

A THEORETICAL EXPLORATION OF THE MODERN HEALTH CARE CRISIS  
IN THE UNITED STATES AND THE LACK OF  
UNIVERSAL HEALTH CARE COVERAGE

by

CHRISTOPHER BIEDENBACH

Presented to the Faculty of the Graduate School of  
The University of Texas at Arlington in Partial Fulfillment  
of the Requirements  
for the Degree of

MASTER OF ARTS IN SOCIOLOGY

THE UNIVERSITY OF TEXAS AT ARLINGTON

December 2008

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## ACKNOWLEDGEMENTS

I would like to thank each of the members of my thesis committee: Dr. Ben Agger (chair), Dr. Heather Jacobson and Dr. Robert Kunovich and for their guidance and assistance through this process. I would also like to thank the entire Sociology faculty and staff for opening up many intellectual doors during my time at UTA. Lastly, I would like to thank my wife, Amy for all that she has had to endure as I work towards my goal with her unconditional support.

August 28, 2008

## ABSTRACT

### A THEORETICAL EXPLORATION OF THE MODERN HEALTH CARE CRISIS IN THE UNITED STATES AND THE LACK OF UNIVERSAL HEALTH CARE COVERAGE

Christopher Biedenbach, M.A.

The University of Texas at Arlington, 2008

Supervising Professor: Ben Agger

The United States is unique amongst industrialized wealthy nations in not providing health care to all of its citizens. The purpose of this thesis is to provide a theoretical explanation as to why the United States does not offer health care to all of its citizens when so many other nations do. The approach is necessarily comparative. For this paper, I compare three nations: the United States, Norway and Canada as prototypical nations (in reference to health care provision) based upon levels of government involvement in health care. I explore the historical development of health care in each of the nations with the goal of identifying commonalities and differences that can enlighten the primary question of this paper that is – why doesn't the wealthiest nation of the world guarantee or provide health insurance for *all* of its citizens.

I find that there are three factors that have hindered the development of universal health care in the United States. Firstly, I explore the structural elements of the political systems that inhibited or encouraged the growth of universal coverage schemes. Next, I look at the role of ideology in each nation, and the reasons for the prevalence of the ideologies. Lastly, in a Weberian sense I look at the role of interest groups – specifically focusing on the

monopolization tendency of medical profession in the United States that occurred to a much lesser degree in Norway and Canada. These three factors have had the effect of making the enactment of universal coverage in the United States much more difficult than in either Canada or Norway. Thus, in the early years of the twenty-first century, the United States has the most costly health care system in the world yet 51 million American remain uninsured. Lastly, in terms of the factors I have identified, I discuss the future of health care reform efforts in the United States.

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CHAPTER 1  
INTRODUCTION

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

*United Nations: Universal Declaration of Human Rights 1948*

The move or the lack thereof, towards universal health care coverage in the United States has become the proverbial eight hundred pound gorilla in the room. The topic more generally of health care reform is one that is increasingly discussed in the private sphere within national and local political discourse. I am a self-diagnosed news-o-phile, and seldom a day goes by that a story related to the failure of health care does not pass through my browser from the information superhighway and onto my screen where it is consumed, read and re-written in a Derridean sense.

In fact, nearly sixty years have passed since the Universal Declaration of Human Rights was penned in a world recovering from the previously unseen brutalities of this world's deadliest war. An optimistic, and war weary, General Assembly passed this monumental work as a reaction to the gross abuse of human rights by the NAZI regime. Contrary to the mostly obstructionist modern American political attitudes towards the United Nations, the Universal Declaration of Human Rights was spearheaded by Eleanor Roosevelt and was routinely supported by the United States.

Fast-forward sixty years, and the world's richest nation struggles to provide that human right, which it identified, supported, and was signatory to in 1948. For this paper, I propose a set of questions that relate to the lack of universal health care in the United States. The first set of

questions seeks to describe the current situation of health care in the United States. First, I ask what are the fundamental attributes of the health care system in the United States in reference to the uniquely American problem of the uninsured? Next, I ask how effective are the prevailing systems in providing quality health care? The last string of questions I propose is theoretical and the heart of this paper. Why has the United States not adopted a universal health care system when most other developed countries have, and what is preventing America from doing so now?

## CHAPTER 2

### HEALTH CARE IN THE UNITED STATES

The United States is unique in the wealthy industrialized world in its reliance on the private market to provide a vast majority of health care needs. Because of the entrepreneurial character of the health care system, the United States has a large proportion of people who do not have access to reliable or affordable health care. This has led to a system in the United States which is increasingly complex and which health coverage is provided through employers, on the private market, through the government for the elderly and *some* poor, or in which people have no insurance coverage. This first chapter seeks to describe the present status of Americans in regards to health insurance coverage and to explore some of the financial pressures present in the United States health care system. This chapter will also seek to describe the uniquely American classification of the uninsured.

#### 2.1 The Privately Insured, the Publicly Insured and the Uninsured: A Snapshot

In the United States people fall into one of three categories in reference to health coverage. First, there are the uninsured, which represent 17.6% of the population. Second, there are those persons covered by private health insurance, which as of 2005 was 66.3% of the American population under 65 (Cohen and Martinez 2006). Lastly, are those covered by public health plans (Medicaid, Medicare, SCHIP and other state programs, and military related coverage) which amount to 16% of the non-elderly population (Kaiser Family Foundation (KFF) 2007).

In whatever form universal coverage is proposed or possibly enacted, there is one fact that remains immutable: many Americans remain uninsured. In 2005, 51.3 million Americans (17.6% of the American population) were uninsured at some point in 2005 (Cohen and Martinez 2006). At the time-point of the survey 41.2 million Americans (14.2%) were uninsured, while 29

million of those under the age of sixty-five (13.8% of adults and 5.3% of children) were uninsured for more than a year (Cohen and Martinez 2006).

By far, the largest numbers of Americans are covered under private insurance plans. Those insured by private insurance represent 66.3% (172 million) of the non-elderly population of the United States (KFF 2007). The majority of those (60.9% or 158 million) receive employer-sponsored insurance (ESI) from their employer as part of the compensation package (Kaiser Family Foundation 2007). The remaining 5.4% (14 million) purchase their own private insurance on the open market. While the vast majority of the privately insured are covered through ESI, there are growing problems with the employer provided systems. First, employers are not obligated to provide coverage. Increasingly, employers (especially those with employees earning less than four times the federal poverty line) are electing not to cover employees, or low paid employees are unable to pay for their increasing share of the premiums (KFF 2007). There has been a significant decline from 2001 to 2005 in the percentage of employees covered under ESI: for those under the federal poverty line (36.8% in 2001 compared to 30.4% in 2005), for those at the poverty line up to two times it (58.7% in 2001 compared to 51.7% in 2005) and for those earning between two times and four times the federal poverty line (82.4% in 2001 compared to 78.5% in 2005). In fact the only group not showing a statistically significant decline was those earning four times or more (92.9% in 2001 compared to 92.2% in 2005) the federal poverty line (KFF 2007).

The cost pressures on employers providing ESI are real, as they are on employees (particularly those earning the lowest wages). Consequently, the number of businesses offering health insurance has decreased (69% in 2000 compared to 60% in 2007) over the last seven years. For corporations still offering ESI, the premiums that employers pay to cover employees has nearly doubled between 2000 and 2007 (KFF 2007). The average cost to cover a single employee in 2000 was \$2,471 compared to \$4,479 in 2007. Meanwhile, the price for an employer to cover a family increased from \$6,438 in 2000 to \$12,106 in 2007 (KFF 2007).

During that time employers have absorbed a large part of the cost of insuring their employees from an average of \$2,137 in 2000 for a single employee to \$3,785 in 2007, and \$4,819 for a family coverage in 2000 to \$8,824 for family coverage in 2007 (KFF 2007). However, percentage wise employees have seen a similar rise in yearly premiums (from \$334 in 2000 to \$694 in 2007 for a single and from \$1,619 in 2000 to \$3,281 in 2007 for a family) (KFF 2007). While these increases may put strains on solid middle class families, they may be nearly impossible for the working poor where \$3,281 a year accounts for 16% of a family's pre-tax income at the federal poverty line (\$20,650 in 2007 for a family of four). Furthermore, that does not include additional medical expenses like deductibles, co-pays, and prescription costs.

In 2006, 46.5 million (18%) Americans under the age of 65 had no health insurance. Contrary to popular portrayals, 8 out of 10 uninsured Americans come from working families, with most having at least one family member working fulltime (KFF 2007). Additionally, the number of uninsured is growing, adding an additional 9.4 million to the rolls between 2000 and 2007 (KFF 2007). Two-thirds of the uninsured are poor (income less than the federal poverty level of \$20,650 for a family of four) or near poor (income up to twice the federal poverty level) (KFF 2007). Of the remaining third, 16% are between two and three times the federal poverty level, 8% are between three and four times the federal poverty level and 11% earn more than four times the federal poverty level (KFF 2007). Of the third earning more than twice the federal poverty level, many actually have "lower incomes but live with others" or their "higher income or lack of insurance is transient" (Kuttner and Rutledge 2007).

Amongst the uninsured, young adults, ethnic minorities and non-citizens are more likely to be uninsured (KFF 2007). A full 71% (33 million) of the uninsured are between the age of 19 and 54. Only 20% of the uninsured are under the age of 18, as most children qualify for public insurance in the form of either state children health insurance programs (SCHIP) or Medicaid. Hispanics were most likely to be uninsured for at least part of the last year (35.1%), compared to 20.3% of blacks and 13.2% of whites (Cohen and Martinez 2006).

