CANADIAN-AMERICAN PUBLIC POLICY

An occasional paper series sponsored by

The Canadian-American Center
The University of Maine
Orono, ME 04473-1591 U.S.A.

CANADIAN-AMERICAN PUBLIC POLICY is sponsored by the University of Maine's Canadian-American Center, which supports a nationally prominent program of Canadian Studies. Designated by the U.S. Department of Education as a national resource center for the study of Canada, the Center coordinates a comprehensive program of undergraduate and graduate education; promotes cross-border research in the humanities, social sciences, and natural sciences; and directs outreach programs to regional and national audiences. For further information: The Director, Canadian-American Center, University of Maine, 154 College Avenue, Orono, ME 04473-1591 U.S.A. (207) 581-4220.

CANADIAN-AMERICAN PUBLIC POLICY (ISSN 1047-1073) is published on an occasional schedule, with four issues appearing annually, by the Canadian-American Center. Subscriptions rates, U.S.: 1 year, $21.00; 2 years, $39.50; Canada and foreign subscriptions: 1 year, $26.00; 2 years, $47.00. Single copy cost: U.S., $6.00; Canada and foreign, $7.50. Bulk order rates in US dollars (plus postage): 1-10 copies $6 ea.; 11-25 copies $5 ea.; 26-50 copies $4 ea.; 51+ copies by arrangement. Payment should be made to the Canadian-American Center. Credit card orders, Canadian checks, and money orders in Canadian currency are welcome. Please call (207) 581-4220 for subscriber services. Advertising rates are available upon request.

Editorial correspondence should be directed to Prof. Robert H. Babcock, Department of History, University of Maine, Orono, ME 04469-5774 U.S.A.

The Canadian-American Center gratefully acknowledges the support of the Business Fund for Canadian Studies in the United States and Foreign Affairs, Canada.

Printed on acid-free paper by Furbush-Roberts Printing Co., Bangor, ME 04401 U.S.A.

Number 23 NOVEMBER 1995
ISSN 1047-1073
ISBN 1-882582-11-X

THE MORAL ECONOMY OF HEALTH AND AGING IN CANADA AND THE UNITED STATES

Phillip G. Clark

Canadian seniors who remember what it was like before Medicare existed in their country, mobilizing to preserve and protect it in the face of perceived waning federal support for the program; the elderly in the U.S. and such powerful lobby groups as the American Association of Retired Persons, bracing for Congressional battles on the fate of Medicare south of the border—these images have recently taken center stage in both the media and the public consciousness of the two neighboring nations. They also make apparent the important connections between the elderly and health care. These two related topics—how they are described, linked, and inevitably addressed—have taken on increasing prominence in public debate in the United States and Canada over the past several months.

The fate of the Medicare programs in both countries is an issue of growing importance socially, politically, and economically. The ways the U.S. and Canada grapple with the

interconnected issues of the graying of their populations and the escalating cost of health care reveal much about the social institutions, public policies, and guiding principles of these North American neighbors. This is so because aging in a social context is both a lens and a prism.[1] It is a lens because an examination of the experience of growing older enables us to study the detailed relationships among societal, political, and economic institutions that together create the collective environment in which individual aging occurs. But aging is also a prism, splitting up the shaded tones of moral obligations, collective and individual responsibilities, and principles of social justice that affect how the elderly are treated in a particular social setting such as the health care system.

A comparative study of these issues across two societies can help to shed much light on the differences and similarities between them. While there has been growing interest in comparative gerontology between the U.S. and Canada,[2] there are also observers who counsel caution about overly facile cross-national comparisons in areas such as social policy and aging: "For every de Tocqueville there is some number of superficial commentators whose observations are best ignored."[3] Nevertheless, cross-national explorations of the aging experience help illuminate how the differences among societies (with regard to their institutions, shared principles of social justice, and resultant social and health care policies and programs) can have a profound impact on how aging is defined, experienced, and understood. In particular, the emerging field of comparative gerontology must become more cognizant of the need to develop a theoretical framework for understanding cross-cultural comparisons and not rely on descriptive information alone.[4]

The framework to be utilized throughout this discussion has been recently conceptualized by Minkler and Estes as the "moral economy of aging." This approach "helps to surface and make explicit the often implicit cultural beliefs and values underlying societal policies and practices affecting the old."[5] An exploration of the interrelationships among moral principles, aging, and public policy has also been proposed in the concept of "public ethics" which deals with uncovering and examining the principal values underlying and guiding the public policy process.[6] In particular, the approach of public ethics can help to examine the assumptions implicit in definitions of public policy "problems" and to evaluate the range of "solutions" proposed to address them. Some observers in the field of aging have suggested that we sorely need greater reliance on public ethics in clarifying the goals and methods of public policies affecting the elderly,[7] especially because the phenomenon of aging forces upon societies and governments challenges in the form of policy choices that have major underlying value implications.[8]

The discussion that follows attempts to develop a framework for thinking about these issues as they currently emerge from an historical backdrop of social institutions and health care policies. Because the health care context in both countries is rapidly changing, and anything published will quickly become out of date, my goal is to develop an analytic tool that can further an understanding of the current debates surrounding health care and aging policies in both countries. Pursuing a comparative "moral economy" approach to exploring these concerns, this discussion will be divided into four major sections. First, emerging issues in the current concerns of both countries about the effects of aging on health care policy considerations, particularly cost, will be explored. Health care policy in both countries is under intense scrutiny and reassessment, an examination fueled in part by growing concerns over the perceived effects of population aging on the skyrocketing costs of health care services. It should be noted here that this analysis will focus specifically on issues linked to aging, as other recent discussions have provided excellent comparative analyses of current health care policy reform initiatives in both countries.[9] Second, the backdrop to these current

---

Phillip G. Clark is professor and director of the Program in Gerontology at the University of Rhode Island. As a visiting professor at the Universities of Toronto and Guelph during 1988-89, he focused on comparative U.S. and Canadian geriatric health care policy. He is the author of "Public Policy in Canada and the United States: Individual Lives, Family Obligation, and Public Responsibility," in J. Hendricks and C. Rosenthal, eds., The Remainder of Their Days: Domestic Policy and Older Families in the United States and Canada *(New York: Garland, 1993): "Moral Discourse and Public Policy in Aging: Framing Problems, Seeking Solutions, and 'Public Ethics'," Canadian Journal on Aging 12 (1993): "Ethical Dimensions of Quality of Life in Aging: Autonomy vs. Collectivism in the United States and Canada,"* The Gerontologist *31 (1991).*

discussions will be examined, particularly in the context of previous studies, reports, and projections that sketched out the assumed linkages between aging and health care service needs. Here, a striking contrast between Canada and the U.S. will start to emerge. The third section will highlight differences in the changing normative underpinnings of health and social service policy between the two societies, including reflection on the shifting balance between the competing values of individual and collective responsibility for health care. In particular, implications of changing values for the process of policy reassessment and development will be considered. Finally, the conclusion will summarize the major themes in this cross-national comparison, particularly with regard to the likely future of health care policies and programs for the elderly in both countries. Included also will be a discussion of the relevance of the moral economy approach for furthering an understanding of both societal aging and the development of new directions in health care policy.

I. EMERGING ISSUES IN AGING AND HEALTH CARE POLICY

The growth in health care costs and the aging of the population are frequently linked in the popular press, governmental reports, academic studies, and public consciousness. After all, the elderly are the heaviest users of health care, and their numbers are increasing (particularly the "old old," those 85 and older, who are the greatest consumers of health care services of all), an assessment leading to the obvious conclusion that health care costs will continue to skyrocket in the future, fuelled by the volatile mixture of aging baby boomers and high health care demands. We will examine this presumed linkage, and the social creation of the "problem" of population aging, in the next section.

Whatever the validity of this connection, it is certainly apparent that seniors in the U.S. and Canada have played an active role recently in the debates over the future of health care policy. In both places they are concerned about the level of continued health care program benefits, access to needed services, and the costs to the consumer. The discussion below will "set the stage" for a more comprehensive examination of issues in aging and health care policy by describing some of the themes that have emerged in recent discussions, reports, and conferences in both countries. What will become clear is that there are major similarities as well as some striking differences in the public debate and discussion on aging and health care in the U.S. and Canada.

A. The Struggle to Preserve Medicare in Canada

Persons 65 and older currently constitute 12.3 percent of the Canadian population, and their numbers are expected to exceed 20 percent by around the year 2025. With regard to the costs of care, health expenditures in Canada represented 9.9 percent of Gross Domestic Product (GDP) in 1991, a figure that is the highest among countries with national health insurance. In contrast, during the 1960s total spending on health care ranged from 5.5 to 7.0 percent of GDP.[10]

While the linkage between aging and increasing health care costs is seen to some degree in Canada, there are other more powerful forces at work as well that tend to fuel the popular and governmental perception of a looming crisis. The summary that follows is an attempt simply to describe the current key issues and players in this unfolding drama, organized around the following themes: (1) preserving Medicare, (2) national debate and dialogue, (3) the concerns of seniors, and (4) emergent directions for health care in Canada.

1. Preserving Medicare. Primary among current issues is the tradition of universal access to medical services, available nationally as Medicare in every province by 1971, based initially on a model of physician availability and acute hospital care funded by equal matching federal dollars to the provinces on a one-to-one basis. Hallmarks of the system include universality, accessibility, comprehensiveness, portability, and public funding. Important changes were made not long after the original program was put into place. In 1977 the Established Programs Financing (EPF) Act replaced the original hospital and medical insurance legislation with block grants to the provinces tied to rates of demographic and economic growth. Subsequent continuing legislation has further cut the amount of federal transfer payments to the provinces, reducing the original "50 cent dollars" to about "30 cent dollars". Recent legislation provides the basis for the eventual reduction of federal support for health care to the provinces to zero. In spite of the federal government's reassertion in 1984 in the Canada Health Act of the importance of universal access to services by its attempt to eliminate user fees and "extra billing" by providers, recent legislation has undercut this policy by

simultaneously increasing provincial taxing authority to make up for the federal reduction and weakening the federal government's ability to prevent extra-billing and insure comparable services across provinces.[11] The burden of health care costs has now effectively been shifted to the provinces, which are in turn being pressured to pass it on to both providers and consumers.[12]

Fears about the future of the still very popular universal health care system have led to major initiatives to assess the current state of affairs with Medicare and to recommend ways to simultaneously maintain its universality, reduce the rate of growth in health care costs, and potentially expand its coverage to areas such as long-term care in general and home and community-based care in particular.[13]

2. National debate and dialogue. Asserting that "Canada's health system is changing and there needs to be a national dialogue with Canadians to chart the future, building on the fundamental values that are embedded in the Canada Health Act," in 1994 the federal government created the National Forum on Health, a 24-member citizen's advisory group, to make sure that "national priorities are identified and that Canadians are involved and informed about the issues and options....The Forum will examine specific issues, help focus discussion, and assist in developing solutions and strategies to improve the health of Canadians and ensure that the health system is equipped to deal with the challenges of the future."[14]

