care and to provide access to affordable health insurance, even if this means paying higher taxes. In addition, these polls underscore the sentiment that health reform is one of the most important issues that the U.S. government must tackle.[16]

III. CURRENT HEALTH CARE REFORM STRATEGIES

A. Solving the cost/access conundrum in the United States

With the passage of Medicare and Medicaid in 1965, health reform in the United States focused on improving the access to health care of specific demographic groups. This approach reflected the institutional and political constraints surrounding health reform and represented a politically feasible alternative to universal, national health insurance. Targeting the elderly and the poor also reflected the means-tested tradition of the American welfare state that placed emphasis on "deserving" groups in society.

Through Medicare and Medicaid, the U.S. government took on the responsibility to guarantee access to health care for those groups most likely to be shut out of the voluntary and employer-based market for health insurance in the United States. In other words, government was relegated to the role of insuring groups with the highest actuarial risk. Although both insurance interests and the medical lobby were initially hostile to such reforms, they were given important roles in the organization and delivery of these benefits. As originally written, Medicare instructed the federal government to cover any "reasonable costs" billed by hospitals and doctors. Therefore, the public sector was obliged to participate in the private market for health care, even though it had little influence in controlling costs.

The steep increase in the cost of health care and the explosion of public expenditures for health in the United States led to a shift in the focus of health reform from improving access to health insurance to controlling the costs of health care. The Nixon administration's program for group-based health insurance was unsuccessful, although it did encourage the proliferation of HMOs in the United States and was considered the forerunner of "managed care" proposals.[17] Throughout the 1970s Congressional Democrats (led by Senator Edward Kennedy) attempted to link access and cost concerns with renewed demands for national health insurance, but the enduring divisions within the Democratic party on the issue, the hostility of the Republican opposition, and the persistent resistance of provider groups precluded such reform initiatives.[18]

The widespread reluctance to embark on new spending for entitlement programs and the neoconservative backlash pushed national health insurance out of the spotlight in the 1980s.[19] At this point, reforming health care meant reducing federal expenditures, particularly spending on entitlement programs such as Medicare and Medicaid. Federal payments for Medicaid programs were substantially reduced, forcing states to modify their benefits and eligibility criteria. Medicare was a more difficult target since it enjoyed widespread bipartisan support, bolstered by a large and politically influential clientele group, the aged. Despite the free-market rhetoric of the administration, the focus of health reform shifted to the regulation of the market for health services by imposing limits on Medicare payments to doctors and hospitals. In 1982, the reimbursement of "reasonable costs" was replaced with a prospective schedule of fees based on "Diagnostic Related Groups" (or DRGs), and Medi-

care beneficiaries were encouraged to use "Preferred Provider Organizations" (or PPOs). In 1984 and 1986 freezes were imposed on Medicare reimbursements for physician fees. Private insurers, at the same time, began to impose greater restrictions on the type and extent of reimbursement they would cover. Ironically, American doctors, who had fought compulsory national health insurance on the grounds of physician autonomy, now found themselves increasingly regulated by insurers and awash in more paperwork and billing problems than their Canadian counterparts working within a public health insurance system.

By the late 1980s, as health expenditures continued to soar in the United States, cost concerns became inextricably related to questions of access to care. A major health initiative of this period, the 1988 Medicare Catastrophic Coverage Act, was designed to improve the access of the elderly to long-term care. The measure was repealed under pressure from the elderly who objected to the self-financing of the program through premiums and increased personal income tax.[20] The passage of this bill reflected a bipartisan recognition of the linkage between problems of cost and access, but its subsequent demise revealed the limits of incremental change and pointed toward the need for a more fundamental restructuring of the American health care system.

The retrenchment of federal financing of existing programs and the relative inaction in addressing problems of health care costs and access encouraged states to think about initiating their own health reform. Until 1988 the only successful state-level health insurance model was that of Hawaii, which combined mandatory employer-based coverage with cost containment. By 1992 Massachusetts, Minnesota, Vermont and Florida had enacted (though not yet implemented) health care legislation; Oregon also proposed the rationing of certain Medicaid benefits.[21] Within the next year several more states would act, while virtually every state legislature would consider some type of health reform proposal (see Table 1). This state-level activity bolstered confidence in the idea that a national health insurance system could develop from sub-national initiatives, as it had in Canada, and that such initiatives could allow states to experiment with different types of reform ranging from managed care to single-payer plans.[22] But the problems surrounding state action (e.g., postponement of implementation in Massachusetts, controversy surrounding the Oregon plan) and the difficulty of

reaching consensus in state legislatures highlighted the limits of state-led reform in the U.S. and the dangers of a "crazy quilt" approach to health care (unlike the coordinated Canadian system) in the absence of a clear federal policy direction.