The last group of American is those covered by public insurance: Medicaid, Medicare, SCHIP, or military insurance. This amounts to 16%, or 41 million, of the non-elderly population of the United States. By far the largest portion is those covered by Medicaid (including SCHIP) which is 13.5% (35 million) of the non-elderly population. Medicaid “provides medical benefits to groups of low-income people” (Centers for Medicare and Medicaid Services (CMMS) 2005). It is run as a joint program between states and the federal government with the federal government establishing general guidelines, with the states actually establishing the program requirements (CMMS 2005). Over half of Medicaid beneficiaries are children, while the other categories of persons that are eligible are parents, pregnant women, and persons with disabilities (KFF 2007). However, most adults without dependent children are ineligible, and even many poor parents whose children are eligible are ineligible because income eligibility for parents “are much lower than congressionally mandated standards for children and pregnant women” (KFF 2007).

One prevailing misconception is that Medicaid is insurance for all the poor. However, it is important to note that even according to the Center for Medicare and Medicaid Services (CMMS) “Medicaid does not provide medical assistance for all poor persons,” Furthermore, according to CMMS:

Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the designated eligibility groups (CMMS 2005).

In fact, with 36% of the uninsured earning less than the FPL, and another 29% earning between the FPL and twice the FPL, it is easy to see how that is the case (K.F.F. 2007).

There are numerous reasons to be concerned over the present insurance system in the United States. At the top of these concerns are the millions of uninsured Americans who have virtually no access to health care in America. Additionally the uninsured in the United States

tends to affect typical underserved groups in America; disproportionately affecting the poor, ethnic and racial minorities, young adults and non-citizens. While in most other wealthy nations health care has been firmly entrenched in the realm of human rights in line with the 1948 United Nations declaration, the same cannot be said for the United States. In the next chapter, I will explore the development of universal health care schemes in other nations in an effort to explore differences and similarities between the United States and nations that offer universal health care.

## CHAPTER 3

### A MULTINATIONAL COMPARATIVE ANALYSIS

Comparative analysis of social institutions are integral to the study of social institutions that are devised, implemented, and enacted in varying manners throughout the world and through different times. There is a practical approach to comparative analysis that is policy driven and is grounded “in a recognition of alternative ways of doing things and a capacity therefore to learn from the experience of others” (Hill 2006:10). At the same time, an intellectual case for comparative studies is based on the classic argument of Emile Durkheim:

We have only one way of demonstrating that one phenomenon is the cause of another.

That is to compare the cases where they are both simultaneously present or absent, so as to discover whether the variations they display in these different combinations of circumstances provide evidence that one depends on the other (Durkheim 1982:141).

Durkheim provides the rationale for comparative studies that are especially pertinent in international macro-level comparisons where data for statistical analysis may be limited. Furthermore, the underlying question for this paper (why universal coverage did not develop in the United States) is difficult to address empirically. This is a question based upon the very nature of cultural, social and political assumptions within the United States.

In this realm, a comparative study can be useful in flushing out the assumptions within the United States by comparing the United States to countries who have envisioned different types of health care system. By doing so, I propose two areas of concentration for comparing different nations health care systems. First, I will explore the historical development of health care systems between nations. In doing so, I hope to explore the values that were important within each nation as they developed their health care institutions. Secondly, I will compare various nations' health care systems using available comparable data. Both the World Health

Organization and the Organization for Economic Co-operation and Development (OECD) have comparable health care data and both will be used.

This paper is inherently limited in its scope of coverage. It would not be feasible to compare the whole set of nations that have developed differing health care models. Thus, some selectivity is needed in choosing nations. In choosing, I use a model developed by Milton Roemer (1991) and adapted by Donald Light (2005). This model compares health care systems by their respective nation's affluence (as defined by per capita income and G.D.P) and the degree of governmental control. The relationship between the two is identified in Table 3.1. For this paper, I will be selecting only nations that are designated as affluent. These nations have the most to offer, comparatively, to the primary question on why there is no universal health care coverage in the United States. They are similar in terms of per capita income and have similar financial resources available to invest in the health care model they choose. Secondly, I will be choosing one country from three of the four models based on degree of governmental control. I will not be looking at the most centralized version of health care systems (national insurance, state-run system) because both systems have significantly redeveloped since Roemer first identified them in 1991. The former East Germany health care system has been consolidated into the German model. The Soviet Union, or Russia and its satellites, will not offer good comparative information because the system, like former East Germany, is in a state of flux. Since the fall of the Soviet Union, health care spending in Russia bears little comparison to the other affluent countries. Russia spends much less than the other countries for health care in terms of actual dollars, percent G.D.P., and per capita spending.

The three nations that will be the basis of this comparative analysis will be the United States, Canada, and Norway. The choice of Canada over Germany for the national insurance, private regulated services category is owed, in part, to Canada's proximity to the United States. Additionally, Canada and the United States are similar due to our collective status as predominantly immigrant nations, and largely at least through the 1800's, patterns of

immigration were similar. In the category of national insurance, public regulated services, Norway was chosen over Great Britain for two reasons. First, if Norway were conceptualized as being on a scale and not categorically, Norway would be closest to the most centralized government control. Thus, it is the most varied from the United States (as far as governmental control) that still spends similar amounts of resources on its health care system. Second, Norway as a Scandinavian nation falls into the larger classification of what is become commonly known within welfare studies as the Nordic, or Scandinavian, model of welfare. Thus, Norway operates in this study as the nation with the greatest government control and the Nordic model representative. Comparatively, at least at first sight, Norway is the polar opposite of the United States with Canada having elements in common and in opposition to both Norway and the United States.

Table 3.1 Health Care Systems by Wealth and Control

The Degree of Governmental Control				
	Decentralized			Centralized
Affluence	<i>Private Insurance, Private, Entrepreneurial Services.</i>	<i>National Insurance, Private, Regulated Services</i>	<i>National Insurance, Public, Regulated Services</i>	<i>National Insurance, State-run System</i>
Affluent	United States	Germany Canada	Great Britain Norway	Former East Germany Former Soviet Union
Wealthy, but developing	—	Libya	Kuwait	—
Modest and developing	Thailand	Brazil	Israel	Cuba
Poor	Ghana	India	Tanzania	China

Adapted from Light 2005

### 3.1 Historical Overviews

History is crucial to the development of varying levels of social welfare regimes within nations. In light of this, I turn the discussion to the historical situation in Canada, Norway and the United States.

### *3.1.1 Canada*

Canada has developed a two-pronged healthcare system based on government-financed healthcare operated at the provincial level. In large part, the development of a national insurance system in Canada was highly decentralized with reforms originating at the provincial level and later codified at the national level under profit sharing arrangements between the provinces and the national government. As such, health care developments within Canada occurred on the periphery with, initially, little input from national groups and interests. Regional interests and players were more successful in pushing reforms in part because of the lack of a strong medical lobby and health care policies that largely halted the creation of such insurance in Canada. Taken together, these factors created breathing space for social activists to develop a universal health care coverage scheme.

The two-pronged Canadian health care system is based upon national insurance, while at the same time, highly decentralized in that there is provincial responsibility for the administration and delivery of most health care services (Marchildon 2005). Additionally, Doctors and hospitals are still generally independent structures that work on a fee for service basis. Traditionally, hospitals in Canada were offered subsidies from provincial governments to treat those patients who were unable to pay for medical care. This was vastly different from the attitudes taken by states in the United States. The poor in the United States were reliant upon charity, which under the prevailing protestant ethic was voluntary and philanthropic in its nature. Thus, hospitals for the poor in the United States were largely separate facilities sponsored exclusively by religious groups, wealthy philanthropists and received no public funding. Conversely, in Canada beginning with the Charity Aid Act of 1874 the Ontario government required not-for-profit hospitals (both municipal and religious denomination based hospitals) to accept patients with medical needs in return for a per diem reimbursement (Marchildon 2005). The passage of the Charity Aid Act of 1874 was a considered a victory for Catholic charities, in which “individuals would learn by example rather than through the imposition of moral

responsibility” (Maurutto 2003:28). Of course, the success of passage was not limited to Catholic reformers but was rather the mobilization of groups with varying purposes. For Catholics, their incentive for support was partly ideological (a rejection of laissez faire welfare ideology that focused on instilling a proper work ethic in the poor) as well as pragmatic in that a disproportionate number of Catholics were poor and more likely to benefit from welfare legislation (Maurutto 2003:26). In concert with the Catholics, various Protestant reform groups pushed for the Charity Aid Act of 1874 as a way to guarantee income into their denomination based hospitals. Tied to that, and contrary to American politics, many Canadian political elites supported such legislation as a way to gain oversight of hospitals who were serving the public interest. Thus, there was a trade-off for charity groups and non-profit hospitals in that provincial funding provided a per diem rate of remuneration to hospitals, which helped the hospitals survive while the government gained oversight of the hospitals receiving public funding.

The Charity Aid Act of 1874 excluded aid from going to private-for-profit hospitals, which served to limit the growth of for-profit hospitals in Canada. This also meant though that the growth of municipal hospitals and charitable aid hospitals minimized the creation of state owned or controlled hospitals (Marchildon 2005; Boychuk 1999). There was a prevailing notion in much of Canada that hospitals and health care should be, in the least, under the oversight of the provincial government. Furthermore, in what Boychuk calls policy paradigms Canada and the United States differed greatly with the United States paradigm supporting separate hospitals for self-supporting and the poor, while the Canadian paradigm “acknowledged no such social or economic distinctions” (Boychuk 1999:3). The municipal and charity hospitals in Canada were *the* hospitals in Canada – they did not make distinctions based upon income or social status. The provincial government did not have the finances to develop a public health care system in the late 19<sup>th</sup> century, yet political elites found a way to create a pseudo-public system that operated with government oversight over charitable and municipal hospitals and that implicitly restricted the growth of for-profit hospitals.