As stated in public announcements about its work, the Forum "sees its mandate as improving the health of Canadians as well as the efficiency and effectiveness of health services" and is guided by three major principles: (1) supporting a national, universally accessible health system, (2) strengthening public understanding of health and health care and developing support for change, and (3) providing government with recommendations for action, reflecting Canadian values. At the outset, the Forum agreed to an integrated approach leading to the creation of healthy public policy and identified four major themes and work groups around which to organize its activities:

- *Determinants of Health* will assess current evidence on what makes people healthy and what approaches have proven successful, particularly with regard to special groups (such as children and the elderly).
- *Evidence-Based Decision Making* will attempt to discover what is preventing desirable change from occurring within the health system with regard to patient, provider, and policy.
- *Values* will seek a better understanding of how professional, religious, social, and ethical values influence the development of the principles and policies governing health and health care in Canada, and identify those which should be central to any policy change. Importantly, other influencing factors, such as affordability, accountability, and appropriateness, will also be studied.
- *Striking a Balance* represents the task of how best to achieve a balance through making the optimal use of existing resources, improving the efficiency of the system to create resources, and identifying alternative uses of resources, while informing the public and other stakeholders about the various options available.[15]

The Forum considers its primary responsibility as investigating issues, examining assumptions, and asking questions about health care, its delivery and funding.[16] Two presentations by key members of the National Forum provide some insight into its orientation. In an address to a conference in Toronto in May of 1995, Marie Fortier, the Forum's executive director, underscored the central importance of maintaining a single-tier system of health care in Canada, based in no small part on fundamental concerns about cost control and Canadian values. With regard to the latter she emphasized the "fundamental values of Canadian society: our compassion, fairness, and community spirit. Canadians don't want a society where the poor cannot get quality health care. We are proud of a system that provides quality service for everyone."[17] Secondly, in a March 1995 meeting of the National Forum, members confirmed their support for the principles articulated in the Canada Health Act and for public funding of the system. They agreed with the observations of Robert Evans, professor of economics at the University of British Columbia (and member of the Forum), that what the health care system needs is not more money, but better management. In short, they said, "The public system can be maintained through greater efficiency in delivering care, from reducing duplication and by ensuring that money is spent only on services that produce good results and improved health. The

question is how to promote better management, accountability, and control—and better outcomes."[18]

The Forum has already generated both skepticism about its overall mission and controversy over the perception that the federal government has limited provincial participation.[19] Nevertheless, its formation is consistent with firmly held Canadian procedural values about public participation in the policy process, to be discussed in more detail below. In addition, although the National Forum will not focus particularly on issues related to the elderly, it is clear that the elderly are a major population group with which the Forum will have to deal. Indeed, seniors have already mobilized through governmental and national association efforts to make sure that their interests are clearly and forcefully heard in the ongoing debate and discussion over national health care and its reform and redirection.

3. Concerns of seniors. The unique issues relevant to the elderly in the debate over the future of Medicare are represented by two national organizations: the National Advisory Council on Aging (NACA) and One Voice: The Canadian Seniors Network.

The National Advisory Council on Aging, created in 1980 and receiving operational support from the Seniors Directorate of the federal government, consists of 18 members from across Canada who "assist and advise the Minister of Health on issues related to the aging of the Canadian population and the quality of life of seniors. NACA reviews the needs and problems of seniors and recommends remedial action, liaises with other groups interested in aging, encourages public discussion, and publishes and disseminates information on aging."[20] In its recently published monograph, *The NACA Position on Determining Priorities in Health Care: The Seniors' Perspective*, NACA offers specific principles and recommendations for establishing priorities in health care based on consultation with major Canadian seniors organizations and experts in the field. While recognizing that "choices among health care services will have to be made if the health care system is to remain affordable as well as universal," the position paper also reaffirms the belief that "Canada's health care system is a source of pride for Canadians and a cherished symbol of the values of equity and compassion that are intrinsic to our national identity." Supporting a single-tiered system of universal access to essential health services, the report articulates a principled approach to both the content and the process of health care reform, drawing on the ethical values of need, equality, utility, and liberty in determining health care priorities and those of precision, accountability, and autonomy in guiding the process by which decisions regarding the allocation of public resources are made.[21] While the report recognizes that change in the health system is inevitable, it presents a strong case for adopting an approach that preserves the most important values for seniors of the present system, while incorporating new priorities that more effectively capture what health care in general and specifically for the elderly should be and must become.

A second organization that speaks on behalf of seniors is One Voice: The Canadian Seniors Network. It is a national seniors organization that lobbies, educates, and raises consciousness among legislators and the public-at-large in Canada on issues affecting the elderly. In September, 1994, nearly 250 delegates from across Canada met in Montreal to answer the question, "How can we help save Medicare?" and developed a report, entitled *Healthy Aging: A Canadian Commitment?* that embodied their concerns and recommendations.[22] Many conference participants remembered the days before Medicare and were committed to its maintenance as an essential strand in the social safety net in Canada, not only for seniors but for all Canadians. Indeed, participants felt the need to maintain and revitalize the political will needed to keep Medicare intact as an expression of collective responsibility for health care in Canada, especially in the face of the growing threats of deinsuring, privatization, and user fees raised by the specter of shrinking federal involvement and growing provincial responsibility and driven by the apparent need to control costs, restrict access, and reduce benefits.

The One Voice conference developed an action plan to voice its concerns and implement its recommendations. Emphasis here was on defending Medicare, building coalitions among groups, taking national leadership in this area, and communicating among coalitions and organizations to "get the message out" to target audiences including the media, governments, and all age groups, about the threat to Medicare. The conference has already led to the formation of a Seniors Health Action Group (SHAG) both to research what effects proposed cuts in provincial transfer payments and block grant funding would have on Medicare services, and to develop an action plan to win widespread public support for a renewed vision of universal health care and to stimulate action at the local, provincial, and federal levels to achieve it.

4. Emergent directions for health care in Canada. The current debate over the future of Medicare has triggered a reconsideration of how health care services should be defined (broadly or narrowly) and what model (medical, social, or some combination) should structure the system. For example, because of the history of Medicare's support for hospital and physician services, current health care is based largely on an acute care, medical model, an approach that may be difficult to change due to vested interests and system-wide inertia. In addition to general concerns about the efficiency, organization, and effectiveness of the services delivered by the health care system, there are two areas in particular where discussion has been driven by concerns relevant to the care of the elderly: long-term care, and healthy public policy and disease prevention.

Long-term care in Canada exhibits great variation among the provinces with regard to organization, payment, and dominant models. While there may be consensus on the human values underlying the system, as for example, dignity, security, self-determination, and independence, there seems to be substantial variability in other areas.[23] Although Medicare established an essential foundation of medical services upon which a long-term care system could be built,[24] it simultaneously sharply narrowed the view of what constitutes health and how to structure services to achieve it. Long-term care to manage chronic illness and provide supports to improve quality of life of the frail elderly falls considerably outside the biomedical model associated with the acute care system. While long-term services in institutional settings (chronic hospitals and nursing homes) may be covered under Medicare and the Canada Assistance Plan in some provinces, non-institutional home and community-based services are covered only by a crazy-quilt payment system of public and private programs, including non-profit agencies and user fees for consumers. Hence long-term care is increasingly discussed and debated across the Canadian provinces, particularly the importance of increasing public support for home and community services outside an institutional context.[25]

Chappell, for example, argues that there is widespread support among federal and provincial governments for increased recognition of community services, and the challenge now is to redistribute the resources from the acute care system to the community one.[26] Other authors have recently emphasized the importance of maintaining diversity within the long-term care system to maximize individual choice,[27] supporting the needs of families and other caregivers,[28] and recognizing the perils and pitfalls of community involvement in determining the priorities of the long-term care system without adequate definitions for "community" and "involvement."[29]

In addition to concerns about how to increase public support for long-term care services across Canada, observers also emphasize the importance of expanding the model of care to embody a more holistic emphasis on health promotion and healthy public policy. Rather than relying on a health care system that is reactive, "fixing" problems after they have arisen, observers are calling for a greater emphasis (along with increased resources) on health promotion and disease prevention. This is especially the case within the gerontological community,[30] where authors have emphasized the importance of preventing or postponing health problems in designing a strategy for maximizing well-being and quality of life for the elderly. More broadly interpreted, this approach also includes greater recognition of the need for "healthy public policy," supported by the belief that the scope for thinking about health and aging must be broadened well beyond a model based simply on demography, economic costs, and disease and operating within a system characterized by organizational boundary disputes, lack of adequate data, and few mechanisms to coordinate decision-making across the system.[31]

B. Saving the Medicare Program in the United States

In the U.S., elderly persons currently make up about 12.6 percent of the population, with projected increases due to the aging of the "baby boom" generation to approximately 21.8 percent in the year 2030 and 22.6 percent in 2040.[32] As in Canada, concerns are also directed on the southern side of the border toward the skyrocketing cost of health care services, which in 1990 constituted 12.4 percent of the Gross Domestic Product in the U.S.[33] In particular, the U.S. Medicare program has grown rapidly since its inception in 1965, averaging 16 percent annual growth rate in its first 25 years of existence.[34] In spite of efforts over the past few years to stem the rate of growth, such as the development of Diagnostic Related Groups (DRGs) which established limits on hospital care for the elderly, current projections indicate that the trust fund for hospital insurance will be depleted within seven years.[35]

Three developments in the U.S. have highlighted the interrelationships between health and aging policy: (1) the central importance

of health care issues at the 1995 White House Conference on Aging, (2) the Clinton Administration's attempt at health care reform, and (3) the Congressional debate over the future of Medicare. An examination of the discussion surrounding them helps to illustrate current issues related to geriatric health care and the core conflicts over them evident in the U.S. today.

1. Health care issues at the 1995 White House Conference on Aging. Over two thousand delegates representing all states and territories participated in the fourth White House Conference on Aging (WHCoA) held in Washington on May 2-5, 1995. Many "mini White House Conferences" across the country preceded this national forum, allowing states and organizations to develop specific recommendations based on the concerns of the elderly on a number of policy-related issues. Observers prior to this year's conference suggested it was particularly important because the country is about to enter a new phase in national history when the challenges of aging will become more critical. In particular, "The dramatic increase in the elderly population can provide the nation with unprecedented resources of experience, support for younger generations, and volunteerism. However, the growth in the population aged 85 and older will place a strain on existing social and health services."[36] Although the balance between the potential crises and the opportunities represented by an aging society is evident in this observation, the conference itself tended to address mainly the perceived problems in the current system and anticipated issues for the near future.