Democrat Harris Wofford's upset victory over former Attorney-General Richard Thornburgh in the Pennsylvania Senate race in 1991 revealed the emerging political stakes of health reform as a national issue on the domestic agenda.[23] This also showed the depth of dissatisfactions among voters with the perceived inaction of the Bush administration on the issue. In a recession-wracked economy, working Americans feared for their health benefits. These fears were intimately tied to concerns about the future viability of the American health care system. The hard-to-define but politically powerful American "middle class" seemed worried that their access to affordable health insurance was in jeopardy and were apprehensive about the future of the health care system. The medical lobby began to raise concerns about the problems of access to care, in particular the burden of caring for the uninsured and the limits imposed on their practices by third party insurers.[24] Once a bulwark against government intervention, the American Medical Association now endorsed a "public-private partnership" that would guarantee universal access while preserving the freedom of the medical profession in the health care market.[25] Big business, saddled with a major portion of the American health bill, was increasingly frustrated by the seemingly uncontrollable increase in health costs and became another unlikely proponent of government regulation.[26]

During the 1992 election campaign health reform surged to the center of the domestic political agenda in the United States. President Bush seemed incapable of allaying fears about the economic future of the United States and of devising a reasonable scenario for health care reform.[27] By contrast, the "health care crisis" became one of the oft-repeated buzzwords of the successful Clinton campaign that, along with "the economy, stupid", captured the attention of a recession-weary public open to the bold rhetoric of change.

By 1992 as well, Canada had become an unwitting player in the debate over health reform in the United States. Canada was not an unfamiliar model: proponents of national health insurance had taken an interest in the Canadian experience since the 1970s.[28] By the late 1980s Canada was attracting renewed attention in the search for solutions to problems of cost and access to health care. The Canadian

system would figure prominently in the scenarios for health care reform in the United States, alternatively portrayed as a familiar model "vital in countering the powerful disinformation campaign against public medicine"[29] or, as the "cure worse than the disease."[30]

Advocates of the Canadian model pointed out that a "single-payer" system could reap substantial savings in the overall costs of health care while at the same time guarantee universal access to comprehensive benefits. A widely-cited 1991 GAO report projected that such an arrangement could save the United States $3 billion of its total health bill.[31] Another study estimated that the United States outspent Canada by 117 percent on overhead and administration costs and that a single-payer system could save the U.S. as much as $20 billion.[32] These savings were accrued through simplified billing systems, global budgets, and negotiated fee schedules as well as the substantially lower administrative costs of a single-payer system.[33] In addition, cross-national studies found that while the quantity of physician services was higher in Canada, health costs in the U.S. were greater due to more "procedure-oriented" specialists.[34] Differences in hospital expenditures were accounted for by leaner administrative overhead and the centralization of high-tech equipment and personnel that kept costs considerably lower in Canada.[35]

Detractors of national health insurance in the United States have used the Canadian model as a "straw man" to demonstrate the impossibility of single-payer reform.[36] The administrative savings of such a system inevitably would be offset by excessive demand and the "hidden overhead costs" from the lack of incentives to economize in a universal system.[37] Alternative estimates showed that total costs could actually increase by $21 billion under a Canadian-style system.[38]

Beyond the question of costs was the more fundamental question about the inevitable trade-off between quality and access. It was argued that Canada controlled health costs by limiting access to quality health care. The "rationing" of health care and "queue-ing" for treatment were associated with the arbitrary government control of health resources and the constraints this imposed on freedom of choice. Media coverage in the U.S. increasingly focused on the shortage of high-technology equipment, waiting lists for surgery, and epidemic overcrowding in hospitals. In addition, the Canadian medical community was accused of free-loading off the United States

for high quality research, innovative procedures and medical technology.[39]

These attacks against the quality of Canadian health care were criticized for extrapolating apocalyptic scenarios from anecdotal evidence.[40] Supporters of the Canadian model emphasized the benefits of allocating health resources on the basis of relative need, rather than on the ability to pay as is often the case in the United States.[41] Although waiting lists and the restricted allocation of high technology intervention are present in the Canadian system, these are limited to specific elective surgical procedures and are not the basis for the delivery of care.[42] The difficulty of separating anecdotes from reliable statistics is also apparent in the cross-border use issue. The number of Canadians that voluntarily seek, and are willing to pay for, medical attention in the United States is difficult to estimate. While media reports made much of Canadian patients being "dumped" across the border for faster medical attention, the evidence points to a very small, and dwindling, number of cases sent to the United States by health providers in Canada.[43]