Province based social movements sought to create a health care system that served all Canadians regardless of income. These social movements' forged alliances that varied depending on the social make-up of the provinces. In the eastern provinces, they were largely composed of various religious denominations in concert with likeminded politicians. As the reforms spread west into the more agrarian provinces the make-up of the social movements there were vastly different both from the ideological background behind the movements and the actors involved. This was especially clear when reform hit Saskatchewan. Saskatchewan had not been accepted as a province until 1905 thus hospital development was slower than in the Eastern provinces. Initially, the hospitals had a similar character to those in the Eastern provinces with many having been established by denomination based charitable aid organizations as well as municipal hospitals (Houston 2003). In Saskatchewan, much of the push for government-subsidized care was in the hands of political elites who understood that the development and running of hospitals in the new province would be nearly impossible without some sort of governmental funding. Dr. Maurice Seymour who was in charge of public health in Saskatchewan from its inception in 1905 until his retirement in 1927 was able to "harness Saskatchewan's highly developed cooperative spirit" (Houston 2003:26). By enlisting, the support of traditional power networks (municipal councils, teachers and clergymen), Seymour was able to garner widespread support for public health issues from provincial funding to disease control mechanisms.

The social movements in the earliest day of Canadian health care reform were largely without detractors. From the late 19<sup>th</sup> century until the mid-twentieth century, these reforms were limited to government assistance for the poor in reference to hospital care. These reforms were supported by political elites, religious organizations (and their members) as well as by the general population. As was seen in later movements in the United States these movements did not have to cope with a strong organized medical professional movement, nor capitalist based special interests as the Canadian system had inhibited the development of profit related health

care services. The movements did not face serious adversaries in the limited realm of which they operated. However, as the movements sought to expand benefits in the post-World War II era, there was increasingly more unified opposition to further health care reforms.

It is generally accepted that Saskatchewan was the province that helped develop the framework of what would become Canadian universal coverage. The movement within Saskatchewan was pragmatic, rural and alternated between the local (city and county) and the provincial level. Saskatchewan is often viewed as the birthplace of Canadian universal health care coverage. Drawing from the work of John Markoff (2003), Saskatchewan follows the same pattern of the women's suffrage movement in that it was "pioneered in lesser places in the geography of wealth and power and then advanced to more central locations" (90). This can occur on different scales – within the world as a whole, within broad geo-cultural regions or within individual nation states (Markoff 2003). It is often away from the nexus of power and wealth concentration that reforms occur. Saskatchewan was the poorest province and among the most rural. The rural character and relative poverty of the province made Saskatchewan more distant from the national government in Canada – both in terms of geographical distance and ideological connectedness. This distance allowed local elites in peripheral regions more leeway to respond to local challenges in unique ways, as the powers of the day did not have the same amount of influence because of geographical distance as well as lack of interest.

For example, one chronic problem was finding doctors to staff poor rural areas. In 1914, the rural municipality of Sarnia, Sask placed an advertisement for a municipal paid physician to serve its residents. The municipal councils had made a decision independent of the province to retain a physician in probably the only way possible (with guaranteed income for the physician) working on salary on behalf of the municipal citizens. This program expanded throughout the province and eventually had the support of the province wide government. Contrasting with the local driven program of municipal physicians in 1916, Saskatchewan passed legislation that created hospital districts and provided for the employment of salaried doctors to provide general

health and welfare services (general medicine, maternity, and minor surgery) for all citizens of participating municipalities regardless of income (Marchildon 2005; Taylor 1987; Houston 2002). Thus, though the localities had initiated programs that were within the scope of their finances (municipal doctor services), it was up to the province to establish programs to support hospitals which often encompassed more than one municipality and required a larger capital investment than localities could afford.

I have referred to the reforms prior to 1920's as social movements. This is accurate as the goals of the reformers within the social movement were to change the norms related to health care provision in Canada. However, up until the 1920's these reforms were largely tied to the development of a health care system and lacked a cohesive outsider movement that could, or would, be effective in halting changes. There were conservative political factions (or classical liberal depending on preferred terminology) which promoted a laissez faire attitude towards the health care system; yet, these forces were largely marginalized in the 1920's due to the broad coalition of insiders whose basis for support was partly due to the limited nature of reforms. Beginning in the 1920's, Canadian universal care movements became true reform movements – seeking to change the legal norms that had traditionally limited government health care involvement to indigent persons.

During the 1920's, as public interest in expanded coverage increased, there was increasing pushback from political elites and medical professional groups. Up until this point, the services offered by the government (hospital coverage for the poor) had the effect of securing income for physicians by financing care for patients who would have been unable to pay. During the 1930's (in the midst of the depression), coalition building for increased government involvement in health care was difficult as many political elites increasingly were leery of increased government spending during a time of declining revenues. Certain expanded benefit programs had the support of political elites from the socialist based parties, and were even supported by physicians in Saskatchewan. However, this must be taken in the context of the

times in Saskatchewan (which was already one of the poorest provinces) and which was hard hit during the depression with an estimated drop in physician income of 72% over four years (Naylor 1986:66). Even in Saskatchewan, which became the forebearer of universal coverage for Canada, physicians and their organizing bodies only reluctantly supported increased government involvement as a necessity because of the conditions created by the depression, but they still harbored deep reservations over the apparent desire to abolish private fee practice (Naylor 1986:66). The itinerant support of physicians during the depression years was more about economic survival than an ideological acceptance of the CCF and other socialist leaning parties programs.

It is during the 1930's that sea change occurs among physician groups in relation to government proposals towards universal care (Alberta in 1929 and British Columbia in 1932). The 1932 report from British Columbia recommended a social insurance health system and despite being passed by the provincial government, it was never enacted as provincial physicians were opposed. Physician groups (the Canadian Medical Association and the British Columbia Medical Association) supported the process in British Columbia up until the reality of adoption sunk in. Doctors became increasingly concerned that in the long term they would lose fee-for-service payments in favor of salary based or per person payment structures. Increasingly, business owners allied themselves to the physicians over the tax burdens of providing such services. In order to appease the evolving coalition of doctors and business owners, compromises limited the numbers of people eligible for the programs decreased the proposed tax rate on employers' payrolls from 2% to 1% to appease business interests (Naylor 1986:75). However, in British Columbia even the negotiated compromise position faltered as provincial politicians felt it necessary to have a robust coalition with physicians and business leaders in order to enact such reforms. Under pressure from the business-physician coalition, the pro-health care reform coalition faltered in British Columbia.

Regional physician opposition was in part a reflection of changing attitudes as the universal care movement (or at least the assumptions behind it) became increasingly diffuse throughout society. As Eike-Henner W. Kluge (1999) notes, in the wake of the depression and World War II, there was a significant restructuring within Canada as to how health care was viewed. Canada, like most other countries pre-World War II, viewed health care in a “commodity perspective”, in that health care was a privilege to be earned through success within the capital market (Kluge 1999). The transformation from a commodity perspective to a rights perspective was essentially complete by the 1940’s, in large part because most Canadians did not have access to health care in the 1930’s for financial reasons related to the depression (Kluge 1999). This public change in attitude was not lost on national politicians who made their first real attempt to enter the universal care foray during the Dominion-Provincial Reconstruction Conferences in 1945 and 1946. During these post-war years the federal government offered to share 60% of the public hospital and medical care insurance costs assuming nearly all the provinces would sign on to the tenets of the program. However, Ontario and Quebec held out, arguing that the national government did not have the constitutional right to control health care affairs (Crichton et al. 1997:9). It was not coincidental that Ontario and Quebec both developed universal health care programs much later than the other provinces did. Constitutional issues over control became convenient arguments (much like the United States state rights movements) for those who sought to inhibit the role of the government in the provision and financing of health care. Pro-reform provinces took these failures to mean they needed to move reforms independent of the national government.

The national movement had been slowed by provinces who did not desire health care reform. However, the failures of the national government to build reform consensus only served to reenergize the provincial reformers who, realizing there would be no national reform soon, redoubled efforts to create provincial universal coverage programs. Because of this, the universal care reform movements refocused their attentions on the provinces that had been

friendly to governmental involvement prior to World War II. Saskatchewan became the perfect province for reforms to continue. There was a socialist provincial government under the leadership of Douglas and his party (the CCF) which made universal coverage a priority. The social conditions of Saskatchewan (agrarian and poor) meant that the mediating effects of the traditional opposition (business interests and physicians) were more limited in nature. In fact, as a note to the regionalization of physician attitudes, in 1947 the Saskatchewan College of Physicians and Surgeons stated the college favored –

...state-aided, contributory health insurance on a reasonable fee-for-service basis which shall include every resident of the province, provided that the administration of such arrangement is put in the hands of a non-political independent commission in which the medical profession is adequately represented (Schnur and Hollenberg 1966:112).

The physician led opposition to reform that was prevalent in other provinces was mediated by the preceding adoption and widespread perceived success of the municipal physician program and the lingering necessity for someone (or something) to smooth out physician income because of the disproportionate number of persons who were at any given times unable to pay for medical services. Because of regional relative physician support and a socialist leaning government committed to reform, in 1947, Saskatchewan implemented a universal hospital services plan popularly known as hospitalization. Unlike private insurance plans, which had begun to develop, the plan placed no restriction on the number of “entitlement days” as long as the hospital services were medically necessary (Marchildon 2005). This essentially halted any further development of a private insurance market in Saskatchewan.