Of the fifty resolutions adopted by Conference participants, approximately half deal in some way, directly or indirectly, with health care and long-term care. Because many of the resolutions embody similar principles and recommendations, it is difficult to present a unified picture. Nevertheless, the preservation of Medicare benefits and coverage, the development of a universal health care system, better support for a unified home and community-based long-term care system, and more emphasis on health promotion and disease prevention for the elderly are recurrent themes. Clearly, health-related issues dominated the White House Conference, revealing a continuing concern and anxiety over the future of health care in the U.S. generally and especially with regard to the elderly. This pattern was evident as well in the pre-White House Conference state hearings. For example, in Rhode Island nearly 40 percent of comments at one series of public hearings dealt with health care in general, and about 20 percent were related to long-term care in particular.[37]

2. The Clinton Administration's attempt at health care reform. The Clinton Administration's proposed Health Security Plan, and the resultant debate and ultimate failure of the proposal, can teach many lessons relevant to health care reform in the U.S. The elderly have been deeply involved in these issues because concerns over the cost of health care for the older population continue to play a major role in thinking about programs, benefits, and eligibility for services. The Clinton plan included the concepts of universal coverage, comprehensive benefits, effective cost containment, national rules with local flexibility, avoidance of explicit taxes, and reform of the health care delivery system to remedy the current problems of cost and access to services in the U.S. Its failure has been attributed variously to the American distrust of government, to fears of increased costs felt by small businesses, to general tax phobia, to provider and insurer self-interest and profit motives, to the complexity of the plan itself, to weak grassroots support, to lack of positive information, to the spread of misinformation and misperception, and to political partisanship.[38]

The Clinton proposal generated considerable discussion in the gerontological community about the relationship between the Medicare program, which was to have remained essentially independent of the more systemic reforms under the Health Security Plan, and health care reform in general. This examination took two forms: the first was to assess the specific impact of the proposed Clinton plan on the health of older adults, particularly in creating "discontinuities" in care that would have been introduced by two separate programs, one for persons under 65 and one for those over it;[39] and the second dealt more generally with the interrelationships between Medicare and health care reform, including the lessons to be learned from the former for the latter. This discussion will focus on the second aspect.

As a program, Medicare has some major lessons for health care reform in general, regardless of the fate of specific proposals such as the Clinton plan:

- *Government programs can be popular.* The elderly generally like Medicare, as does the public at large, and it has made major

contributions to access to health care services and to economic well-being.

- *Ability of providers to adjust to change*. Changes in hospital and physician payment mechanisms, while causing short-term opposition, did, in fact, serve to help hold down costs, particularly in hospital services, without having major negative impacts on quality of care.
- *Ability to reduce administrative costs*. A major success of Medicare is its low administrative overhead: less than 3 percent compared with 10 percent for private health insurance and as much as 40 percent in the small group market. This significant differential has important implications for reform in other parts of the health care system.[40]

Another area highlighted in discussions about Medicare and health care reform is that of long-term care. In particular, observers have seen these debates as an opportunity to move the long-term care agenda ahead as a major issue to be considered in any substantial reform of the health care system in the U.S. For example, in spite of the predominant acute care focus of Medicare (or because of it?), the Clinton health care task force long-term care work group considered adding a voluntary Part C Medicare benefit, enabling individuals to purchase public insurance to protect up to $30,000 in assets.[41]

Some policy observers have suggested that there are major issues which must be resolved before long-term care can really move ahead on the health care reform agenda.[42] These include:

- *The place of long-term care on the health care reform agenda.* Although the focus of many attempts to reform health care is on acute care services, long-term care is increasingly important.
- *Determining the proper balance between public and private roles.* The value or political ideology of governmental support versus the responsibility of individuals and their families for providing and paying for long-term care is central. In addition, the kinds of private sector programs that might be made available, and their affordability, are critical: e.g., the provision of affordable, private, long-term care insurance.
- *Institutional versus non-institutional services*. The question of how much resources to invest in home and community-based care efforts, as opposed to the traditional emphasis on nursing-home care, is essential. It is unlikely that policymakers will invest more resources into institutional care until a more balanced home and community-based alternative has been developed.

Beyond these crucial "big picture" items are more specific issues that will need attention in adding any long-term care benefit to a health care reform package, including: what is the appropriate role for the states? How will expenditures be controlled? Will there be a broad benefit package and how does that affect service entitlement? Will acute and long-term care services be integrated? How will the needs of the elderly and nonelderly disabled be met? And, how will adequate financing be assured?[43]

3. Congressional debate over the future of Medicare. Finally, recent budgetary debates in the U.S. Congress have thrust Medicare cost projections into the public consciousness, with resultant concerns raised about the impending insolvency particularly of the Hospital Insurance (HI) trust fund. Televised images of members of Congress brandishing copies of the Medicare Trustees' Report as evidence that "something must be done" about "runaway" health care costs for the elderly have contributed to a public perception of a looming disaster. The Hospital Insurance program pays for inpatient hospital and other related care for those aged 65 and over, and for the long term disabled. In calendar year 1994, HI covered about 32 million aged and about 4 million disabled enrolles at a cost of $104.5 billion.[44] Under "intermediate" cost assumptions, projections of the solvency of the HI trust fund indicate the fund will be exhausted in only seven years, and suggest generally long- term financial instability over the next seventy-five years. The cost of the HI program is projected to increase from 1.6 percent of Gross Domestic Product to 4.4 percent in 2065, as a result of anticipated increases in hospital admissions, the complexity of services provided, and changing demographics. By the end of the seventy-five year projection period, the study finds that the HI cost rate will be roughly three times the income rate. The report also notes that currently about four workers support each HI enrollee. This ratio will decline rapidly early in the next century, however, even before the major demographic shifts

associated with the baby boom begin to occur, and by the middle of the century only about two workers will support each HI enrollee.[45]

In concluding their report to Congress, the trustees urge the government to take action, based on their summary assessment that there has been "deterioration in the long-range financial condition of the Social Security and Medicare programs and an acceleration in the projected dates of exhaustion in the related trust funds....These adverse trends can be expected to continue and indicate the possibility of a future retirement crisis as the U.S. population begins to age rapidly."[46] While the report recognizes past achievements in slowing down the rate of growth in Medicare HI expenditures, it strongly suggests that "Medicare reform...be addressed urgently as a distinct legislative initiative" in light of the failure of recent attempts to introduce broader health care reform changes. For example, the structure of parts A and B may require review and change.

What is clear at this writing is that Congress has undertaken a major assessment of the future of Medicare, with both Democrats and Republicans prepared to assess its benefits levels, structure, and rate of growth. Urged by the twin specters of looming budget deficits and the graying of the population, Congress seems intent on restricting the annual rate of growth in Medicare by reassessing what it pays for or where the money comes from—or both. The perceived "crisis" in Medicare, as announced by its own trustees, will certainly strengthen the hand of those who would not feed it any longer.[47]

Additionally, a comparison of current issues in geriatric health care policy on both sides of the border gives evidence that mounting concerns over the cost of health care, emerging from the lengthening shadow cast by demographic aging, are increasingly driving public discourse on the future of health care service delivery systems, payment mechanisms, and appropriate care models. Whether or not the two countries' systems are converging from past histories representing very different assumptions about the role of government in health care,[48] what is clear is that the elderly and their health care concerns are taking a prominent place in the intense current debate over the future of the health care systems in both the U.S. and Canada. In order to understand how these two countries arrived at their current situations, we must examine their recent pasts in the context of studies, reports, and forces shaping the nexus between aging and health care policy and, in particular, the development of a perceived "problem" of health and aging.

II. IS POPULATION AGING A "PROBLEM PARADIGM"?: VIEWS FROM BOTH SIDES OF THE BORDER

The current debates over aging and health care in Canada and the U.S. have an interesting and important historical backdrop, an understanding of which enriches our insights into the emerging trends currently shaping health care policy in both countries. At present health care services and policies are a "moving target," constantly changing and difficult to characterize in a single cross-sectional "snapshot" in time. Rather than to admit defeat because of this fact, however, we should examine the past, analyze the present, and design a framework to think about the future. The development of a meta-analysis of the patterns and themes in previous studies on the relationships between population aging and health care can capture the trends and forces shaping the issues facing a society and its government and thereby provide a firm foundation for informing our thinking about the future.

The development of the concept of aging as a "problem paradigm" helps to provide a basis for this approach. For example, studies of population aging may lead to forecasts of demographic doom based on projections of age composition, dependency ratios, disability rates, and the economic impact of population structure into the future, an activity characterized as "alarmist or apocalyptic demography."[49] In this approach there is an implicit faith that the emphasis on quantitative data will free policymakers from the difficult (and ultimately value-based) decisions implicit in making choices and establishing priorities. But no matter how interesting demographic projections may appear, their pattern of use in the present is more revealing of their true intent and impact. Numbers may simply be used to mask a call for more money to respond to an imminent "health care crisis," obscure important facts, or veil alternative options that should be considered by the policymaker. Numbers can be manipulated and "massaged" to generate quite different conclusions and interpretations.[50] Indeed, even recent demographic research itself suggests that concerns over the negative impact of population aging on rates of economic growth may have been greatly exaggerated.[51]

In this same vein, Susan McDaniel reminds us that "ideas, research and policy thinking about aging can never be divorced from

the socio-economic context in which the phenomenon occurs."[52] The emergence of population as a "problem paradigm," a model of shared social reality, can be traced to the interaction between researchers, policymakers, and program developers and funders. In this view, demographic change becomes the engine driving a number of emerging crises, all of which are tied in some way to the growing numbers of the elderly, rather than the underlying social and economic relationships that characterize a society. This mindset prevents us from seeing the "problem" of an aging society differently, and therefore limits the range of potential "solutions" that might be considered.[53] Seen from this perspective, Canada and the U.S. have different histories and emerging patterns.

A. Canadian Demographic Projections: Looking Beyond the Numbers

The mid-1970s saw the beginning of published reports based on the empirical study of population aging in Canada. Canadian observers have usually been more reluctant than their U.S. counterparts to embrace a one-dimensional, quantitative approach to the aging "problem." For example, some of the earliest studies focused on general issues and trends dealing with a changing age structure, or more specifically with concerns about its impacts on health care services.[54] There were also concerns raised early-on about the "problem" of population aging, especially with respect to its impact on pensions and health care services.[55]

Alarmist themes could be detected in some of these early studies, but most tended to downplay the "problem" of demographic aging and to avoid the more apocalytic tones that were beginning to emerge in the U.S. For example, in their 1978 study on health care impact, Boulet and Grenier[56] used utilization and cost data on hospital and medical care services to project the effects of an aging Canadian population to the year 2031. Although the graying of Canada would have a significant impact, the authors concluded that it would not be unmanageable in its effects on per capita growth of medical and hospital costs. As Robert Evans concluded in his review of this study, "This information is most important. It suggests that present attempts to justify major increases in health system capacity to cope with impending demographic shifts are...fallacious....Whatever drove or will drive increases, it is not population structure."[57]

Similarly, at about the same time Ridler[58] accurately captured the growing Canadian concern with questions about the country's ability to continue supporting pension programs and health care services in the face of an aging population. He concluded that these anxieties were overstated because: (1) the proportion and absolute numbers of young Canadians would decrease, yielding savings in the costs associated with education and family allowance payments; (2) the proportion and absolute number of taxpayers could be expected to increase, offering a broader base to fund public programs; and (3) the age structure of the Canadian population was not inevitable but was subject to conscious manipulation through economic policies affecting fertility and immigration.