In addition to portraying the Canadian model as undesirable, there has also been a considerable effort to discount it as unfeasible due to the political differences between Canada and the United States.[44] This argument presupposes that Canada's political culture is more oriented toward the collectivity, with greater legitimacy accorded to government intervention in social policies, as compared to an American value system based on liberalism and distrust of government.[45] Nevertheless, opinion polls are indicating that Americans are amenable to government intervention in the health sector. Growing concern over accessible and affordable health care reflects a genuine "collective interest" in reforming the system for the "national good" and shows that the "conventional wisdom that portrays Americans as individualists, and nothing more, is myopic."[46] The interest in alternatives like the Canadian single-payer model may not be as idiosyncratic as its critics imply, since the Canadian health insurance system, based on fee-for-service medicine and the private delivery of health care services, is arguably more compatible with American "liberalism" than are alternative suggestions for "managed care" or the increasing encroachment of insurance bureaucracies, both private and public, on the doctor-patient relationship.[47]

Many influential medical leaders continue to endorse the Canadian model.[48] In Congress, substantial numbers in Congress continue

to champion a single-payer health care system,[49] and such initiatives are gaining support at the state level.[50] Nevertheless, the latest policy signals from the Clinton administration suggest that "Canada-bashing" efforts have been successful in restraining its supporters "for fear of being dismissed as cranks or out-of-touch."[51] In presenting his legislative proposals for health reform in 1993 President Clinton categorically rejected the Canadian single-payer model on the grounds that it was impractical and would require a massive influx of new taxes.[52] Clinton and his administration continue to stress that their reform proposals for "guaranteed private insurance" represent the feasible, market-based alternative to a "government-run" single-payer system.[53] Indeed, apart from the universal coverage promised by the health security card, there is little evidence of the Canadian model in the President's complex health reform package or in the alternative proposals under consideration in Congress.[54]

B. Searching for a cost/access equilibrium in Canada

At the same time that the politically fractious debate over health reform in the United States involves the Canadian model, in Canada health care reform has also become an important political issue. In the past few years party leadership candidates, federal politicians, and provincial leaders have all had to deal with the health reform issue. The debate north of the border also hinges on the whether to preserve the status quo or to change the system, but the nature and stakes of reform proposals are, of course, much different.

As in the United States, the major emphasis of Canadian health reform until the 1960s was improving access to health care. In Canada, however, this was achieved through a universal system of national health insurance, reflecting the social-democratic principles of the Saskatchewan experiments. Nevertheless, many features of the private delivery system persisted, and these important concessions reflected the power of professional groups. Curative medicine and high technology, for example, were promoted to a much greater degree than were efforts to develop preventative medicine and other public health goals geared toward reducing inequities between social class and health.[55] Medical services continued to be offered on a fee-for-service basis, allowing doctors the license to bill the government for virtually every act they administered to their patients. Initially, in addition, doctors were allowed to opt out or extra-bill

patients, clearly putting into question the *leitmotif* of universal access. Attempts to curtail extra-billing by doctors were fiercely opposed by the medical lobby, leading to open confrontation and unsuccessful strike actions by doctors in Quebec (1970) and Ontario (1985). The Canada Health Act of 1984 finally imposed a federal ban on these measures, although discrepancies in health status and income still persist.

After the implementation of health insurance programs in the provinces was completed in the early 1970s, the federal government began placing more emphasis on controlling health expenditures. The development of a publicly-financed system with negotiated fee schedules and government-monitored hospital budgets allowed for some measure of cost control and avoided the problems encountered in the United States, where the public sector participated in the private market with little control over the price of health care. However, the fee-for-service system did inflate the demand for health services and overall health expenditures in Canada. Although the Canada Health Act was primarily designed to ensure the principles of universal access, it also had a cost containment element. Extra-billing had pumped substantial extra dollars into the health care market, so the ban was also designed to reduce the rapid rate of increase in total health expenditures in Canada.

Tightening controls over the supply of health care was part of a two-pronged federal strategy for cost containment. The second strategy was aimed at closing the "open-ended" cost-sharing arrangements of 1957 and 1966 that obliged the federal government to share equally in the financing of health costs by reimbursing the provinces. The 1977 Established Programs Financing Act (EPF) replaced cost-sharing with block grants tied to fixed per capita amounts that would increase in tandem with the GDP growth rates.[56] In doing so, the federal government effectively reinforced the provinces' responsibility to exercise fiscal restraint in controlling health care expenditures.

As in the United States, concerns about government spending were bolstered by the arrival in power of a party with a neoconservative fiscal platform in the 1980s. The Conservative government's agenda on social programs turned out to be more modest than that of the Reagan administration. This was in part because conservatism had developed differently in the Canadian polity, but also because the political and social consensus associated with universal social pro-

grams, particularly health insurance, imposed certain constraints on what the Conservative government could say and do about social reform.[57]

The widespread acceptance of government intervention to ensure social benefits meant that the public sector had, in Prime Minister Mulroney's own words, a "sacred trust" in maintaining these programs.