As Kluge (1999) noted there was a continuing drive that was largely accomplished by 1945 in which Canadians came to view health care as a right and not from a commodity perspective. Thus, throughout Canada the necessary ideology had been formed to support governmental involvement in guaranteeing health care for all. During the intervening years from

Saskatchewan's first successful universal coverage program in 1947 to the last provinces (Yukon) 1972 adoption of universal coverage there was a never ending push towards universal coverage at the regional and national level. However, facing increasing public support for universal care, opposition interests increasingly attempted to stop, delay or halt such reform attempts. Yet because Canadians expected and accepted the prospect of government, financed health care as the way to ensure that the right of health care was provided to all, governments at all levels still pursued such goals. This culminated with the 1957 Federal Hospital Insurance and Diagnostic Services Act, which passed Parliament and established the general requirements that provinces would need to meet in order to be eligible for health financing cost sharing with the federal government. In the following two years, all the provinces signed on to the agreement (minus Quebec that signed on in 1961).

Physician and business interests were not successful in influencing the government to cease promoting such reforms. This was partly a reflection of splintering within those groups. Not nearly all physicians were opposed to government sponsored universal healthcare and the CMA had itself supported similar government schemes up until the 1930's. It is important to remember that until the 1950's we are still talking about the extension of universal *hospitalization* coverage. Hospitalization covered doctors' fees in relation to providing care in hospitals, but it was not so inclusive as to handle a majority of doctors' income (at least for most doctors) which occurs in offices away from the hospitals. Though it is dangerous to say that attempts to halt the universal coverage reform movement were a lost cause after the passage of the 1957 Federal Hospital Insurance and Diagnostic Services Act, it was certainly becoming increasingly difficult for opposition movements to alter the virtual tide of the pro universal coverage movement. Physicians were unable to halt the universal coverage movement but they became increasingly concerned as provinces moved towards universal coverage that included all medical services including doctor services. Such a system would have had the potential to limit physician income more so than any previous reform. Saskatchewan became the first

province to push forward legislation to create such a program under the direction of the Premier T.C. Douglas that became a key component of his election platform in 1960.

Politics can drive public opinion and it can reflect public opinion. In the multi-party election of 1960, Douglas' CCF made passing comprehensive universal health care coverage the center of its policy. Interestingly, of the three main opponents to the CCF in the election two parties (Progressive Conservatives and Liberals) were not opposed to universal health coverage, though they were not actively pushing for such. The Social Credit party was the only party openly opposed to universal coverage, yet tellingly they finished last of the big four parties securing only 12% of the vote (Elections Saskatchewan 2008). Perhaps, most important was the centralization of opposition to reforms that occurred in Saskatchewan by the provinces physicians. The previous remarks in 1947 by the Saskatchewan college of Physicians and Surgeons in support of universal coverage was supplanted in October of 1959 when the Royal College declared that the member of the college "oppose the introduction of a compulsory Government controlled province-wide medical care plan..." (Schnur and Hollenberg 1966:112). Physicians' had become overwhelmingly opposed to government involvement in health care financing particularly as it related to direct payments for all of doctors' services. During the election cycle, the College of Physicians and Surgeons organized opposition to universal coverage and most doctors had literature in their offices opposing Douglas' plan.

Interestingly, opposition movements composed of physicians were conflicted as to what level of opposition to bring to bear against Douglas' proposals. While the Saskatchewan College of Physicians and Surgeons reiterated their opposition and attempted to mobilize opposition within Saskatchewan, the Canadian Medical Association released contradictory statements in regards to Douglas' plan for universal coverage. While steadfastly opposed to the plan before the election, after the CCF's victory the CMA's national general secretary, Dr. A.D. Kelly, issued a statement that the decision of the voters in re-electing the CCF would be honored by the profession and that the election could be considered an endorsement of the CCF's plan (Schnur

and Hollenberg 1966). However, the Saskatchewan division leader of the CMA released a statement affirming its opposition. Unlike recent elections in the United States, the election of 1960 made the enactment of universal coverage *the* centerpiece of the campaign and the results were widely viewed as public support for that mandate. The opposition movement had not been effectively able to reformulate public opinion before the election and was in a situation in which further actions could further alienate themselves from the clear popular will. The national CMA's statement seems to be an acknowledgement of just that.

Douglas' CCF victory in 1960 led to the enactment of comprehensive universal coverage system that was passed in November 1961 and enacted on July 1, 1962. Although the debates between the government and physicians continued throughout the intervening period, the deadlock over physician opposition to "universality, compulsory participation and administration by a public authority" was unable to be overcome (Schnur and Hollenberg 1966: 116). This led 85% of Saskatchewan's 700 physicians to institute a strike. Physicians couched this as civil disobedience in that they were protecting the individual against "the intrusion of the welfare state" (Badgley and Wolfe 1965: 468). Yet, in spite of widespread public support evidenced in the election of the CCF, doctors chose to strike. This decision has been interpreted in a variety of ways but the key elements behind the decision seem to be related to the insulation of the profession by an elite coalition that created a perception that blunted the facts of public support for reform. This has been attributed to grass root support from local citizens' Keep our Doctors Committees, a mostly supportive partisan press, other professional groups (both within and outside the province) as well as the Chamber of Commerce (Badgley and Wolfe 1965).

The physician opposition to the governments program was in some ways to be expected. The Saskatchewan government was deviating from the norms of entrepreneurial health care delivery in a way that exceeded any previous attempts at universal coverage schemes (including hospitalization and municipal doctor schemes). The government had taken

on the role of innovator and reformer and thus had accepted the risks that innovators face which increase “the more his program departs from what is customary” (Badgley and Wolfe 1965: 472). In this regard, physician opposition was likely. Coupled with this were mistakes the reformist government made in their notions of the medical professions. The government was willing to negotiate with the doctors over fee schedules; however, they wrongly viewed the medical establishment as one similar to teachers and other professions with whom the government had experience negotiating. Physicians were not used to collective bargaining agreements for wages, as they had typically prided themselves on being professional private entrepreneurs (Badgley and Wolfe 1965). Though the Saskatchewan College of Physicians and Surgeons and the other related medical associations had a similar appearance in structure to other professional and labor union organizations, they had not typically served the bargaining function that their related professional organizations had.

In light of this, it was not surprising that though the government agreed to continue negotiations with the doctors during the implementation phase in early 1962 that the doctors refused without a cessation of implementation of the universal health program. The strike lasted 23 days and was characterized initially by unswerving attitudes on each side. Doctors refused mediation or further negotiations and the government began importing physicians from the United States and Great Britain to cover doctor shortages. Both sides seemed steadfastly determined to drive forth their particular goals. However, the government’s denial of any attempt to halt the program and the importation of doctors to replace the striking doctors sent a message to Saskatchewan’s striking physicians that the newly created universal coverage program was here to stay. The doctors’ strike was short lived as the Keep our Doctors committees’ support waned and brought the doctors back to the bargaining table. The agreement referred to as the Saskatoon agreement allowed doctors to practice outside the plan, emphasized the “contractual autonomy of physicians from the provincial government”, and set

government reimbursement rates at 85% of the physician recommended rates (Marchildon 2005; Naylor 1986; Taylor 1987).

After the rocky but successful implementation of universal coverage in Saskatchewan, the federal government of Canada moved forward with the promotion of comprehensive universal coverage schemes throughout the nation. Saskatchewan's successful implementation of universal coverage presented the federal government a blueprint for success thus minimizing the risks as the Saskatchewan had already blazed the innovator trail. The official rationale for federal government support came with the sanctioned 1964 Hall Commission report that recommended to the prime minister that the federal government encourage provinces to introduce public coverage for physician care through cost sharing between the provinces and the federal government (Canada 1964). Thus, the federal government embraced a role as cost-sharing partner and financier of the provincially organized universal coverage schemes. Responding to the Hall Commission, in 1966 the federal government passed the Medical Care Act in 1966 which led to federal cost-sharing funds going to the provinces that agreed with the four federally established principals of "universality, public administration, comprehensiveness and portability" (Phillips and Swan 1996). By 1972, all the provinces and territories had implemented universal public insurance for physician care.

It took a quarter century from the time that hospitalization was first introduced by Saskatchewan until the time that public insurance for physicians was implemented by all provinces. The result was the creation of a universal public health care insurance system. This system runs as an "individual single-payer schemes by the provinces and territories but tied together nationally through a set of common principles set in federal law, is commonly known by Canadians as "Medicare" (Phillips and Swan 1996). Medicare became the essence of Canadian health care.

Development of a universal health care system in Canada was regional by its nature. Various structural, political, and social factors placed the reform movement at a more local (or

provincial) level. Because of this the Saskatchewan experience with reform established the rationale for reform, showed the limits and reach of reform opponents, and displayed the success and failures such reforms (Maioni 1997). Thus, when the national government found the motivation to pursue reform, they had a model system that was popular and well received within Saskatchewan in order to base reforms upon. Reforms varied in their scope but the goal throughout Canada by reformist groups was to ensure that every Canadian had access to equivalent medical care. These reforms showed a distinct variation from prevailing laissez faire ideologies in the United States that viewed healthcare in terms of a market (and private charity) driven enterprise.

Table 3.2 Public Health Care in Canada: 1945-1984.