These early studies are significant because they set the tone that the "problems" potentially associated with an aging population were overblown and could be addressed through appropriate governmental policies. Because there is sufficient time to prepare for the potential impacts of an aging population, the crisis rhetoric is defused and the "problem" becomes a socio-economic and political "challenge" instead.

Skepticism with data-driven decrees of doom continued into the decade of the 1980s. In 1984 the Canadian Medical Association (CMA), asserting its professional stake in discussions of national health care policy, released a report by the Task Force on the Allocation of Health Care Resources.[59] This study devoted an entire section to the health care needs of the elderly with particular attention to their impact on future health care costs. A separate research report explored the impacts of population aging over a forty-year period.[60] Although this study did not answer the question of whether projected increases in health care service utilization would be economically manageable, it did examine the impact of such alternate forms of care as, for example, substituting less costly community-based services for institutional ones. The report concluded that the effect of such resource re-direction would be considerable savings to the health care system, and it observed that the overall impact of the graying of Canadian society could be greatly reduced by appropriately designed policies. The implication was that collective will and governmental policies could prevent any "crisis" from being created by growing numbers of the elderly.

This same theme has been sounded in over twenty years of studies by Frank Denton, Byron Spencer, and their colleagues at

McMaster University. Based on a series of earlier analyses[61] completed in the 1970s investigating the socio-economic impacts of a changing demographic structure, Denton and Spencer concluded in 1987 that a significant proportion of elderly Canadians need not pose a crisis for two reasons: (1) rising health care costs in the future will at least be partially offset by increases in gross national product, and (2) important reductions may occur in the cost of health care services though advancements in technology, and the use of less expensive forms and settings of care and health care professionals which could generate substantial overall savings.[62] That such policy choices may not be easy is a point made by the same authors in 1988, when they concluded that rather than a question of insufficient levels of social resources to support the increased impact of the elderly, population aging's greatest challenge is to deal with shifting dependency ratios. Government will have to decide whether and how to redirect social resources and public spending for education, pension, and health care programs.[63] This point underscores the importance of making social choices and suggests that effective options depend less on numbers and data than on shared societal consensus and collective decision making.

Denton and Spencer[64] have carried this theme forward in their most recent (1995) study, where they suggest that their projections of population aging do, indeed, have major implications for the future costs of health care services, and they summarize some of the recent methods employed in Ontario to limit the rate of increase in health care costs. But more importantly, they suggest that greater attention must be paid to an integrated systems approach to health care policy, emphasizing the interdependencies among different sectors of the system. Such a perspective can lead to a more careful review of existing services, based on their effectiveness and necessity, and the possible elimination of ones not meeting certain criteria. The consistent theme remains one of the necessity of making choices, based on a firm working knowledge of the system and what expenses are really necessary. In other words, government must take a hard look at the system, keep what is good and necessary, and eliminate what is bad and ineffective—a mission recently articulated by the National Forum on Health.

Another study by Canada's chief statistician in 1988 explored trends in fertility, labor-force participation, and income and their impacts on dependency ratios and the future costs of health care, pensions, and educational programs.[65] Once again, the author concluded that although population aging represents a significant challenge, more powerful than demographic forces are the kinds of social and economic policies developed by government in response to them. Public policy approaches to promoting healthier lifestyles among the elderly, improved housing, and stronger informal support systems were all seen as sufficient measures to respond to the challenge of an aging society.

Finally, Robert Evans, Morris Barer, and their colleagues at the University of British Columbia have studied the "risks" associated with an aging Canadian population for several years, and they have consistently defused the apocalyptic rhetoric associated with the looming "crisis" created by the perceived impact of the elderly on health care service utilization. For example, in 1987 they drew attention to the important distinction between simple population aging and the ways in which the health care system responds to the needs of the elderly and how these needs may be changing.[66] Drawing on the political economy of aging perspective, the authors concluded that the "problem" of the elderly has been created by vested interests who perceive a new "growth industry" in the aged and seek to divert more resources into the health care sector. They also suggested that government might simply be using this "crisis" as a lever to pry greater efficiency from the health care system. As stated earlier, what is important is not the numbers themselves, but the way in which they are used.

Similarly, Robert Evans argued in 1988 that challenges to the Canadian universal health care system based on the pressures of an aging population are factually and analytically wrong. Rather, they are simply thinly veiled professional or political agendas intended to use a demographic smokescreen to hide other objectives. The real challenge for an aging society is to develop a collective decision-making context to determine how to understand health itself and to delineate the appropriate boundaries of health care services: "[T]he way ahead involves the development not only of programs and policies, but of new intellectual and conceptual frameworks for thinking about health in a broader social context, and about the nature of the interrelationships and obligations among the individual, the family...and the wider society".[67] From this perspective, the "problem" of aging is simply a challenge to the community and the government to respond reflectively to the needs of the elderly

based on a shared dialogue about the appropriate objectives of health care and how they can be met. For example, as we have already seen, some critics of the current Canadian health care system suggest that it is too medically oriented and should instead provide more support for long-term care services (especially community-based programs) that better serve the needs of the elderly and their families.

Most recently, Barer, Evans, and their colleagues attempt once more to lay the demographic apocalytic rhetoric to rest:

> The reality, as reflected in a steadily accumulating collection of research studies, is that to date the effects of aging per se on health care costs have been quite limited...Projections suggest that future effects...will appear gradually, and will be within the capacity of historical rates of economic growth. Yet these consistent research findings, like a lighthouse lost in the fog, have remained obscured by the persistent claims that the aging of the population will bankrupt our health care systems.[68]

Using the metaphor of aging as a glacier, not an avalanche, they explain the persistent grip of the image of demographic doom as part of the "problem paradigm" earlier explored by Canadians McDaniel and Northcott.[69] Their suggestion for an antidote to this poisoned projection is the realization that the forces driving health care cost increases are the outcome of a struggle over social priorities, an outcome that can be altered if the social and political will exists. Patterns of health care for the elderly need to be changed, and this is a management issue, not one dealing with absolute levels of social resources. In other words, choices will have to be made and government will have to make better decisions about how it spends its money on health care in general and on the elderly in particular. This theme is the same as that articulated recently by Evans on behalf of the National Forum on Health.

B. Apocalyptic Aging in the United States

Optimistic and pessimistic studies and projections of the effects of aging on health care costs can be found on both sides of the border. But unlike the predominant skepticism north of the border, policy analysts in the U.S. seem, on the whole, to have embraced quantitative studies of population aging as an objective validation of "worst case" fears about the looming geriatric "crisis." Some U.S. observers suggest that this unquestioned reliance on numerical interpretations of the gerontological "population problem" is tied to the emergence of the biomedical paradigm of aging.[70] The overall characterization of this "culture of crisis" has four distinct but interrelated aspects: (1) demographic, (2) epidemiologic, (3) economic, and (4) technologic.

1. Demographic forces. Simple numerical projections are often used to create a sense of the helpless inevitability about the future aging "crisis." One recent study finds that "middle series projections" predict that the number of persons over age 65 will increase to 52 million by the year 2020 and to 68 million by the year 2040.[71] By the year 2030 the elderly will constitute roughly 21 percent of the U.S. population. Projections of the "aged dependency ratio" (i.e. the number of aged persons per working population aged 19 to 64, a crude measure of "dependency") show similar supposedly alarming trends: set at 20 percent in the mid-eighties, it is expected to increase to 33 percent by the year 2025 and to 38 percent by 2050.[72] Moreover, persons 85 and older, those most likely to use health care services, are the fastest growing population group; by the year 2020 there will be 7 million individuals in this group, or approximately 2.5 percent of the total population, up from roughly 1.4 percent at present.[73]

2. Epidemiological trends. Closely related in popular consciousness to the demographic "facts" are epidemiological trends, especially projections of the disease burden which the skyrocketing numbers of the elderly represent. Based on the concept of the "failures of success" explaining the growing prevalence of chronic illness due to the successful treatment of acute diseases,[74] epidemiologists point to the specter of a "pandemic of chronic diseases and associated disabling conditions."[75] Although more optimistic projections of declining duration of chronic illness (the "compression of morbidity" at the end of life) have been made by such observers as James Fries,[76] many of his critics have suggested that there is little, if any, evidence for this trend as yet.[77] Indeed, with regard to the combined effects of aging and chronic disease, most projections seem to agree that "the number of very old people is increasing rapidly; the average period of diminished vigor will probably rise; chronic diseases will probably occupy a larger proportion of our life span; and the needs for medical care in later life are likely to increase substantially".[78]

An increased burden of chronic illness will impact most directly on the institutional long-term care system. A recent U.S. General Accounting Office (GAO) report estimates that costs will almost triple in the next 27 years and then nearly triple again by the middle of the next century.[79] In constant 1987 dollars, costs are expected to rise from $42 billion in 1988 to $120 billion in 2018 and $350 billion by 2048. The number of elderly persons using a nursing home during the course of a year is projected to increase 76 percent over the next 30 years, from roughly 2.3 million in 1988 to about 4 million in 2018. The report also suggests that shifting dependency ratios will place a greater burden on the working population in paying for these increased costs.

3. Economic forces. Concerns about costs, especially those for medical care, arise naturally from projections of the growing numbers of the elderly with chronic illness. Although the elderly currently represent over 12 percent of the American population, they use roughly a third of the total U.S. expenditures on health care. A recent study of future Medicare expenses concludes that "the projected total cost...rises impressively during the upcoming decades, nearly doubling by the year 2020....By 2040, the average age of a baby boomer will be 85 years, and the level of Medicare spending...could range from $147 to $212 billion".[80] In 1991, the Medicare Board of Trustees projected that the Medicare hospital insurance (HI) fund would be exhausted by the year 2005,[81] and the more recent 1995 alarmist projections of insolvency by 2002 have already been discussed in the previous section.

4. Technology. Progress in medical technology tends to be seen by many observers as inevitable. Such progress also raises concerns over whether our society will be able to continue funding unlimited access to this technology. As ever more sophisticated and expensive diagnostic procedures and interventions become available to treat the symptoms and causes of chronic illness, and as more and more members of our aging society have at least one chronic illness, it is clear that the U.S. is increasingly likely to be caught in a medical Malthusian dilemma: the demographic-epidemiologic demand will far outstrip the economic "carrying capacity" of our society to meet it. This widening gap will inevitably result in the need for explicit rationing of health care services.[82] The best known of age-based rationing suggestions are those of Daniel Callahan, based on his argument about the natural human lifespan and the necessity for "setting limits."[83] This suggestion has created controversy among its reviewers, drawing fire based on philosophical, clinical, and policy-related grounds.[84]

III. MORAL ECONOMY AND THE SOCIAL CONSTRUCTION OF THE "CRISIS" OF AGING AND HEALTH CARE

Differences in approaches between the U.S. and Canada with regard to the interpretation of population aging and its impact on health and social programs and resources suggest that there may be underlying forces at work beyond simply different numbers. Indeed, how data are defined and how information is collected, analyzed, and presented reveal the presence of other social, economic, political, and moral agendas. As Carroll Estes and her colleagues suggest, "[E]ach of the crises making their way into the public consciousness is socially 'produced,' or constructed by what politicians, economists, experts, and the media have to say about or impute to the issues they address".[85] In this regard, a comparison of the U.S. and Canada reveals different approaches to the "crisis of aging," to how the "problem" of the elderly and their impact on the public purse is defined. A clue to these differences is provided in an observation made ten years ago by Robert and Rosalie Kane[86] who concluded with respect to long-term care:

> The difference between the Canadian and American responses to essentially the same demographic pressures is instructive. The aging of the United States population has been looked upon as a fiscal crisis. The effectiveness of programs is measured by their ability to control costs....[I]t appears that Canadians are more likely than we are to approach long-term care primarily as a question of how to meet the service needs of the functionally impaired. Some service is assumed to be needed for the elderly population; the issue is how to provide it decently and efficiently. Public and scientific statements in Canada are calmer than the crisis-oriented pronouncements in the United States.