But attempts to reduce the federal deficit would necessarily involve cutting government spending, either through widely publicized attempts to de-index pensions and reduce unemployment benefits, or by surreptitiously chipping away at the universality of family allowances and child benefits through the taxation system.[58] Because national health insurance had become institutionalized as part of the Canadian political culture, the federal government was loathe to be saddled with dismantling such a popular program. Nevertheless, attempts to "off-load" the deficit onto the provinces involved curtailing federal responsibilities in the health sector, reducing the growth of block grants in 1986 and freezing them in 1991 so that the federal government now covers less than a third of the total health bill in Canada.[59] This has shifted the burden of health costs to the provinces and also pressured them to reduce their health expenditures by shifting the burden, in turn, to health care providers and, ultimately, to consumers.

In the past decade numerous provincial commissions or task forces have tried to find a viable balance between access and costs concerns.[60] In Quebec, for example, which emphasizes community-based health care delivery, a major restructuring has recently taken place to decentralize the health care sector and reorganize the distribution of resources to better respond to changing needs of the province's population.[61] Still, the dominant concern of provincial governments has been the more stringent control of health expenditures and more efficient use of health resources in the context of rising health costs, soaring public deficits, and the continued attrition of federal transfers. This has involved transferring responsibility to both providers and consumers of health care. To do so, provincial governments have made use of both increased regulation and increased reliance on market mechanisms.

The demand for health care is transferred through physicians acting as "gate-keepers" in the Canadian health care system. Many critics point to doctor-driven demand as a major reason for the

spiraling costs of health care and the persistent inequities in the allocation of health services.[62] Several provincial governments have tried to regulate the supply of doctors and the services they provide by imposing limits on physician billing and reducing the number of admissions into medical schools and, in addition, have tried to redistribute physicians outside of major urban areas. Hospitals, faced with reduced global budgets that are more and more stringently enforced, have had to rely on creative juggling of resources, including the reduction of hospital beds, limiting new equipment and construction, encouraging the reallocation of health care delivery through waiting lists for non-emergency diagnostic or surgical procedures, and transferring certain services to outpatient or home-based care.

Political leaders in the provinces have also demonstrated a growing interest in market mechanisms to control the demand for health care and in opening the door to the role of private insurance. Several provinces have begun to reduce the range of services covered by public insurance, such as optometrist services, dental care for children, or coverage of outpatient pharmaceuticals. Proposals to introduce hospital user-fees, once considered an affront to the principle of universal access, are now being considered as a way of discouraging over-consumption and to curtail reliance on expensive emergency-room care. In addition, there has been renewed interest in increasing individual responsibility to pay for health care through copayments, deductibles, and the imposition of specific "health taxes."[63] Finally, there have been renewed efforts at curtailing abuse in the health care system, mainly by non-residents who fraudulently avail themselves of health care services. Ironically, a substantial number of these are Americans crossing the border into Canada.[64]

As more provincial governments consider implementing solutions to control health care costs, the federal government has taken a renewed interest in ensuring that these actions do not interfere with the principles of the Canadian Medicare program. This interventionist attitude has been in evidence since the election of a Liberal government in November, 1993, and has led to clashes with both provincial governments and providers. For example, the Liberal government recently withheld $1.75 million (Can) from federal payments to British Columbia in retaliation against the extra-billing practices of certain doctors there.[65] The long-awaited National Forum on Health in Canada, a Liberal election promise to promote a

"new vision" of Canadian medicare, has been mired in controversy because of the federal government's attempts to limit provincial participation. Tensions will continue to mount in the health care sector as the federal government loosens its fiscal responsibilities while at the same time attempts to increase its interventionism.

The early 1990s have thus been marked by a profound reflection on the future course of national health insurance in Canada. This has involved a somewhat contradictory strategy of more government regulation coupled with increasing interest in the role of private-sector strategies for health care. The inherent irony in this, of course, is that just as observers in the United States look northwards for lessons from the Canadian experience, in Canada more attention is being focused on "American-style" market mechanisms.

"Canada-bashing" in the United States has had inevitable repercussions in Canada. At the same time that the Canadian model has come under scrutiny in the United States, the distorted image reflected back from the American mirror has contributed to the internal "crisis-mongering" in Canada.[66] Critics of the Canadian system within Canada have been able to use the American health reform debate to warn of the dire trade-off involved in a single payer system and to advocate a private market for health care. Echoing critics south of the border, proponents of market alternatives in Canada decry the amount of government regulation, the scarcity of advanced technology, and the rationing of certain medical services.[67]

If anything else, the rebound effects of Canada-bashing show that Americans are not "unique" in their preference for the private market for health care, just as not all Canadians necessarily espouse social-democratic ideals. The overwhelming support for national health insurance in Canada derives in large measure from what it does; namely, its perceived success in controlling costs and ensuring universal access to health care. The enduring popularity of the publicly administered system in Canada shows that once such a system is in place, the social consensus that emerges over the successful trade-off between universal access and reasonable costs makes it difficult to dismantle by political means so long as it continues to respond to the needs of the population it covers.