Year	Government Acts
1945	Federal offer of cost-sharing for public health insurance during Dominion-Provincial post-war reconstruction conference rejected by some provinces
1947	Saskatchewan implements universal hospital insurance
1948	Federal government introduces National Health Grants Program to strengthen public health initiatives and assist provinces in building hospital infrastructure
1949	British Columbia introduces a universal hospital services plan
1950	Alberta establishes user fee-based hospital insurance via municipalities
1957	Federal cost-sharing of provincial hospitalization provided in the Hospital Insurance and Diagnostic Services Act and implemented over next few years
1962	Saskatchewan introduction of universal medical (physician) care insurance accompanied by a bitter, province-wide, doctors' strike
1964	Royal Commission on Health Services, chaired by Emmett Hall, recommends national system of medical care insurance based mainly on the Saskatchewan model
1966	Medical Care Act passed in federal parliament
1968	Implementation of Medical Care Act through federal-provincial negotiation and federal transfers on cost-sharing basis
1972	Yukon is last jurisdiction to join the Medicare plan
1974	Lalonde report on the determinants of health is published

Table 3.2 – *Continued*

1980	Emmett Hall reports to federal Minister of Health and Welfare on impact of physician, hospital and health facility billing practices on accessibility to Medicare
1984	Canada Health Act passed: mandatory financial deductions from federal transfer to provinces for user fees and extra charges

Adapted from Marchildon 2006

### 3.1.2 Norway

Norway has the most centralized health care system of the nations in this study. The impetus for universal coverage within Norway has a longer and clearer history than either in the United States or Canada. A 1672 law established the professional dominance of the physician within the health care field in Norway, by requiring physicians to be accredited through the medical faculty at Copenhagen and gave them authority over apothecaries and midwives (Hubbard 2006). It also had a clause that would be of continuous importance through Norway's health care development over the years; it required physicians to provide free health care to the poor. However, the law was farsighted as Norway had only five physicians at the time.

In 1740, the state developed initiatives, which established a medical collegium in Copenhagen. It further increased the role of the state by developing a network of medical civil servants who, in their respective areas, administered state policies and reported on medical issues in their area (Hubbard 2006). By 1810, the civil corps of medical officers numbered thirty-five, while there were 100 practicing physicians within Norway. From 1811 to 1825 (separated from Denmark in 1814), Norway developed their own training facilities for medical professionals including the University of Christiania in Oslo in 1812, a school of midwifery in 1818, and in 1826 the national teaching and research hospital, Rikshospitalet (Hubbard 2006). This led to the growth of district medical officers, smallpox vaccination programs, and the development of a nationwide publicly paid midwives program.

Unlike Canada, where health care reform was promoted and enacted on the intra-national periphery, reforms within Norway generally were initiated under the auspices of the national government. However, taken within the global sphere or more locally within the

European sphere of nations, Norway was on the periphery of the power agents within Europe. Within Norway, health care reform was (in the earliest days) derived and implemented in a top down manner. The earliest health care reforms (public health officers and medical schools) probably owe to the monarchical regimes that governed Norway from the 1200's until the 1800's. Furthermore, Norway has vigorously opposed in modern times any attempts to join the European Union (most recently in 1999).

One driver for social change was the role of epidemics such as cholera in the 1830's and 1840's (Hubbard 2006). This led to, among others, Public Health Laws in 1860 that created local boards of health (with representatives from the community) all overseen by the district medical officer who represented national health authority (Hubbard 2006). The decrees of the local councils had the rule of law, but were rarely used due to economic constraints and deference to other purely local councils. These medical boards had varied outcomes with larger urban areas developing wide-ranging health services under the board's oversight, while in smaller rural areas the boards were virtually nonexistent.

Through the late 1880's, professional medical groups (physicians, midwives, and nurses) developed professional organizations with the intent of "promoting medical influence—specifically the importance of public and private hygiene—in society" (Hubbard 2006). However, it was the growth of the campaign to stop Tuberculosis (TB) (the most frequent cause of death at the time) in the early 1900's that pushed the development of modern universal health care in Norway. New legislation in 1900 further enhanced the powers of district health officers, allowing for the registration and monitoring of all TB sufferers; they could order medical intervention like disinfection, and require hospitalization (Hubbard 2006). In order to have facilities to treat TB patients over 100 publicly owned sanatoriums were built for sufferers.

From the 1900's to the 1940's various laws were passed that provided mandatory sickness insurance for 30% of the workforce, and increased the role of the government in health matters including "the construction of hospitals and public baths, school physicians, and centers

for counseling and medical control of pregnant women, infants and young children” (Hubbard 2006). However, public health growth was limited in the years between World War I and World War II due to economic stagnation. Although the fundamentals for a centralized government run public health system was developed (e.g. public hospitals, public medical training facilities, and district medical officers) in the pre-war years, like many other countries Norway post-World War II quickly developed a much larger, more inclusive health care system.

Under the leadership of the social democratic Labour Party and under the longtime direction of the Health Director Karl Evang Norway developed a comprehensive health program whose two goals were to be “egalitarian and universal: all Norwegian regardless of personal income or place of residence would be guaranteed both good protection against disease and high-quality treatment of sickness and injury financed by the state” (Hubbard 2006). Additionally, it was during Evang’s time in the United States during the World War II, that he had an impact on the creation of the 1948 World Health Organization definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (Hubbard 2006; Ringen 1990). During Evang’s long reign as Health Director (1945-1972), this definition guided Evang’s development of the Norwegian health care system. In the post war years, Karl Evang led the expansion of preventative health care carried out by district medical officers (*distriktsleger*) who were assisted by public health nurses (*helsesøstre*) and supervised by county medical officers (*fylkesleger*). Second, Evang oversaw the re-organization of the numerous small-local hospitals into a network of large centralized hospitals for the treatment of the chronically ill (Hubbard 2006). (See figure 3.2 for a listing of health care related policy measures during Evang’s time as Health Director).

Like many countries, the argument for centralization verses decentralization has continued within the Norwegian system for the last fifty years. Through Evang’s term as Health Director (1945-1972) the Norwegian public health system was managed by a strong central administration at the Health Directorate. As pressure grew for more local control and

decentralization through the 1970's the government responded by transferring control for nearly all health services (e.g. physicians and public health centers) to the local cities, while central hospitals were transferred to county control. However, the pendulum may be swinging in the other direction as 2002 legislation reverts control over all hospitals to the national government.

Table 3.3 Health Care Related Legislation in Norway 1947-1972

Year	Legislation
1947	School Dental Services
1948	General Nursing
1956	Universal Sickness Benefit
1957	Public Health Nursing
1957	School Medical Services
1959	Home Nursing
1960	Occupational Rehabilitation and Disability
1961	Mental Health and Psychiatric Care
1963	Nurse Auxiliaries
1966	Universal Social Security Benefit
1969	Hospitals
1972	Public Health Centers

### 3.1.3 The United States

The United States has the most decentralized health care system of any affluent nation. As it is often noted, the United States is the only affluent industrialized nation that relies on a private insurance, private service model of health care provision. Because of such an arrangement, the United States is the only nation of this study that does not provide universal health care coverage to its citizens. From its earliest inception, the American health care model has differed vastly from both Canada and Norway. In both Norway and Canada the role of the government as either the provider (in the case of Norway) or the financier (in the case of Canada) were well-established trends by the late 19<sup>th</sup> century. Interestingly, the United States medical system developed largely without the direct involvement of the government in either the financing or provision of medical care.

By 1875, medical care in the United States was still largely a cottage industry. Physicians and pharmacists were entrepreneurs who largely did their work in patients' homes and in their own offices (Anderson 1985:14). General hospitals had not developed, as surgical

intervention was still crude and poorhouses or almshouses, staffed by volunteer physicians and staff, served the destitute and persons who had no family. Medical professionals were fee for service based and received little, if any, governmental or philanthropic support (Anderson 1985:14). There was an “implied obligation to persons unable to pay” but not any codified responsibility as in Norway, or remunerative support as in Canada (Anderson 1985:14).

Surgical intervention became increasingly successful as it was perfected in the charity houses and poorhouses in America. This coupled with the advent of anesthesia and antiseptics fostered an increased demand for surgical procedures from within the middle and upper classes. Consequently, a great boom for public hospitals occurred between 1875 and 1900 with 4000 eventually constructed by 1900 (Anderson 1985:14). These hospitals were largely developed by voluntary community boards and church bodies and were increasingly constructed using money provided by philanthropists and wealthy capitalists. Though often obligated by charters to provide service to the poor, they were a “minority of their patients” (Anderson 1985:14). Often physicians and surgeons made deals to admit their private patients and, in addition to pay, were granted a free place to provide surgery for poor patients. Thus, Americans developed a health care system based on voluntary support for the poor.

Anderson notes a clear delineation between public health care and personal health care in the United States. Personal health care, or those dealing with individual illnesses and disabilities, are the health factors that developed largely within the private sphere (Anderson 1985:41). While public health care, those relating to factors outside individual control – communicable diseases, clean air and water – begrudgingly developed within the public sphere. These were, in America, entirely separate medical focuses. The publicly funded boards of health were initially locally based and gradually spread in the late 19<sup>th</sup> century to the state level (Anderson 1985:42). The federalist bent of the Constitution had not ceded power over health to the national government, so in principal, States retained the rights to manage health care. Attempts to create a national body with health care responsibilities were difficult and met with

resistance by states rights advocates. The earliest national involvement in any health care issue was the Marine Hospital Service which, in 1878, was given the power to oversee epidemics mostly because they originated, or entered, at water ports. However, even so such influence was based almost entirely “on the constitutional power to maintain commerce”, while health problems were “more or less incidental” (Anderson 1985:42). It was not until 1912 that the Marine Hospital Service became the U.S. Public Health Service. Taken as a whole, the activities of the national government in health care administration, provision, and funding was virtually non-existent through the early 20<sup>th</sup> century.