> On both sides of the border, the projected growth of the "old-old" population is recognized; but Canadian analysts make frequent reference to offsetting reductions in the numbers of other dependent groups, especially children, when they write about the needs of the elderly over the next decades.

In summary, it appears that more is at stake in defining the demographic "problem" of the elderly than simply numbers. It is here that differences based on underlying values play an important role, and where the approach of moral economy, outlined earlier, can be instructive.

In a fundamental way, the resolution of geriatric health care policy debates in the U.S. and Canada will depend on the outcome of a shifting balance between the values of individualism and collectivism as they are interpreted within the political ideologies of these two countries. The elderly in Canada are concerned about the unravelling of the welfare net that many of them can remember being woven: will government retreat from its more recent historical commitment to social programs that were built on a strong collectivistic ethos and replace it instead with growing emphasis on individual responsibility? In Canada, seniors are fighting to preserve Medicare and to keep its basic structure intact. Similarly, in the U.S. the elderly are lobbying to preserve their Medicare benefits in the face of a Congress threatening to dismantle or at least restrict or reduce them. And in the U.S. there is no history of a strong role for government in supporting universal health care for all Americans.

Collectivism versus individualism: this fundamental tension lies at the core of the emerging social and political debate in both countries with regard to the future of health care in general, and in particular with respect to health care for the elderly. An examination of these two value themes, as suggested by the moral economy approach, can reveal underlying trends in the two countries and help further an understanding of what may happen in the future. The purpose of this discussion is to analyze Canada and the U.S. as unique contexts, shaped by historical contingencies within which the debate on policies for the elderly is unfolding. Within this analysis, values and value conflicts play a major role.

A. Universal Health Care in Canada: Eroding Consensus or Solid Bedrock?

Differences in social values, and their disputed role in determining something called "national character," are hotly debated issues. It is striking that many observers of differences between Canada and the U.S. have commented on a more collectivist ethos north of the border, in both "popular" Canadian publications and presentations in the U.S.[87] and in the more "academic" literature.[88] A fundamental issue at stake in this debate is the origin and presumed permanence of this difference. Some observers, such as Seymour Martin Lipset,[89] Gad Horowitz,[90] and Louis Hartz[91], argue that out of the American Revolution emerged a relatively unchanging value system for the U.S. and Canada: the U.S. more individualist, Canada more collectivist. Others have vigorously questioned the extent to which such events were central to shaping national character differences and suggest that this earlier thesis is now discredited among many sociologists and historians.[92] This is not to say that there are no value differences between the two societies; it is just to assert that far from being determined by some historical event in the distant past, these values have evolved (and will continue to evolve) under the influence of changing social, political, and economic forces. John Conway[93] asserts, for example, that the Canadian sense of community draws on a political and religious history different from the U.S., extending across generations to unite the society through time. In addition, he observes that there is a less marked separation between church and state in Canada. Historian John Herd Thompson[94] sees the real roots of social democratic institutions in Canada as arising after 1945 and during the Cold War, when the U.S. invested its resources into the military-industrial complex and Canada into social welfare programs such as universal health care insurance.

In health care in particular, the universal system in effect in Canada certainly embodies the collectivist principle that the community has responsibility for the welfare of its members.[95] Robert Evans, for example, has argued that the different structures of the health care systems in the U.S. and Canada may act as a mirror or a lens through which their different value systems may be observed:

> Each nation is both legatee and prisoner of its own history and its enduring cultural values and symbols. Students of comparative health care systems emphasize the funda-

> mental continuity of institutions....This underlying stability reflects the fact that a nation's health care system is a massive and complex social undertaking...[I]t also serves as a symbol of the fundamental shared values of the society.[96]

Of course, a major issue here is the "durability" of these underlying social values and their tendency to shift in the face of changing economic and political forces—themes explored throughout this discussion.

Other observers have noted that collectivist ideals have differentiated Canada in the past from the U.S. in defining the very nature of the problems in geriatric health care and in quality of life considerations for the elderly.[97] Moreover, this universalist approach to social welfare policy has effectively short-circuited any development of polarizing "intergenerational equity" rhetoric in Canada by meeting the health care needs of all persons across the entire family life cycle.[98] Some observers attribute this relative lack of divisiveness on social welfare policy issues to less conflict over issues of race and poverty, though the clash between English- and French-speaking Canadians is obviously a major issue.[99]

Another expression of the value of collectivism is found in the openness and vigor of public debate and dialogue over major social issues in Canada and in differences in the political systems between the two countries. For example, Canada has a parliamentary form of government, greater citizen participation, and less domination of politics by special interests (such as business)—what one set of observers has called the greater likelihood that "public opinion will be more easily translated into public policy" north of the border.[100] In addition, there has traditionally been a sense of reliance on government to deal with pressing social issues, though there are signs that this value is declining as the average citizen's trust in government's ability to confront major economic and political problems has been eroded.

In spite of this, historically the universal health care system has forced discussion of important issues and priorities out into the open. As Robert Evans and his colleagues have suggested,[101] a hallmark of the Canadian health care system is continuing debate over health care expenditures, as for example in annual fee negotiations between provincial medical societies and governments, and the establishment of global hospital budgets. There is some faith that this open discussion will serve to reveal the underlying social values necessary to guide the health care system through difficult times.[102] As one participant suggested at a major Canadian conference on aging and health care,

> what is becoming more clear all of the time is that the distribution and utilization of health care resources is a public issue. As such, ethically sound decision making cannot occur until the values in question are clarified. The clarification of individual values is a first step. The clarification of whether there is a public ethic is yet another step. Let us reflect together then on some of the issues that need to be clarified if we are to take any steps at all.[103]

It is interesting that this same participant now chairs the "values" work group of the National Forum on Health, which is overseeing the general public debate on health care reform currently occurring in Canada. This effort is a striking example of both the tradition of open debate on social issues and the recognition of the central importance of values in this process.

It is also clear that major changes in thinking are occurring in Canada that portend a reassessment of the traditional assumptions about government. For example, Susan Fletcher, the executive director of the Division of Aging and Seniors of Health Canada, spoke at the annual meeting of the Canadian Association on Gerontology in late 1995. Her message was that new "ways of doing business" will characterize the federal government in the future. The commitment to consultation and participation in discussion and consensus-building will remain an important principle. But a process of reviewing existing programs to determine "core activities" has begun, including an assessment of what are legitimate and necessary roles for government and how programs and policies can be realigned to be made more efficient and sustainable. Government will increasingly become more of a "partner" than a "parent," emphasizing the development of interdepartmental, multi-sectoral, and horizontal collaboration and partnerships. Leadership will continue, but "steering not rowing" emerged as a major metaphor in Ms. Fletcher's presentation. The federal government is still committed to a universal health care system, but it is clear that the meaning of this commitment will be

influenced by major shifts in the ideology about government's role in health and health care.

Hence changing economic and socio-political contingencies may once again influence the role of universalism in shaping health care policies in Canada. Pressures exist that may cause change, but the development of a health care system similar to that in the U.S. seems opposed by everyone. Growing emphasis on population health, the determinants of health, health promotion, and groups at risk for health problems will expand the definition of health and health care in Canada. Though the future is uncertain, it is clear that major changes will, in fact, force a redirection of the relative roles of federal, provincial, and local governments in promoting the health of Canadians in general and that of the elderly in particular.

B. Social Values in Health Care in the United States

In considering the social value base of current political ideology south of the border, it can be argued that the individual in the U.S. serves both as the unit of need or service, and as the core organizing principle around which government policy is formulated and developed. This perspective has achieved new prominence in the recent ascendancy of the Republican party agenda in the Congress which emphasizes the value of smaller and weaker central government and of increased personal and local control over social problems. The Republican victories in the last congressional elections could be interpreted as a distinct rejection of broader principles of social welfare policy, as evidenced in the recent congressional efforts to dismantle 30 years of health care policy since Medicare and Medicaid were enacted in 1965. This ideology is evident in the tendency to define problems as individual rather than as social, political, or economic, thereby making it more difficult to achieve far-reaching social reforms.[104] Social researchers such as Robert Bellah and his colleagues have found that individualism is a major characteristic defining how persons in the U.S. view themselves and organize their relationships and lives.[105] Indeed, the pre-eminence of the individual is enshrined in the notion of individual rights, which are reinforced in our legal system and in ethical guidelines in such areas as health care, and which make the individual the center of attention, professional obligation, and governmental and insurer scrutiny.

This individualistic ethos has profound implications for how public policy is formulated. First, the individual is seen as bearing the main responsibility for meeting his or her primary needs. Only when the individual fails to do this will the government step in as a last resort to guarantee some minimal level of social assistance. Within the domain of health care, for example, services have traditionally been allocated based on individual need and the ability to pay—in other words, by a market-based mechanism. Even in theories of social justice that could underlie an expanded health care system, a strong bias toward individualism discourages dialogue and discussion leading to a more universalist and less market-driven system.[106]

At a social level, a perceived public policy polarization between the young and the old, "kids versus canes," in the intergenerational equity debate further exemplifies the growing fragmentation and group-based nature of U.S. politics. Originally presented as a demographic and economic argument,[107] the intergenerational "war" has been correctly unmasked as an ideological struggle between competing forces over the future of the welfare state,[108] the nature of social inequities,[109] and differing interpretations of the relationship between the state and families.[110] Unlike many other nations, the U.S. particularizes and compartmentalizes social policies along lines of individual or static group-based need, rather than seeing public programs as responding to changing life course needs across the entire society.[111] In this view, the U.S. has spawned the generational equity debate *precisely because* it does not have adequate social programs to meet the needs of families over the entire life course. In spite of calls for recognizing the inextricably related needs of individuals and families across the generations[112] and for a new intergenerational politics to forge a common agenda uniting people of all ages in expanding social welfare policies,[113] it remains unclear how successful such efforts will be. At heart, the U.S. remains a society based on individualist interpretations of social problems, rather than joint efforts uniting people of different ages, cultures, socioeconomic statuses, or political ideologies.