C. Patterns of Convergence and Divergence in Health Reform

While the delivery of health care has remained similar across time in Canada and the United States, the health reform priorities of

the two countries have diverged considerably. The fateful policy decisions of the 1950s and 1960s charted a radically different course for the two countries, one in which Canada would follow the European model of universal, publicly financed health insurance while the U.S. would struggle within the limits of its two-tiered system of health insurance. The institutional constraints and political choices that led to these outcomes also colored the way in which future reform was developed.

In Canada, universality and the right to health care were not challenged as long as the political consensus around the issue remained stable. For many years this stability was reinforced by the presence of successive Liberal governments at the federal level committed to retaining a social reform agenda borrowed from the left. Open confrontation over fee schedules and extra-billing at the provincial level also helped to defuse tensions between governments and provider groups and shore up public support for the system. In the United States, by contrast, the multiple constraints of the separation of powers system and the inability of the Democratic party to coalesce around health reform makes it more difficult for a national health insurance initiative to gather momentum. Congressional politics tend to diffuse this momentum and open doors more easily for opponents to reform. The tensions between legislative and executive branches, regardless of the party in power, have made it more difficult to formulate coherent policy.

Has there been a shift toward convergence in the recent health reform debate in the two countries?[68] It is true that as the United States moves farther into the realm of public involvement in health care, Canadian governments are looking for ways to reduce their direct exposure in the health sector. The focus of health reform is manifestly shifting from access to cost concerns as policy makers seek to reallocate the burden of paying for health care. Providers are preoccupied with the impact of budget cuts and increased regulation on their professional autonomy, but they also have a vested interest in maintaining most of the features of national health insurance. Consumers still support national health insurance, but this support is contingent upon satisfaction with the delivery of health care at a reasonable cost. Should services suffer at the expense of health care budgets, or if increasing costs push the tax burden too high, there may be evidence of cracks in this consensus. Meanwhile, political leaders have to be sensitive to both societal demands and the institu-

tional constraints they face in the Canadian political system. Much will depend on the changing nature of the partisan system as the NDP declines as a political force while a new right-wing Reform party flexes its muscle in Parliament. In addition, the direction of the health reform in Canada will undoubtedly be influenced by the struggle for control between the federal and provincial levels of government.

While the 1992 Democratic primary and presidential election were marked by promises to reduce barriers to health care through more government intervention in the U.S., the 1993 Conservative leadership race and federal election in Canada, as well as recent provincial election campaigns, point to new political concerns about the limits of such intervention and a renewed debate about the merits of market-driven reform. The Reform Party of Canada openly supports allowing private health care programs as a way of lessening the fiscal burdens of government.[69] In some provinces, concerned voters seem prepared to accept hospital user fees in order to maintain the level of services offered.[70] The wave of attacks on the quality of Canadian health care has undoubtedly fueled the polemic about costs and access and may reopen the fundamental question whether health care should be considered as a "right" or a "privilege." Just as there seems to be an ideological shift in American attitudes about the "right" to health care, in Canada there may also be a shift in the social consensus surrounding universal health insurance, buffeted by the winds of neoconservatism, the rhetoric of globalization, and the urgency of spiraling deficits.

In the United States, costs remain the major concern of health reform, but there is a growing emphasis of the need for adequate access to health care and the recognition that the burden of paying for care must be more efficiently shared. This sentiment is echoed by almost all the players in the health debate from the general public, to policy makers, to the American medical lobby and business community. Nevertheless, there is no agreement yet on the best way to realize these goals, in part because there is no firm consensus about whether health care is a "right" or a "privilege." The Clinton administration's plan builds on the existing employer-based and private-insurance model for health insurance but mandates universal coverage for all Americans. This universal mandate has been opposed by a wide variety of political and societal actors, including the Republican party, insurance lobbies, and small business leaders. At the same time, there is considerable division within the Demo-

cratic party itself on how to best guarantee universal coverage while controlling costs, from the Cooper proposal for voluntary universal access to the McDermott-Wellstone single-payer plan.[71] However, as the imperatives of political compromise constrain the scope of health reform still further, even the basic principle of universal access to health insurance is now at issue.[72]

The United States seems mired in a situation that, if we look at historical precedent, does not bode well for the rapid enactment of comprehensive reform. As in the past, opponents of health reform have been able to exercise much more influence through the legislative process than in Canada. Powerful lobbies, such as insurance and small business interests, have been able to exploit a political system in which groups with concerted interests and financial resources can exert considerable influence. In the absence of party discipline, individual legislators are well attuned to the convincing arguments of these lobbies, and of constituents that absorb their message. In addition, the broad coalition of political interests under the Democratic banner makes the party a useful target for the divide-and-conquer strategy of opponents to reform. Democratic leaders must fight a rearguard action to the right from conservative Democrats and the Republicans, leaving the left and progressive forces for reform without the political clout they need to impose sweeping change.