Before 1930, most medical services were provided on a fee for service basis. Often, except amongst the poor, competition between physicians was considerable and there were often more physicians than demand for services in certain areas (Showstack et al. 1979). Thus, doctors were concerned about price cutters, and established formal fee schedules that were adopted by medical societies (Showstack et al. 1979). Physicians further cemented their professional dominance in health care through licensure standards and increasing standards in medical school which led to a reduction in the number of doctors from 146 per 100,000 in 1910 to 125 per 100,000 by 1930 (Anderson 1985:60).

During the early decades of the 20<sup>th</sup> century, many American social movements developed all fighting for a greater access to the American Dream. These movements (women rights, labor rights, senior, welfare and African American rights) all differed from the initial movement for universal health insurance in that they were grassroots organizations or “change from below” movements (Hoffman 2003). Universal insurance movements during the first decades of the 20<sup>th</sup> century were elite organized and received varying level of support from traditional populist organizations – organized labor, left-wing parties and other established social reform movements (Hoffman 2003). The organizers of the 1915 proposal for universal health insurance (the American Association for Labor Legislation’s (AALL) were a group of academic reformers who largely ignored the populace in favor of persuading physicians to

support universal health care (Hoffman 2003). Although the AALL eventually partnered with more populist movements (women's movements, suffragists and other progressive movements), some labor union leaders (Samuel Gompers, president of the American Federation of Labor) opposed the AALL plan for government intervention in favor of gaining benefits from employers through union negotiation. By the 1920's the collective opposition by physicians, businesses, insurance companies, and conservative politicians that labeled the reforms attempts as 'bolshevism' led to a collapse of the public insurance movement (Hoffman 2003).

The creation of the private insurance market came about largely in the late 1920's, after attempts at universal coverage failed in the 1910's (Thomasson 2002). The creation of the employee-sponsored system was, in many ways, an accidental development that occurred in an entirely unplanned way (Blumenthal 2006). During the early 1900's the predominant problem related to illness was related to lost wages, thus instead of health insurance, sickness insurance developed which paid workers for days missed due to illness or injury. In the late 1920's, hospitals created Blue Cross (hospital insurance) and later Blue Shield (physician insurance) as a pre-payment system, in part because of "fluctuating demand" which led to hospitals being able to smooth out capital fluctuations (Thomasson 2002). Thus, health insurance became a part of the American health care system in conjunction with rising medical costs (and increased medical prestige due to scientific advances in medicine) and rising incomes (Thomasson 2002). Interestingly, Blue Cross was able to grow because it was recognized as a non-profit, tax exempt corporation thus freeing itself from regulatory requirements for other insurance companies (e.g. certain cash reserve sizes)(Thomasson 2002). This exemption was given because Blue Cross plans were seen as being in society's best interest because it served low-income individuals (Eilers 1963:62).

Though hospitalization insurance began in the 1920's, insurance that covered physician fees and services developed slower. The present symbiosis between insurers and providers

was not always the case. Physicians, in general, were opposed to health insurance (both public and private) because they feared third party involvement would “restrict their income and limit their ability to price discriminate” (Thomasson 2002).

Like Canada and much of the rest of the world health care reformers in the years surrounding the great depression saw increasing difficulty in drawing attention to health care reform issues. Largely this was related to citizens and governments focus on unemployment and financial system collapse amongst these problems health care cost problems seemed incidental (Hoffman 2003). Indeed, even the socialist leaning radical parties in the farm belt (like Minnesota’s Farmer-Labour party) proposals for universal social insurance focused on wage replacement due to illness as opposed to health care insurance (Hoffman 2003). The increasingly strong physician lobby under the leadership of the AMA even caused Roosevelt to drop health coverage from his New Deal agenda largely because there was not a strong grassroots social movement to ally with against the AMA (Hoffman 2003).

Following World War II and in the midst of the cold war, attempts at reforms faltered in face of strong AMA, conservative, and business opposition to ‘socialized’ medicine. In the midst of the red scare (and without a strong alliance of labor and grassroots movements) universal coverage became toxic. A well funded campaign from the AMA (over one million dollars following Truman’s election in 1948) helped unseat congressional supporter of universal health care (Hoffman 2003). In the wake of the AMA’s successful mobilization and universal care supporters lack thereof universal health care movements in the United States nearly disappeared.

Although labor unions generally came around to the universal health care movement, the failures to mobilize earlier and form coalitions that are more robust meant that labor unions had to settle for negotiating well-received private health insurance benefits for their members through employers (Hoffman 2003). This itself became the impediment to reform as “most of the working-class constituency for social insurance had been accommodated [through private

coverage], the potential for building a mass movement . . . dwindled” (Hoffman 2003). The United States became unique amongst countries in that in addition to strong medical profession opposition and business opposition, the United States had allowed the creation of a large private insurance market that made future attempts at universal coverage schemes even more difficult.

The last major reformation of the health care system in the United States occurred in the 1960's when Kennedy and Johnson adopted the concept of universal health care for the elderly. The eventual adoption of Medicare was strongly supported by organized labor in order to ensure care for the uninsured elderly and to “eliminate the increasingly costly problem of negotiating health benefits for [union] retirees” (Hoffman 2003). Retirees sent out millions of pieces of literature in order to defuse the AMA's campaign against the passage. The AMA had a difficult time attacking the Medicare reformers, as Americans were highly sympathetic to the elderly as a group. Additionally, though the AMA was opposed to Medicare (as they have been opposed to all public health care schemes) they had a harder time portraying Medicare as socialized medicine as there was no pragmatic alternative for elderly who were out of the workforce. Indeed the American Association of Retired Persons (AARP) was founded in 1958 in “response to the need of retired teachers for health insurance” (see [http://www.aarp.org/about\\_aarp/aarp\\_overview/a2003-01-13-aarphistory.html](http://www.aarp.org/about_aarp/aarp_overview/a2003-01-13-aarphistory.html)). The AMA's attempts to frame the debate over Medicare were countered by a more effective campaign from the elderly-labor coalition. As a result, in July of 1965 Medicare became a part of the Social Security Act.

The last major attempt at reform is the now infamous Clinton plan, which sought to provide universal coverage through a “complex system of health alliances” (Hoffman 2003:78). The Clinton proposal would have preserved the employee sponsored insurance and the commercial insurance market. Traditional advocates for universal coverage were split over the Clinton plan with the AFL-CIO supporting the plan, while many other labor unions and

grassroots organizations were opposed, instead favoring a single-payer system like that in Canada (Hoffman 2003). Other influential unions (the United Auto Workers and the American Federation of State, County and Municipal Employees) supported a single-payer system but did not want to mobilize in favor of it if it meant attacking the Clinton administration. In the end, this led to a fractured coalition that was unable to mobilize effectively against the well-funded and well-organized physician, business and insurance coalition.

Attempts towards universal health care in the United States have had a more tortured history in the United States than in Canada or Norway. One central tenant behind the failure to bring universal care in the United States has been related to the inability to create a strong grassroots coalition actively willing to mobilize in support of universal health care. At various times, and for various reasons, the typical supporters of universal health care (e.g. labor unions) have opposed or only reservedly supported universal health care. On the other side, the AMA has been extremely effective in centralizing their control over the medical profession and (in partnership with insurance and business interest) vigorously opposing universal care schemes throughout the United States from the early 20<sup>th</sup> century to the present.

### 3.2 The Present Status of Health Care: A Comparative Analysis

Is the American health care system broken? It is a simple question with a not so simple answer. Clearly, the United States has unequal health care. The uninsured in the United States are a prime example of the institutional inequalities that are more likely to affect poor and minority groups. This section seeks to answer the question of how effective the American system is in providing health care. The World Health Organizations (W.H.O.) 2000 report "The World Health Report," ranked health care systems across the world. The W.H.O measured five areas to assess health systems – "distribution of health in the population; the distribution of health in the population; the overall level of responsiveness; the distribution of responsiveness; and the distribution of financial contribution" (W.H.O. 2000:27). These factors, according to the W.H.O. should work towards the three goals of what a good health system should do: *good*

*health* (“making the health status of the entire population as good as possible across the whole life cycle”), *responsiveness* (“responding to people’s expectations to respectful treatment and client orientation by health care providers”) and *fairness in financing* (“ensuring financial protection for everyone, with costs distributed according to one’s ability to pay”) (Bureau of Labor Education 2001). Comparing the United States to Norway and Canada paints a mixed picture of health care in the United States.

It is to be expected that the United States would do worse on the “fairness in financial contribution.” Viewed economically, the uninsured in the United States are those priced out of the market. It makes sense that any nation with universal coverage would be fairer in expected financial contributions because at the very least everyone has a certain level of coverage. There could, of course, be variations of fairness within those nations depending on co-pays, drug coverage, and types of taxation (e.g. regressive or not) that fund the health care system. The World Health Organization defines fairness in financial contribution as “the ratio of total household spending on health to its permanent income above subsistence” (WHO 2000). Within this conceptualization, the United States ranks between 54-55th, Norway between 8-11th, and Canada between 17-19th. This correlates inversely with the level of government involvement in health care. Fairness in this context does correspond to overall spending in health care as the United States spends the most in the world, Canada is tenth and Norway sixteenth (WHO 2000). The United States spends more on health care than any other nation but generally does not provide a well supported safety net for those at the bottom of the economic scale (when compared to Norway and Canada).