As a consequence, emphasis on individualism makes the development of more universalist policies difficult, if not impossible. If concern is directed mainly toward the self rather than to the welfare of others, then there is little chance that a sense of community responsibility will evolve to underwrite a significantly broadened social policy base, such as universal health insurance. Indeed, little sense of identification with the broader societal interest precludes the kind of social discussion and debate that is needed to forge a moral

consensus on new social priorities, especially in the health care field. Increasing emphasis on cost-cutting measures and the blind pursuit of the "perfect" technology cannot substitute for social discussion on health care policies and priorities.[114] The recent history of the Clinton health care reform effort certainly reveals the enormous difficulty in having a rational and well-informed public debate and discussion on health care in the U.S., free from attempts at distortion, destruction, and disintegration of facts and values. And as Antonia Maioni has recently observed from a Canadian perspective about the fragmented state of health care reform in the U.S.,

> the United States seems mired in a situation that, if we look at historic 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.[115]

Indeed, as discussed earlier, not only is the U.S. currently not making progress in expanding access to health care, but it is also engaged in the virtual demolition of the foundation that some observers hoped would eventually be built upon to provide health care benefits for everyone, and not just the poor and the elderly. Indeed, the focus of the recent White House Conference on Aging was primarily on keeping in place those programs currently enjoyed by the elderly rather than on enacting broader and more substantial programs to meet other needs of the nation's seniors.

IV. CONCLUSION: TOWARD A COMPARATIVE MORAL ECONOMY OF AGING AND HEALTH CARE

Aging is a universal process affecting all individuals and, inevitably, societies and governments as they deal with the design of social policies and programs to respond to the unique challenges represented by the experience of growing older. As noted earlier, a major weakness in the emerging field of comparative gerontology is the lack of a conceptual framework for facilitating cross-cultural study of the experience of aging within a policy context. This essay argues that a moral economy framework is essential if we are to understand fully the similarities and differences both in the definition of the "problem" of aging and in the development of "solutions" to it found in different countries. A major task for comparative gerontology is to uncover these differences and examine their implications for designing humane social and health care policies.

In this process, we must consider both the facts and the values implicit in any policy debate.[116] In spite of what policymakers might like to believe, purely quantitative or factual approaches are insufficient for a complete understanding of a social "problem." Empirical data can be used as an instrument to advance agendas based on social ideology and embodying values rooted in historical, social and political assumptions about the nature of the state and the responsibilities and obligations of individuals and families. Thus aging may be seen as a "problem" to be "solved," rather than as a modern triumph of the maintenance and extension of life on a scale unparalleled in human history. Instead of seeing the elderly as the "enemy" and a burden, we must come to see them as embodying needs like any other social group—a group that we are all becoming. As Pogo, the cartoon character, once observed: "We have met the enemy, and he is us."

The moral economy perspective allows observers to uncover and study the prevailing social values underlying current public policy discussions and debates, allowing insight into questions about our relative priorities as a society and whether these are the right priorities. That this is a dynamic process has been made evident in the preceding description of the shifting balance between individualism and collectivism in the U.S. and Canada. South of the border, the debate a few years ago on health care reform seemed to suggest that the U.S. was moving toward a realization that government must play a greater role in ensuring more equitable access to health care services, and not be concerned only about cost issues, though the means to achieve this goal were bitterly contested because of divisive political ideologies and loyalties. Now this role for the federal government has been cast into doubt by the Republicanization of Congress. Conversely, in Canada government seems to be engaged in a process of reinterpreting the meaning of the value of universal access, with greater emphasis on concerns about costs, including cost-

limiting and cost-sharing strategies. Whether the two countries are actually converging from very different recent histories remains to be seen.[117]

What is apparent in both countries is that the elderly and their advocates are moving health care policy toward embracing a broader vision of health than has traditionally been evident in either nation. Growing recognition of the importance of disease and disability prevention, as well as long-term care for the chronically ill, has emerged from the realization that the prevailing acute care, medical model is not adequate to deal with the unique health problems of the elderly. What is yet to be seen, however, is whether and how this new and expanded interpretation of health will actually be translated into real policy shifts and new programs. Canada's traditional reliance on an open process to involve all elements of society in determining new policy directions, as well as its current commitment to changing the ways in which the health care system is managed, seem to offer a brighter future for this possibility than in the U.S. But some observers remain skeptical and emphasize the sometimes large gap between rhetoric and reality. South of the 49th parallel, gridlock in any attempts to bring about major changes in health care seems to be the norm, particularly in the absence of any tradition of collective responsibility for ensuring universal access to it and in light of current efforts to turn back the clock on social welfare policies in general.

In sum, it seems that the fundamental conflict evident in health care concerns driven by the recognition of an aging society is between collectivist and individualist values. On a stage of competing values in a theater constructed by historical, social and political forces, the emerging drama of geriatric health care policy will be acted out in each nation. In this play, however, we need to be aware not only of the stage, but also of what is going on in the theater with regard to assumptions about the nature of the aging "problem." Reality may go beyond appearances and in fact be obscured by the social construction of the "stage set", or social "problems" in the service of other agendas. In reviewing how this play is performed in both the Canadian and the U.S. we can gain much insight into why aging can be seen as both a lens to magnify and scrutinize social institutions in our two countries, and as a prism to separate the underlying moral assumptions that make living in society possible and enriching. Taken together, more light will be shed both on aging as an individual and social experience, and on the underlying assumptions of public policies that respond to it.

NOTES

[1] Phillip G. Clark, Review of Meredith Minkler and Carroll J. Estes (eds.), *Critical Perspectives on Aging: The Political and Moral Economy of Growing Old* (Amityville, NY: Baywood Publishing, 1991) forthcoming in *Canadian Journal on Aging.*

[2] See, for example, Eloise Rathbone-McCuan and Betty Havens (Eds.), *North American Elders: United States and Canadian Perspectives* (Westport, CT: Greenwood Press, 1988); and Jon Hendricks and Carolyn J. Rosenthal (Eds.), *The Remainder of Their Days: Domestic Policy and Older Families in the United States and Canada* (New York: Garland Publishing, 1993).

[3] Theodore Marmor, "Fact, Fiction, and Faction: The Politics of Medical Care *Re-form* in Canada as It Appears South of the Border." *Canadian Journal on Aging, 4* (1995): 426.

[4] This point has been made by both Neena Chappell, in her review of Robert L. Kane and Rosalie A. Kane, *A Will and a Way: What the United States Can Learn from Canada about Caring for the Elderly* (New York: Columbia University Press, 1985) in *Canadian Journal on Aging, 6* (1987): 177-180; and by myself in the review of Rathbone-McCuan and Havens, *North American Elders* in *Canadian Journal on Aging, 8* (1989): 380-383.

[5] Meredith Minkler and Carroll L. Estes, *Critical Perspectives on Aging: The Political and Moral Economy of Growing Old* (Amityville, NY: Baywood Publishing, 1991): 4.

[6] This term was coined by Albert R. Jonsen and Lewis H. Butler, "Public Ethics and Policy Making," *Hastings Center Report, 5*(4) (1975): 19-31.

[7] See, for example, Bart Collopy, "Medicare: Ethical Issues in Public Policy for the Elderly," *Social Thought, 11*(2) (1985): 5-14.

[8] See, for example, the Canadian perspective outlined by Ellen M. Gee and Susan A. McDaniel, "Social Policy for an Aging Society," in *Aging: Canadian Perspectives,* edited by Victor Marshall and Barry McPherson (Peterborough, ON: Broadview Press, 1994): 219-231; a

more general perspective offered by Edmund D. Pellegrino and James T. Howell, "Science, Technology, and Values in an Age of Aging," *Socioeconmics and Planning Science, 19* (1985): 225-226; and Beth J. Soldo, Edmund D. Pellegrino, and James T. Howell, "Epilogue: Confronting the Age of Aging," *Socioeconomics and Planning Science, 19* (1985): 289-293.

[9] See, for example, Antonia Maioni, "Divergent Pasts, Converging Futures? The Politics of Health Care Reform in Canada and the United States," *Canadian-American Public Policy, 18* (August, 1994).

[10] Frank T. Denton and Byron G. Spencer, "Demographic Change and the Cost of Publicly Funded Health Care," *Canadian Journal on Aging, 14* (1995): 177.

[11] Neena L. Chappell, "The Future of Health Care in Canada," *Journal of Social Policy, 22* (1993): 490.

[12] Maioni, "Divergent Pasts, Converging Futures?," 20.

[13] A recent survey, reported in the 26 October 1995 *Globe and Mail,* however, shows some erosion in the support for the five principles—especially universality—of the Canada Health Act among higher-income persons, "suggesting that those who feel they can afford more privatization are increasingly ready to accept paying part of the cost of their health care up front" (p. A21).

[14] National Health Forum, "Background Information" (Ottawa, ON: Author, no date).

[15] National Forum on Health, "Activities Update" (Ottawa, ON: Author, no date).

[16] National Forum on Health, "The Public and Private Financing of Canada's Health System: A Discussion Paper" (Ottawa, ON: Author, September, 1995).

[17] National Forum on Health, "Remarks for the Financial Post Conference by the Executive Director of the National Forum on Health" (Ottawa, ON: Author, May 2, 1995).

[18] National Forum on Health, "The Members of the National Forum on Health Support Public Funding for Health Care" (Ottawa, ON: Author, April 4, 1995).

[19] Maioni, "Divergent Pasts, Converging Futures?," 22.

[20] National Advisory Council on Aging, *The NACA Position on Determining Priorities in Health Care: The Seniors' Perspective* (Ottawa, ON: Minister of Supply and Services Canada, Cat. No. H-71-2/2-17-1995, 1995).

[21] *Ibid.*, 13-15.

[22] One Voice: The Canadian Seniors Network, *Healthy Aging: A Canadian Commitment? A National Conference on Protecting and Improving Canada's Health Care System* (Ottawa, ON: Author, 1995).

[23] Francois Beland and Evelyn Shapiro, "Ten Provinces in Search of a Long Term Care Policy" in Marshall and McPherson, *Aging,* 154-255.

[24] Kane and Kane, *A Will and a Way.*

[25] See Beland and Havens, "Ten Provinces."

[26] Neena L. Chappell, "The future of health care in Canada." As an example of a national document supporting this perspective, see the working paper produced by the Health Services and Promotion Branch of Health and Welfare Canada, titled *Aging: Shifting the Emphasis* (Ottawa, ON: Health and Welfare Canada, 1986).

[27] Betty Havens, "Long-Term Care Diversity Within the Care Continuum," *Canadian Journal on Aging, 14* (1995): 245-262.

[28] Sheila M. Neysmith, "Developing a Home Care System to Meet the Needs of Aging Canadians and Their Families" in Hendricks and Rosenthal, *The Remainder of Their Days,* 145-167.

[29] Raisa B. Deber and A. Paul Williams, "Policy, Payment, and Participation: Long-Term Care Reform in Ontario," *Canadian Journal on Aging, 14* (1995): 294-318.

[30] See, for example, Chappell, *The Future of Health Care in Canada*; Marshall, "A Critique of Canadian Aging and Health Policy," in Marshall and McPherson, *Aging*; and Herbert C. Northcott, *Aging in Alberta: Rhetoric and Reality* (Calgary, AL: Detselig Enterprises Ltd., 1992).