IV. CONCLUSION

This essay compares the development of health insurance and the evolution of health reform in Canada and the United States and offers some clues about the future of such reform in the two countries. It also discusses some of the ways in which the two countries seem to be converging in terms of their current health care strategies. This can be seen in the growing American preoccupation with access to health care and demand for government intervention, at the same time that Canada becomes more preoccupied with the need to control costs and the potential of market-based strategies to do so. Whether the two will somehow meet at a mid-point is unlikely, given the nature of the political institutions that condition the health care debate in the two countries and their different policy legacies in health insurance development. Nevertheless, the willingness of both sides to look across the border for reform directions suggests we should avoid making assumptions about the intolerance of Americans, or the

predilection of Canadians, toward predetermined types of solutions to perceived problems in the health care sector.

Like almost every other industrialized country, Canada and the United States are facing important choices about the future direction of the modern welfare state. In the area of health care these choices are conditioned by the same basic concerns about rapid increases in health expenditures, preoccupation over gaps in coverage and access to health care, and problems of efficiency and effective administration. Every country will respond to these challenges differently, based on their disparate political and economic histories, their array of social forces, and the nature of public demand. But a common thread is the realization of the need for some kind of government regulation in the health care market. Whether this regulation will grow stronger or weaker over time, and the impact of the resulting mix on these health systems, remains to be seen. It seems clear, however, that any interest in the privatization of health care must be tempered with the recognition of the limits of market-driven reform and the proven, even necessary, role of the state to ensure the distribution of health benefits at reasonable cost.

Although the two countries took divergent paths in the past over health reform, Canadians are concerned with essentially the same issues as are their American neighbors; namely, how to fashion an affordable, comprehensive health care system that ensures access to quality health care. The fundamental support for universal health insurance in Canada is bound to persist so long as it responds to the needs of Canadians. This ideological consensus took a long time to develop, as evidenced by the political struggles and practical experiments in its history, and has persisted in no small part due to the success of the national health insurance system. In the American context, this process has been much longer and has involved even more bitter political struggles. The emergence of a consensus over the right to health care and the role of government in guaranteeing that right is possible, but it will depend on the ability of political leaders to harness support behind a program that promises fundamental yet feasible reform and also effectively delivers on that promise.

NOTES

[1]Address to the Congress of the United States by President Bill Clinton, Washington, D.C., September 22 1993.

[2] David J. Bell, *The Roots of Disunity: A Study of Canadian Political Culture* (Toronto: Oxford University Press, 1992); Seymour Martin Lipset, *Revolution and Counterrevolution: Change and Persistence in Social Structures* (New York: Anchor Books, 1970).

[3] Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton: Princeton University Press, 1990).

[4] Robert T. Kudrle and Theodore R. Marmor, "The Development of Welfare States in North America" in P. Flora and A. Heidenheimer, eds., *The Development of Welfare States in Europe and America* (New Brunswick, NJ: Transaction Books, 1981).

[5] On the development of health insurance in Canada, see Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System* (Montreal: McGill-Queen's University Press, 1987); C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Montreal: McGill-Queen's University Press, 1986); Donald Swartz, "The Politics of Reform: Conflict and Accommodation in Canadian Health Policy" in L. Panitch, ed., *The Canadian State: Political Economy and Political Power* (Toronto: University of Toronto Press, 1975); Geoffrey Weller and Pranlal Manga, "The Development of Health policy in Canada" in M. Atkinson and M. Chandler, eds., *The Politics of Canadian Public Policy* (Toronto: University of Toronto Press, 1983).

[6] On the development of health insurance in the United States, see Theodore R. Marmor, *The Politics of Medicare* (Chicago: Aldine, 1973); Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Odin W. Anderson, *The Uneasy Equilibrium: Private and Public Financing of Health Services in the United States* (New Haven: College and University Press, 1968); Ronald L. Numbers, ed., *Compulsory Health Insurance: The Continuing American Debate* (Westport, CT: Greenwood Press, 1982).

[7] See Antonia Maioni, *Explaining Differences in Welfare State Development: A Comparative Study of Health Insurance Legislation in Canada and the United States*, Ph.D. Dissertation, Northwestern University, 1992.

[8] For an extensive comparison, see André-Pierre Contandriopoulos *et al., Regulatory Mechanisms in the Health Care Systems of Canada and Other Industrialized Countries: Description and Assessment*, Working Paper No. 93-01, Cost-effectiveness of the Canadian Health Care System, Queen's-University of Ottawa Economic Projects, 1993.

[9] John Iglehart, "Health Policy Report: Canada's Health Care System, Part 2" *New England Journal of Medicine* 315 (September 18, 1986): 778-785, 784.