Another measurement the WHO makes is the health level (or DALE) measurement which is “most easily understood as the expectation of life lived in equivalent full health” (WHO 2000). In this measure the United States was 24<sup>th</sup> while Canada was 12<sup>th</sup> and Norway was 15<sup>th</sup> amongst all the nations. When considering the distribution of health level (measured as the index of equality of child survival) Norway is 4<sup>th</sup>, Canada is 16<sup>th</sup> and the United States is 32<sup>nd</sup>

(WHO 2000). This measure shows the varying levels of survival rates *within* each nation based upon various socio-demographic groups. This is essentially a measure of inequality. It is not how well a health care system performs, but how equitably it performs. In this case, the United States does worse than either Canada or Norway which makes sense because access to care is tied to insurance status, which varies unequally, based upon race, income, gender, and location.

There was one area in which the United States did very well. The United States ranked first in responsiveness of health systems - which is defined as the extent to which medical caregivers are responsive to patients' non-health issues such as being treated with dignity and respect. Norway and Canada were both in the 6-7 position on that measure. When taking into account responsiveness for disadvantaged groups (the poor, women, elderly and racial minorities) the United States is tied with Norway and Canada. As was mentioned previously, Doctors still are among the most respected groups in the United States (although there is some declining confidence) as well as in most other countries. Taking into consideration the medical technology available in the United States, the United States has more CT scanners and MRI machines per million of the population than nearly any other country (except Japan) and many more than Norway or Canada (OECD) (see table 3.4). When Americans are able to get care it is among the best in the world. The other side of the coin is that what is not equitable in the United States is access to care.

When comparing for the overall attainment of goals (including health, responsiveness, and fairness in financial contribution) the United States ranks 15<sup>th</sup>, Canada 7<sup>th</sup> and Norway 3<sup>rd</sup> in the world. When taking into consideration the performance of the individual systems the WHO looked at how efficiently health systems translated expenditure into health as measured by the disability-adjusted life expectancy (DALE) (WHO 2000:159). In this measure, Norway was 18<sup>th</sup>, Canada 35<sup>th</sup> and the United States 72<sup>nd</sup>. This is expected as the United States spends more and has lower life expectancies than either Norway or Canada.

There has been much debate and flux in health care systems in all three of the nations mentioned. Generally, health care inflation has been a concern in nearly all industrialized nation over the last several decades and increasingly so since the 1990's. However, there is neither general public will nor political sentiment to alter fundamentally the systems of universal coverage schemes in Norway or Canada. Levels of government control (e.g. federal vs. provincial) have changed through time, though in no discernible pattern (from more to less and less to more). Increasingly, there is changing public sentiment in the United States both amongst the general public and health care providers that the present system is flawed and in need of serious reform. What is clear from the OECD data and WHO data is that health care in the United States is a tale of two cities – the uninsured (and inadequately insured) and the well insured. The United States has developed a health care system that is increasingly inequitable. This is precisely why President Bush and other politicians say the United States has the best health care system in the world (more than likely true if you have quality insurance) but is at the same time the worst amongst industrialized countries (and even does worse than many poorer nations) in guaranteeing health care to all of its citizens.

Table 3.4 Comparative Measures: United States, Norway and Canada

	Canada	Norway	United States
<b>Country</b>			
<b>Measure</b>			
Total expenditure on health, % GDP	9.8	9.7	15.2
Total expenditure on health, Per capita US\$ PPP	3161	4103	6037
Public expenditure on health, % total expenditure on health	70.2	83.6	44.7
Pharmaceutical expenditure, % of total expenditure on health	17.3	9.4	12.5
Practicing physicians, density per 1,000 population	2.1	3.5	2.4
Medical graduates, density per 1,000 practicing physicians	25.8	28.9	26.5
Acute care beds, density per 1,000 population	2.9	3.1	2.8

Table 3.4 - *Continued*

MRI units per million population		4.9	18*	26.6
CT Scanners per million population		10.8	14.3*	32.2
Life expectancy at birth, Females (in years)		82.6	82.3	80.4
Life expectancy at birth, Males (in years)		77.8	77.5	75.2
Life expectancy at birth, Total population (in years)		80.2	79.9	77.8
Infant mortality, Deaths per 1,000 live births		5.3	3.2	6.8
Cerebro-vascular diseases: Hospital discharges, per 100,000 total population		147	345	247
Diseases of the respiratory system: Hospital discharges, per 100,000 total population		778	1413	1213
Diabetes, deaths per 100,000 females		..	6.4	17.6

Source: OECD 2004 \*see [www.emrf.org](http://www.emrf.org)

## CHAPTER 4

### A SOCIOLOGICAL EXPLANATION

How it is that the United States developed a health care system that was nearly entirely private while Canada and Norway developed health care systems (at different paces) that were largely public? What I turn to now is a socio-historical analysis of why the United States does not have universal health care when Canada and Norway do. I will be looking at the political structural factors relating to various health care systems, political and welfare ideology differences between the nations, as well as the role of professional dominance in the lack of universal coverage.

#### 4.1 Political Structures and the Health Care System

One aspect that is important from a structural perspective is the form of government in each of the three countries. Both Canada and the United States have a federalist form of governance with powers shared between the national and provincial or state levels. Structurally, Norway is a unitary system with powers concentrated at the national level. That is not to say there is no regionalization or localization of political powers. The difference is that even when powers are delegated or given to the regional or municipal branches of government those powers (or the rights to them) are retained by the nation, therefore, the nation can recall those powers at any time. Canada and the United States both have more limiting factors for national control (especially in the realm of health services). These factors are both real (in the sense that there are codified restrictions that make establishing universal coverage regimes more difficult) and political as government regimes could “fall back on the constitutional dilemma as an excuse for inaction” (Coburn, D’Arcy and Torrance 1998:13).

There were practically no structural limiting factors to the growth of universal coverage schemes within Norway. As a constitutional monarchy, and developing from a classical

monarchical form of government, Norway had centralized control over health care early in the 1700's. This is reflected in the creation of the civil corps of medical officers, centralized publicly funded medical colleges, and a publicly created network of medical facilities and hospitals. Through time, various schemes of increased centralization and decentralization have occurred (within the health care field) but what has not is the fundamental power of the national government. This structural aspect was evident in the 1970's as the Norwegian government transferred control for public health centers to the local cities and for hospitals to the counties, but in 2002 reverted control of the hospitals to the national government. Control over the hospitals and health centers were decentralized to more local governments, but the *right* to control was not. Though the structural element for Norway is not sufficient condition for universal coverage, it does turn out to play an important part in the ease of establishing a universal coverage scheme.

Both the United States and Canada have more decentralized governmental institutions. In Canada, this hampered the creation of a universal coverage program, while in the United States it has been a factor in the lack of universal health care. For Canada, the British North America Act placed the responsibility of health at the province level (Coburn, D'Arcy and Torrance 1998). Thus, before the 1966 passage of the Medical Care Act (that established modern Canadian universal coverage) health care was nearly exclusively under the dominion of provinces to choose the level of private and public involvement. This led to variations in health care provision models that were not evident in the United States. The provinces were able to establish insurance schemes (or not) depending on the prevailing ideological perspectives, roles of elective leaders, and citizens desires. Reforms, initiated at the province level (with municipal input) established varying systems. The 1916 Saskatchewan Municipal Hospital Act allowed municipalities to make grants to hire municipal doctors. Thus, the decision to provide health care to citizens was passed to the local level with municipalities deciding whether to hire (mostly) salaried doctors to provide services for their residents with funding from property taxes.

This led to the more agrarian western provinces (Saskatchewan, Alberta, and British Columbia) providing more public health care services while many other provinces retained private fee-for-service health care. The system of municipal doctors was generally viewed favorably by those Doctors who were struggling with unpaid bills due to the inherently tenuous financial situation of farmers.

The United States was not dissimilar structurally to the Canadian system. The role of the national government was perceptually limited by the structure of the constitution and equally by the will of the national leaders. In the United States, one element of the Constitution made nationalization of health care difficult. The 10<sup>th</sup> Amendment to the Constitution or the reserved power clause states that “*powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people*” (U.S. Constitution, amendment 10). Though various governments have expanded national powers, the amendment was generally thought to give the states control over internal health and security issues such as policing, fire departments, education and prisons. Since health care was never specifically enumerated in the Constitution, it was often perceived as the right of the states.

Expanding the structural factors and looking at the role of health care reform from a neo-institutionalist perspective can help shed some light on why universal coverage developed in one country (Canada) with a limiting factor, while it did not in the United States. Neo-institutionalism approaches outcomes from a structural perspective that the rules of political system “impose certain constraints and opportunities conditioning legislative outcomes” (Maioni 1997:411). Amongst these structural institutional factors Maioni (1997) notes that the formal rules in Canada led to the creation of multiple parties in Canada; while major parties “failure” led to political protest movements in both Canada and the United States, in was only within Canada that these movements were translated into successful, lasting third party movements. The parliamentary system in Canada offered certain structural benefits towards third party formation.

First among these is related to “parliamentary party discipline”, which in Canada reduces the ability of the prevailing parties to absorb “dissident factions” (Maioni 1997:413). This corresponds to a greater ability in the United States for major parties to absorb dissident factions and ideas; however, in an often more watered down form.

Additionally, when third parties have success in elections (albeit in a minority position) in Canada they have the ability to influence the policy debates as issue entrepreneurs. In this role, they have a national platform to voice their concerns and may even hold the balance of power in minority governments. Though there has been some regional success with third parties in the United States, their national influence has been limited owing in large part to restrictive electoral hurdles for third parties. Even if third parties are successful in attaining Congressional seats, the Congressional committee systems operates under two party dominance and thus limits the ability of third party candidates to have institutional influence. Instead, ideological dissent is largely submerged within the broader coalition *within* the two parties, such as the “absorption of labor and the left within the Democratic party” (Maioni 1997:413).