[31] See especially Marshall, *A Critique.*

[32] Cary S. Kart, *The Realities of Aging* (4th Edition) (Boston, MA: Allyn and Bacon, 1994), 48.

[33] Maioni, "Divergent Pasts, Converging Futures?," 10.

[34] Laurence Z. Rubenstein, Theodore R. Marmor, Robyn Stone, Marilyn Moon, and Linda K. Harootyan, "Medicare: Challenges and Future Directions in a Changing Health Environment," *The Gerontologist, 34* (1994): 620.

[35] Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 1995 Annual Reports* (Washington, DC: Author, 1995).

[36] Karl Pillemer, Phyllis Moen, John Krout, and Julie Robison, "Setting the White House Conference on Aging Agenda: Recommendations from an Expert Panel," *The Gerontologist, 35* (1995): 259.

[37] RI Department of Elderly Affairs and Advisory Commission on Aging, *White House Conference on Aging Regional Public Meetings in Rhode Island* (Providence, RI: Author, 1994).

[38] For further discussion, see "Why Health Reform Disappeared in a Fog of Uncertainty," *AARP's Horizons, 5*(1) (February, 1995): 2-3; and One Voice, *Healthy Aging: A Canadian Commitment*, 13.

[39] See, for example, a special symposium in *The Gerontologist, 34* (1994) which presented different perspectives on this issue: Gene D. Cohen, "Health Care Reform and Older Adults: Introduction," 584-585; Stanley Brody, "A Responsible Geezer's Analysis of the Clinton Health Care Proposal," 586-589; Meghan B. Gerety, "Health Care Reform From the View of a Geriatrician," 590-597; Robert L. Kane and Rosalie A. Kane, "Effects of the Clinton Health Reform on Older Persons and Their Families: A Health Care Systems Perspective," 598-605; Robert H. Binstock, "The Clinton Plan, Medicare Integration, and Old-Age-Based Rationing—The Need for Public Debate," 612-613; Robert N. Butler, "Politics versus Policy in the Health Care Debate, " 614-615; and T. Franklin Williams, "Integrating the Needs of Older Americans Into the Goals and Structures of Health Care Reform," 616-619.

[40] See Marilyn Moon, "Lessons from Medicare," *The Gerontologist, 34* (1994): 609.

[41] Rubenstein, Marmor, Stone, Moon, and Harootyan, "Medicare," 625.

[42] Joshua M. Wiener and Laurel Hixon Illston, "Health Care Reform in the 1990s: Where Does Long-Term Care Fit In?" *The Gerontologist, 34* (1994): 402-408.

[43] *Ibid.*, 405-407.

[44] Board of Trustees of the Federal Hospital Insurance Trust Fund, *Annual Report* (Washington, DC: Author, 1995), 1.

[45] *Ibid.*, 3.

[46] Social Security and Medicare Boards of Trustees, *Summary of 1995 Annual Report*, 11.

[47] Nancy Gibbs, "Medicare: Selling a Painful Cure," *Time Magazine*, August 7, 1995.

[48] Maioni, "Divergent Pasts, Converging Futures?"

[49] Stephen Katz, "Alarmist Demography: Power, Knowledge, and the Elderly Population," *Journal of Aging Studies, 6* (1992): 203-225.

[50] Robert G. Evans, "Illusions of Necessity: Evading Responsibility for Choice in Health Care." *Journal of Health Politics, Policy, and Law, 10* (1985): 439-467.

[51] Richard A. Easterlin, "The Economic Impact of Prospective Population Changes in Advanced Industrial Countries: An Historical Perspective," *Journal of Gerontology: Social Sciences, 46* (1991): S299-309.

[52] Susan A. McDaniel, "Demographic Aging as a Guiding Paradigm in Canada's Welfare State," *Canadian Public Policy, 13* (1987): 330.

[53] For further discussion of aging as a problem paradigm in both the U.S. and Canada, see: Herbert C. Northcott, *Aging in Alberta*; Herbert C. Northcott, "Public Perceptions of the Population Aging 'Crisis'," *Canadian Public Policy—Analyse de Politiques, XX*(1): 66-77; and Ann Robertson, "The Politics of Alzheimer's Disease: A Case Study in Apocalyptic Demography" in Meredith Minkler and Carroll L. Estes (Eds.), *Critical Perspectives on Aging*, 135-150.

[54] See, for example, Lewis Auerbach and Andrea Gerber, *Implications of the Changing Age Structure of the Canadian Population*, Science Council of Canada Pub. No. SS21-3/2-1976 (Ottawa, ON: Ministry of Supply and Services, 1976); Mary K. Rombout, *Hospitals and the Elderly: Present and Future Trends*, Long Range Health Planning Staff Paper 75-2 (Ottawa, ON: Health and Welfare Canada, 1975); and Mary K. Rombout, *Health Care Institutions and Canada's Elderly*, Supplement to Long Range Health Planning Staff Paper 75-2 (Ottawa, ON: Health and Welfare Canada, 1975).

[55] Jacques Legare and Bertrand Desjardins, "La Situation des Personnes Agees au Canada." *Revue Canadienne de Sociologie et d'Anthropologie, 13* (1976): 321-336.

[56] Jac-Andre Boulet and Gilles Grenier, *Health Expenditures in Canada and the Impact of Demographic Changes on Future Government Health Insurance Program Expenditures*, Discussion Paper No. 123 (Ottawa, ON: Economic Council of Canada, 1978).

[57] Robert G. Evans, review of *Health Expenditures in Canada and the Impact of Demographic Changes on Future Government Health Insurance Program Expenditures* in *Canadian Public Policy, 6* (1980): 132-133.

[58] Neil B. Ridler, "Some Economic Implications of the Projected Age Structure of Canada." *Canadian Public Policy—Analyse de Politiques, V* (1979): 533-548.

[59] Canadian Medical Association, *Health: A Need for Redirection*, Report of the Task Force on the Allocation of Health Care Resources (Ottawa, ON: Author, 1984).

[60] Canadian Medical Association., *Investigation of the Impact of Demographic Change on the Health Care System in Canada*, Report of the Task Force on the Allocation of Health Care Resources, prepared by Woods Gordon Management Consultants (Ottawa, ON: Author, 1984).

[61] Frank T. Denton and Byron G. Spencer, "Health-Care Costs When the Population Changes," *Canadian Journal of Economics, 13* (1975): 34-48; Frank T. Denton and Byron G. Spencer, "Some Economic and Demographic Implications of Future Population Change," *Journal of Canadian Studies, 14* (1979): 81-93.

[62] Frank T. Denton, S. Neno Li, and Byron G. Spencer, "How Will Population Aging Affect the Future Costs of Maintaining Health-Care Standards?" in *Aging in Canada: Social Perspectives* (2nd. ed.), edited by Victor W. Marshall (Markham, ON: Fitzhenry & Whiteside, 1987), 553-568.

[63] Frank T. Denton and Byron G. Spencer, "Population Aging and the Economy: Some Issues in Resource Allocation" in *Ethics and Aging: The Right to Live, the Right to Die*, edited by James E. Thornton and Earl R. Winkler (Vancouver, BC: University of British Columbia Press, 1988), 98-123.

[64] Frank T. Denton and Byron G. Spencer, "Demographic Change and the Cost of Publicly Funded Health Care," *Canadian Journal on Aging, 14* (1995): 174-192.

[65] Ivan P. Fellegi, "Can We Afford an Aging Society? *Canadian Economic Observer*, October, 1988: 4.1-4.34.

[66] Morris L. Barer, Robert B. Evans, and Jonathan Lomas, "Aging and Health Care Utilization: New Evidence on Old Fallacies," *Social Science and Medicine, 24* (1987): 851-862.

[67] Robert G. Evans, "'We'll Take Care of It for You': Health Care in the Canadian Community," *Daedalus: Proceedings of the American Academy of Arts and Sciences, 117*(4) (1988): 177.

[68] Morris L. Barer, Robert G. Evans, and Clyde Hertzman, "Avalanche or Glacier?: Health Care and the Demographic Rhetoric," *Canadian Journal on Aging, 14* (1995): 195.

[69] McDaniel, "Demographic Aging as a Guiding Paradigm;" Northcott, *Aging in Alberta* and "Public Perceptions."

[70] Carroll L. Estes and Elizabeth A. Binney, "The Biomedicalization of Aging: Dangers and Dilemmas." In Minkler and Estes, *Critical Perspectives on Aging*, 117-134.

[71] Edward L. Schneider and Jack M. Guralnick, "The Aging of America: Impact on Health Care Costs." *Journal of the American Medical Association, 263* (1990): 2335-2340.

[72] Lynn Etheredge, "An Aging Society and the Federal Deficit. *Milbank Memorial Fund Quarterly, 62* (1984): 521-543.

[73] David L. Rabin and Patricia Stockton, *Long-Term Care for the Elderly: A Factbook* (New York: Oxford University Press, 1987), 6.

[74] Ernest M. Gruenberg, "The Failures of Success," *Milbank Memorial Fund Quarterly, 55* (1977): 3-24.

[75] Morton Kramer, "The Increasing Prevalence of Mental Disorders: Implications for the Future." Paper presented at the National Conference on the Elderly Deinstitutionalized Patient in the Community, Arlington, VA, May, 1981, 6.

[76] James F. Fries, "The Compression of Morbidity," *Milbank Memorial Fund Quarterly, 61* (1983): 397-419.

[77] See, for example, George C. Meyers and Kenneth G. Manton, "Compression of Mortality: Myth or Reality?" *The Gerontologist, 24* (1984): 346-353; and Edward L. Schneider and Jacob A. Brody, "Aging, Natural Death, and the Compression of Morbidity: Another View," *New England Journal of Medicine, 309* (1983): 854-855.

[78] Dorothy P. Rice, "The Medical Care System: Past Trends and Future Projections," *New York Medical Quarterly, 6* (1986): 46.

[79] U.S. General Accounting Office (1991). *Long-Term Care: Projected Needs of the Aging Baby Boom Generation,* Report No. HRD-91-86 (Washington, D.C.: Author, 1991).

[80] Schneider and Guralnick, "The Aging of America," 2337.

[81] Stanford G. Ross, "The Financial Status of the Social Security and Medicare Programs." Presentation at the Annual Meeting of the Gerontological Society of America, San Francisco, CA, November 22-26, 1991.

[82] Roger W. Evans, "Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions," *Journal of the American Medical Association, 249* (1983): 2047-2052, 2208-2219.

[83] Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987); and Daniel Callahan, *What Kind of Life* (New York: Simon and Schuster, 1990).