[10] Gordon Hachter et al., "Health Services in Canada" and Marshall Raffel, "Health Services in the USA" in Raffel, ed., *Comparative Health Systems: Descriptive Analyses of Fourteen National Health Systems* (University Park: The Pennsylvania State University Press, 1984).

[11] David Coburn *et.al.*, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?" *International Journal of Health Services* 13 (1983): 407-432.

[12] Enrollment figures for Medicare and Medicaid are taken from *Statistical Abstract of the United States* (Washington, D. C., 1993), 115; 370.

[13] The U.S. Census Bureau estimates that, in 1991, 33.5 million Americans (13.5 percent of the population) were without insurance (*Statistical Abstract*, 1993, 115). Between 1990 and 1992, 60 million Americans (25 percent of the population) were without insurance coverage for a least one month. Robert Pear, "Gaps in Coverage for Health Care" *New York Times*, March 29 1994, D23.

[14] On the crisis of the uninsured, see Lawrence D. Brown, ed., *Health Policy and the Disadvantaged* (Durham: Duke University Press, 1991).

[15] Robert J. Blendon *et.al.* "Satisfaction with Health Systems in Ten Nations" *Health Affairs*, Vol. 11, No. 1 (Summer 1990): 2-10; Blendon, "Three Systems: A Comparative Survey" *Health Management Quarterly*, Vol. 9, No. 1 (Spring 1989): 2-10.

[16] Hazel Erksine, "The Polls: Health Insurance" *Public Opinion Quarterly*, Vol. 39, No. 1 (Spring 1975): 128-143; Lawrence R. Jacobs *et.al.*, "Trends:Medical Care in the United States—an Update" *Public Opinion Quarterly*, Vol. 57, No. 3 (Fall 1993): 394-427.

[17] See Lawrence D. Brown, *Politics and Health Care Organization: HMO's as Federal Policy* (Washington, D.C.: Brookings, 1983).

[18] On health reform proposals of the 1970s, see Theodore R. Marmor, "Rethinking National Health Insurance" in Marmor, ed., *Political Analysis and American Medical Care* (Cambridge, MA: Cambridge University Press, 1983).

[19] On health reform during the Reagan and Bush years, see Henry J. Aaron, *Serious and Unstable Condition: Financing America's Health Care* (Washington: Brookings, 1991).

[20] Julie Rovner, "The Catastrophic-Costs Law: A Massive Miscalculation" *Congressional Quarterly Weekly Report* (October 14, 1989): 2712-2715.

[21] Michael S. Dukakis, "The States and Health Care Reform" *New England Journal of Medicine*, Vol. 327, No. 15 (Oct. 8 1992): 1090-1092; John Iglehart, "Health Care Reform: The States" *New England Journal of Medicine*, Vol. 330, No. 1 (January 6 1994): 75-79; Virginia Gray, "Federalism and Health Care" *PS: Political Science and Politics*, Vol. 27, No. 2 (June 1994): 217-220.

[22] Howard M. Leichter, ed., *Health Policy Reform in America: Innovations from the States* (Armonk: M.E. Sharpe 1992); Jerry L. Mashaw, "The Case for State-Led Reform" *Domestic Affairs* Vol. 2 (Winter 1993/94): 1-21.

[23] Robert Pear "Its Eye on Election, White House to Propose Health Care Changes" *New York Times*, Nov. 12, 1991, A20.

[24] Emily Friedman, "The Uninsured: From Dilemma to Crisis" and George D. Lundberg, "National Health Care Reform: the Aura of Inevitability is Upon Us" *JAMA*, May 15, 1991, Vol. 265, No. 19: 2491-2495; 2566-67.

[25]25. John L. Clowe *et al.*, "A New Partnership for Change" *JAMA*,

March 3 1993, Vol. 269, No. 9: 1164-65.

[26] Cathie J. Martin, "Together Again: Business, Government and the Quest for Cost Control" *Journal of Health Politics, Policy and Law*, Vol. 18, No. 2 (Summer 1993): 359-393.

[27] During the 1992 Presidential campaign, 66 percent of voters felt that George Bush was not handling health care policy effectively, while 80 percent of Americans felt it was a very important issue in their voting decision (Jacobs *et al.* 1993: 398-399).

[28] See, for example, Spyros Andreopoulos, ed., *National Health Insurance: Can We Learn From Canada?* (New York: Wiley, 1975).

[29] Steffie Woolhandler and David U. Himmelstein, "Physicians for a National Health Program" *International Journal of Health Services*, Vol. 17, No. 4 (1987): 703-706.

[30] President Bush used this analogy in unveiling his strategy for health tax credits and vouchers. Michael Wines, "Bush Unveils Plan for Health Care" *New York Times*, February 7, 1992, A1, A15.

[31] U.S. General Accounting Office, *Canadian Health Insurance: Lessons for the United States.* (Washington: GAO, 1991).

[32] Steffie Woolhandler and David U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System" *New England Journal of Medicine*, Vol. 324, No. 18, (May 2, 1991): 1253-1258.

[33] Robert G. Evans *et.al.*, "Controlling Health Expenditures—The Canadian Reality" *New England Journal of Medicine*, Vol. 320, No. 9 (March 2, 1989): 571-577.

[34] Victor R. Fuchs and James S. Hahn "How Does Canada Do It? A Comparison of Expenditures for Physicians' Services in the United States and Canada" The *New England Journal of Medicine*, Vol. 323 (September 27, 1990): 884-890.

[35] Donald A. Redelmeier and Victor R. Fuchs, "Hospital Expenditures in the United States and Canada." *New England Journal of Medicine*, Vol. 328 (March 18, 1993): 772-778.

[36] See William A. Glaser, "The United States Needs a Health System

Like Other Countries" *Journal of the American Medical Association*, Vol. 270, No. 8 (August 25, 1993): 980-984.

[37] Patricia M. Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs*, Vol. 11, No. 1 (Spring 1992): 21-43.

[38] John F. Sheils *et.al.*, "O Canada: Do We Expect Too Much From Its Health System?" *Health Affairs*, Vol. 11, No. 1 (Spring 1992): 7-20.

[39] Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance*, HIAA Research Bulletin (Washington: Health Insurance Association of America, 1990); see also George H.W. Bush, *The President's Comprehensive Health Reform Program*, (Washington: The White House, February 6, 1992), ch. 6 "Problems with Alternative Approaches."

[40] Morris L. Barer and Robert G. Evans, "Interpreting Canada: Models, Mind-Sets, and Myths" *Health Affairs*, Vol. 11, No. 1 (Spring 1992): 44-61; Jane Fulton, "Americans and Medicare: Setting the Record Straight" *Leadership*, (July/August, 1992): 18-20.

[41] Theodore R. Marmor and Jerry L. Mashaw, "Canada's Health Insurance and Ours: The Real Lessons, the Big Choices" *American Prospect*, (Fall 1990): 18-29.

[42] C. David Naylor, "A Different View of Queues in Ontario" *Health Affairs*, Vol. 10, No. 3 (Fall 1991): 110-128.

[43] J.A. Barnes, "Canadians Cross Border to Save Their Lives" *Wall Street Journal*, Dec. 12 1990: A16. It has been estimated that of 7100 cardiac surgery cases in 1990 in Ontario, only 300 were sent to the United States for attention (Naylor, *op.cit.*, 116).

[44] See, for example, Julie Kosterlitz, "But Not for Us?" *National Journal*, (July 22, 1989): 1871-1875.

[45] These arguments are derived from Seymour Martin Lipset's comparative study, *Continental Divide: The Values and Institutions of the United States and Canada* (New York: Routledge, 1989).

[46] Lawrence R. Jacobs and Robert Y. Shapiro, "Personal Interests and National Interest", *Domestic Affairs*, No. 2, (Winter 1993/94): 254; see

also Jacobs and Shapiro, "Public Opinion's Tilt Against Private Enterprise" *Health Affairs*, Vol. 13, No. 1 (Spring 1994): 285-298.

[47] On the "radical nature" of managed care solutions compared with Canada's model, see Humphrey Taylor, "And the Mother of All Political Battles Has Not Even Begun..." *Inquiry*, Vol. 30, No. 3 (Fall 1993): 228-234.

[48] Marcia Angell, "How Much Will Health Care Reform Cost?" *New England Journal of Medicine*, Vol. 328, No. 24 (June 17, 1993): 1178-79.

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[51] Tom Hamburger and Ted Marmor, "Dead on Arrival: Why Washington's power elites won't consider single payer health reform." *The Washington Monthly*, (September, 1993): 27-32.

[52] Address by the President before the National Governors' Association, Tulsa, Oklahoma, August 17, 1993.

[53] Remarks by the President, Cranston, Rhode Island, May 9, 1994; Remarks by the Secretary of Health and Human Services, Donna Shalala, Washington DC, August 4, 1994.

[54] The White House Domestic Policy Council, *The President's Health Security Plan: The Clinton Blueprint* (New York: Times Books, 1993).

[55] Robin F. Badgley and Samuel Wolfe, "Equity and Health Care" in C. David Naylor, ed., *Canadian Health Care and the State* (Montréal: McGill-Queen's University Press, 1992).

[56] Cost-sharing arrangements are discussed in Lee Soderstrom, *The Canadian Health System* (London: Croom Helm, 1978).

[57] See Pranlal Manga and Geoffrey R. Weller, "Health Policy Under Conservative Governments in Canada" in C. Altensetter and S. Haywood, eds., *Comparative Health Policy and the New Right: From Rhetoric to Reality* (London: Macmillan, 1991): 207-224.

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