[84] See, for example, Robert H. Binstock and Jeff Kahana, a review of *Setting Limits: Medical Goals in an Aging Society,* in *The Gerontologist, 28* (1988): 424-426; Robert H. Binstock and Stephen G. Post, "Old Age and the Rationing of Health Care" in *Too Old for Health Care? Controversies in Medicine, Law, Economics, and Ethics,* edited by Robert H. Binstock and Stephen G. Post (Baltimore, MD: The Johns Hopkins University Press, 1991), 1-12; Daniel W. Brock, "Justice, Health Care, and the Elderly," *Philosophy and Public Affairs, 18* (1989): 297-312; Larry R. Churchill, "Should We Ration Health Care by Age?" *Journal of the American Geriatrics Society, 36* (1988): 644-647; Nancy S. Jecker, "Excluding the Elderly: A Reply to Callahan" [Review of *Setting Limits: Medical Goals in an Aging Society*], *Philosophy and Public Policy, 7*(4) (1987): 12-15; Nancy S. Jecker, "Disenfranching the Elderly from Life-Extending Medical Care," *Public Affairs Quarterly, 2*(3) (1988): 51-68; and Peter Singer, A review of *Setting Limits: Medical Goals in an Aging Society,* in *Bioethics, 2* (1988): 151-169.

[85] Carroll L. Estes, Lenore E. Gerard, Jane Sprague Zones, and James H. Swan, *Political Economy, Health, and Aging* (Boston: Little Brown, 1984), 92.

[86] Kane and Kane, *A Will and a Way,* 256.

[87] Robert Fulford, "The Canadian Difference," *Canada Today, 20*(1) (1989): 2-4; Robert McNeil, "Looking for My Country," *American Review of Canadian Studies, 21* (1991): 409-421.

[88] Peter Dreier and Elaine Bertrand, "Canada: A Kinder, Gentler Nation," *Social Policy, 23*(1) (1992): 6-19.

[89] See Seymour Martin Lipset, *The First New Nation: The United States in Historical and Comparative Perspective* (New York: Basic Books, 1963); and Seymour Martin Lipset, *Continental Divide: The Values and Institutions of the United States and Canada* (New York: Routledge, Chapman, and Hall, 1990).

[90] Gad Horowitz, "Conservatism, Liberalism, and Socialism in Canada: An Interpretation," *Canadian Journal of Economics and Political Science, 32*(2): 143-171.

[91] Louis Hartz, *The Liberal Tradition in America* (Toronto: Longman's, 1955).

[92] See, for example, Robert Babcock, a review of Seymour Martin Lipset, *Continental Divide: The Values and Institutions of the United States and Canada*, in *Histoire Sociale—Social History, 48* (1991): 408-410; Robert J. Brym and Bonnie J. Fox, *From Culture to Power: The Sociology of English Canada* (Toronto: Oxford University Press, 1989); Fay Lomax Cook, Victor W. Marshall, Joanne Gard Marshall, and Julie E. Kaufman, "Intergenerational Equity and the Politics of Income Security for the Old." Paper presented at a symposium on "A North American Look at Economic Security for the Elderly" at Yale University, May 17-18, 1991; and John Herd Thompson, "'National Character' and United States-Canadian Differences: An Exploration of [Seymour Martin] Lipset's Explanation of the Continental Divide." Paper presented at the Learned Societies Conference in Calgary, Alberta, June, 1994.

[93] John Conway, "An 'Adapted Organic Tradition'," *Daedalus: Proceedings of the American Academy of Arts and Sciences, 117* (1988): 381-396.

[94] John Herd Thompson, "'National Character'," 23.

[95] See, for example, 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, 1978); C. Tuohy, "Conflict and Accommodation in the Canadian Health Care System," in *Medicare at Maturity: Achievements, Lessons, and Challenges*, edited by Robert G. Evans & Greg L. Stoddart (Calgary, Alberta: University of Calgary Press, 1986), 393-434; Geoffrey R. Weller and Pranlal Manga, "The Development of Health Policy in Canada" in *The Politics of Canadian Public Policy*, edited by M. M. Atkinson & M. A. Chandler (Toronto: University of Toronto Press, 1983), 223-246.

[96] Robert Evans, "'We'll Take Care of It for You'," 156.

[97] See Phillip G. Clark, "Geriatric Health Care Policy in the United States and Canada: A Comparison of Facts and Values in Defining the Problems," *Journal of Aging Studies, 5* (1991): 265-281; and Phillip G. Clark, "Ethical Dimensions of Quality of Life in Aging: Autonomy vs. Collectivism in the United States and Canada," *The Gerontologist, 31* (1991): 631-639.

[98] Fay Lomax Cook, et al., "Intergenerational Equity."

[99] Dreier and Bernard, "Canada: A Kinder, Gentler Nation."

[100] *Ibid.*, 8.

[101] Robert G. Evans, Jonathan Lomas, Morris L. Barer, Roberta J. Labelle, Catherine Fooks, Gregory L. Stoddart, Geoffrey M. Anderson, David Feeny, Amiram Gafni, George W. Torrance, and William G. Tholl, "Controlling Health Expenditures: The Canadian Reality," *New England Journal of Medicine, 320* (1989): 571-577.

[102] Pranlal Manga, "Medicare: Ethics versus Economics," *Canadian Medical Association Journal, 136* (1987): 113-116.

[103] Nuala P. Kenny, "The Ethics of Restraint," in *Aging With Limited Health Resources: Proceedings of a Colloquium on Health Care*, No. EC22-139/1987E, edited by Economic Council of Canada (Ottawa, ON: Minister of Supply and Services, 1987), 151.

[104] Carroll L. Estes, "The New Political Economy of Aging: Introduction and Critique," in Minkler and Estes (Eds.), *Critical Perspectives on Aging*, 19-36.

[105] Robert N. Bellah, Richard Madsen, William M. Sullivan, Ann Swidler, and Steven M. Tipton, *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley: University of California Press, 1985).

[106] Larry R. Churchill, *Rationing Health Care in America: Perceptions and Principles of Justice* (Notre Dame, IN: University of Notre Dame Press, 1987).

[107] Samuel H. Preston, "Children and the Elderly: Divergent Paths for America's Dependents," *Demography, 21* (1984): 435-457; Samuel H. Preston, "Children and the Elderly in the U.S." *Scientific American, 251*(6) (1984): 44-49.

[108] Jill Quadagno, "Generational Equity and the Politics of the Welfare State," *Politics and Society, 17* (1989): 353-376; Alan Walker, "The Economic 'Burden' of Ageing and the Prospect of Intergenerational Conflict," *Ageing and Society, 10* (1990): 377-396.

[109] Meredith Minkler, "'Generational Equity' and the New Victim-Blaming: An Emerging Public Policy Issue," *International Journal of Health Services, 16* (1986): 539-551.

[110] Elizabeth A. Binney and Carroll L. Estes, "The Retreat of the State and Its Transfer of Responsibility: The Intergenerational War, *International Journal of Health Services, 18* (1988): 83-96.

[111] Hugh Heclo, "Generational Politics," in *The Vulnerable*, edited by John L. Palmer, Timothy Smeeding, & Barbara Boyle Torrey (Washington, D.C.: The Urban Institute Press, 1988), 381-411.

[112] Eric R. Kingson, Barbara A. Hirshorn, and John M. Cornman, *Ties That Bind: The Interdependence of Generations* (Washington, D.C.: Seven Locks Press, 1986).

[113] Eric R. Kingson, "Generational Equity: An Unexpected Opportunity to Broaden the Politics of Aging," *The Gerontologist, 28* (1988): 765-772; Steven K.Wisensale, "Generational Equity and Intergenerational Policies.," *The Gerontologist, 28* (1988): 773-778.

[114] Norman Daniels, "Why Saying No to Patients in the United States is So Hard: Cost Containment, Justice, and Provider Autonomy," *New England Journal of Medicine, 314* (1986): 1380-1383.

[115] Antonio Maioni, "Divergent Pasts, Converging Futures?," 25.

[116] Ralph B. Potter, *War and Moral Discourse* (Richmond, VA: John Knox Press, 1969).

[117] For a more complete discussion of the forces shaping this future, see Maioni, "Divergent Pasts, Converging Futures?"

CANADIAN-AMERICAN PUBLIC POLICY

Occasional papers on a wide range of issues in U.S.-Canadian relations

CAPP 1: April 1990 — **Canada-U.S. Relations in the Bush Era**
Joseph T. Jockel

CAPP 2: July 1990 — **Transboundary Air-Quality Relations: The Canada-United States Experience**
John E. Carroll

CAPP 3: October 1990 — **Canadian Culture, the Canadian State, and the New Continentalism**
Allan Smith

CAPP 4: December 1990 — **Forests, Timber, and Trade: Emerging Canadian and U.S. Relations under the Free Trade Agreement**
Thomas R. Waggener

CAPP 5: March 1991 — **Change and Continuity in Canada-U.S. Economic Relations**
William Diebold

*CAPP 6: June 1991 — **Trade Liberalization and the Political Economy of Culture: An International Perspective on FTA**
Graham Carr

CAPP 7: September 1991 — **If Canada Breaks Up: Implications for U.S. Policy**
Joseph T. Jockel

*CAPP 8: December 1991 — **Ogdensburg Plus Fifty and Still Counting: Canada-U.S. Defense Relations in the Post-Cold War Era**
Joel J. Sokolsky

* CAPP 9: March 1992 — **The Regulation of U.S.-Canada Air Transportation: Past, Present and Future**
Martin Dresner

* CAPP 10: June 1992 — **Emerging Issues in the U.S.-Canada Agricultural Trade Under the GATT and FTA**
Theodore H. Cohn

CAPP 11: September 1992 — **Settling U.S. - Canada Disputes: Lessons For NAFTA**
Annette Baker Fox

* Out of print

CAPP 12: December 1992 — **Canada-U.S. Electricity Trade and Environmental Politics**
William Averyt

CAPP 13: June 1993 — **Canadian Politics in a Global Economy**
Gordon T. Stewart

CAPP 14: September 1993—**The Intersection of Domestic and Foreign Policy in the NAFTA Agricultural Negotiations**
Theodore H. Cohn

CAPP 15: November 1993—**A New Global Partnership: Canada-U.S. Relations in the Clinton Era**
John Kirton

CAPP 16: December 1993 — **The Impact of Free Trade on Canadian- American Border Cities**
Peter Karl Kresl

CAPP 17: April 1994 — **North American Social Democracy in the 1990s: The NDP in Ontario**
Mildred A. Schwartz

CAPP 18: August 1994 — **The Politics of Health Care Reform in Canada and the United States**
Antonia Maioni

CAPP 19: October 1994 — **Public Policy and NAFTA: The Role of Organized Business Interests and the Labor Movement**
Henry J. Jacek

CAPP 20: December 1994-- **The Secret of Transforming Art Into Gold: Intellectual Property Issues In Canada-US Relations**
Myra J. Tawfik

CAPP 21: January 1995--**Anticipating The Impact of NAFTA on Health And Health Policy**
Pauline V. Rosenau, Russell D. Jones, Julie Reagan Watson and Carl Hacker

CAPP 22: June 1995--**Regulation, Industry Structure, and the North Atlantic Fishing Industry**
Peter B. Doeringer, David G. Terkla and Audrey Watson

CAPP 23: November 1995--**The Moral Economy of Health and Aging in Canada and the United States**
Phillip G. Clark

* Out of print

CONTENTS

ISSN 1-882582-11-X