Lastly, federalism, in its different forms, has a significant impact upon the party system. Canadian federalism does not have an institution with the goal of protecting regional or local interests such as the Senate in the United States (Maioni 1997). Because of this, provincial politics remain considerably more important within Canada and it is not unusual for a third party to supplant the traditional parties within the provinces. An example of this was seen when the CCF effectively took control of Saskatchewan nearly uninterrupted from the 1940’s through the 1960’s. Regardless of the ability of such third parties to gain national power, they are often able to gain control over nearly all provincial governmental operations. Thus, provincial politics are increasingly important because there is no national structure whose explicit goal is to protect each region’s interests. In the United States federalism was more centralized with regional interests represented within the Senate (and to a lesser degree within the House of

Representatives) thus despite the arguments proffered by states rights advocates, most social policy was developed within the national sphere.

Government types (unitary verse federalism) and variations within the varying federalist systems have had an impact on the development of universal coverage schemes in Norway, Canada, and the United States. Norway, with its unparalleled level of centralization had the structural factors favorable to the development of universal coverage. The United States and Canada with federalist systems of government had more hurdles to the development in universal coverage. These hurdles were more pronounced in the United States due to a more firmly entrenched two party system and the lack of a parliamentary form of government. Thus, policy entrepreneurs had the difficult task of persuading the broad coalition within the Democratic Party to accept their reformist ideas. Canada had similar structural roadblocks, which were in part mediated by their parliamentary form of governance and the provincialization of social policy. Yet, this is an incomplete picture as to why the United States has not been able to develop universal health care coverage. Structural factors seem to have a role in the ease of enacting large-scale policy reforms. Centralized power structures are more easily able to enable reforms from which there is a political or (more widely) public will. It is apparent that federalists governments have actors that are committed to decentralized powers (e.g. states rights proponents) which makes for natural partners for ideological or corporate special interests groups (e.g. the AMA). This has meant a few things in the world of universal health care reform. Foremost is that, federalists nations have often taken longer to develop universal health care coverage (see table 4.1) while more unitary governments have often developed these quicker. However, these structural factors do not explain the entirety of the question as to why the United States does not have universal health coverage. I propose two additional factors that have had an influence on why the United States has not developed Universal health care while Canada has; the role of ideologies and the role of special interests in each respective country.

Table 4.1 Development of Universal Coverage by Government Structure

Nation	Year	Type of Government
Germany	1883	Unitary at the time (federalist after 1919)
Belgium	1945	Unitary at the time (federalist since 1970)
U.K.	1946	Unitary
Japan	1958	Unitary
Canada	1961	Federalist
Finland	1964	Unitary
Netherlands	1965	Unitary
Norway	1966	Unitary
Spain	1978	Unitary
Austria	1980	Federalist (established earlier reached 99% coverage 1980)
Switzerland	1994	Federalist
The United States	N/A	Federalist

#### 4.2 Political and Welfare Ideology in Each Nation

Health care generally falls within the realm of welfare state. A general textbook definition of the welfare state is the “state responsibility to provide a basic modicum of welfare for its citizens” (Esping-Anderson 1989). Within this definition, all industrialized nations are welfare states – though in widely varying degrees. The differences between the nations in their conceptualization and enactment of welfare policies tell us much about each nation’s ideological foundations. The central question about the welfare state (and by extension health care coverage) is “whether, and under what conditions, the class divisions and social inequalities produced by capitalism can be undone by...democracy” (Esping-Anderson, 1989).

As was introduced in the last section health care provision can be viewed on a continuum from the most centralized governmental control (Norway in this analysis) to the least government control (the United States). What are central to the debate over varying types of health care systems are the distinctions between varying welfare regimes. Donald Light (2005) and Milton Roemer (1991) used a typology that viewed health care in terms of centralization of state control and nation’s affluence. This model is useful for identifying and classifying welfare regimes. A natural extension of that work is to delve into the ideologies behind the level of centralization within welfare regimes in general, and more specifically, within health care welfare amongst nations.

Drawing from Gosta Esping-Anderson's 1990 book *The Three Worlds of Welfare Capitalism*, we have a conceptual framework that matches well with the Light and Roemer's framework for governmental control. Esping-Anderson introduces the concept of de-commodification to welfare research. According to Esping-Anderson, de-commodification "may refer either to the services rendered, or to the status of the person, but in both cases it signifies the degree to which distribution is detached from the market mechanism" (Esping-Anderson 1989). Since, de-commodification is a, if not *the*, predominant schism between classical liberalism on the market side (the United States) and socialist or Marxist ideologies on the other side (Norway) it can serve as an informative conceptual framework. Perhaps, even more succinctly it could be said that de-commodification occurs "when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market" (Esping-Anderson 1989:22). Though the term itself could be faulted, the conceptual heart of the argument is one that would be accepted by both sides. In liberalist welfare regimes such as the United States there is a general consensus that market operated welfare is the best available. To take it one-step further, the free market is the solution to issues of social inequality.

This is based upon what Adam Smith saw as the idealized minimal role of the state – for Smith and his present followers the state intervention stifles equalization and therefore "the state upholds class, the market can potentially undo class society" (Esping-Anderson 1989; Smith 1961: II). It is important to note that Smith's writing is influenced by another archetype of states and the predominant state structure during his time, which was the conservative regime. Mobility was a near impossibility as status was conferred hereditarily in these aristocratic, highly stratified regimes. A key aspect of these regimes was the "preservation of class differentials; rights, therefore were attached to class and status" (Esping-Anderson 1989:27). In traditional liberalist nations, this notion of the market as the corrector of inequality becomes the underlying normative feature that guides thoughts, actions and policies. In liberalist nations, the market, not the government, serves as a correcting agent of inequality even though Smith's underlying

assumptions were based upon conservative regimes in which mobility was nearly impossible. Adam Smith thus shares the same optimism that Marx has been soundly criticized for. Smith assumes the restrictions on mobility are solely a function of the controlling political structures, and the capital market will be emancipatory when those structures are destroyed. The assumption is that the market does not have its own inherently stratifying effects. However, these critiques are not acknowledged within the United States and thus Adam Smith's view of the emancipatory nature of the markets is virtually without critique in the United States.

On the opposite side, such as in Norway, the market is not an appropriate avenue for social welfare as those rights are most equitable and universal which are outside the capital market. In Norway, and in other nations, market free health care are an acceptance of general Marxist doctrine that capital markets are profit driven and serve the interests of the elite classes. Thus, social welfare programs that are in the private realm cannot serve the interests of universality and equality. Fundamentally, what ends up is a question as to whether, in each nation, everything is a commodity that should be valued, priced, bought and sold. Adding de-commodification to the discussion over government control is advantageous because it goes beyond a descriptive typology to explain why governments have differing ideas on social welfare.

Within the framework of de-commodified welfare regimes, we have the same grouping of states with the United States market driven model on one side, Canada in the middle and Norway on the other side. In fact, in terms of de-commodification (and even within Light and Roemer's framework) Canada is not in the 'middle' as much as it is much closer to Norway. Thus, political ideology and the varying strength of socialist ideology verses neo-liberalism becomes a key aspect in why the United States does not have health care when the other wealthy industrialized nations do. A comparative analysis shows one clear element that Norway and Canada have in common that is devoid in the United States – a social democracy

movement predicated on socialist ideologies. Integral to this in both Canada and Norway is the attempt to de-commodify either the services within health care or the status of the person.

#### *4.2.1 Canada*

In Canada, the development of Universal health care was not accidental in where it developed or how it developed. The Canadian system developed mostly at the province level, with different provinces providing additional services which, upon their widespread acceptance and general support, provided the impetus for neighboring provinces to adopt similar practices (for a more detailed discussion of the provincial importance in health care reform in Canada see *Steps on the Road to Medicare* by C. Stuart Houston). This was important because even though there was limited national support for social democrats, pockets existed where social democrats had considerable support and, at times, majorities. One province with a large social democratic party (Saskatchewan) led the way by creating the first publicly funded, government employed, salaried municipal doctor in 1919 (Houston 2003:30). In fact, the employ of municipal physicians had a negative effect on private physicians in neighboring cities and townships (Houston 2003:34).

In 1944, Saskatchewan elected the first social democratic government in North America (Houston 2003:69). As premier, Tommy Douglas the "socialist fighter and orator" made health care his first priority (Houston 2003:69). Social democratic ideologies were particularly well received by rural farming populations as private health care was onerous to provide, difficult to administer, and economically unfeasible in many ways for farmers and physicians. Comparative infant mortality rates at the time were much higher in 1942 in Canada (54 per 1000) than the world leaders (New Zealand and Sweden - both with universal health care coverage - with 29 per 1000). The situation was even worse in many rural areas where infant mortality topped 70 per 1000 live births (Finkel 2006:172). This was not a message missed by Ontario farmers in 1973 that concluded at a conference on health care reform that: "The government pays for the

TB testing of cattle, pays for loss and has blood testing every year free of charge. What about humans? Let's take our hats off to Russia as far as health is concerned" (Finkel 2006:171).

This quote is an important window into social policy as well as to the general ideological feeling from these farmers. Livestock had a certain type of 'health care'. Granted, that health care simply sought to identify and prevent a disease that could cause economic problems. From a Marxist perspective, the value of the functioning stable market superseded individual health or needs. Cattle were not considered an expendable commodity. The agricultural market was predicated on the birth, life, and successful slaughter of cattle in order to attain the value of the meat. Within a near total free-market system (like the United States) this could be viewed as a proper governmental role also because it provides the smooth running market, presumably ensures consumer health, and attempts to ensure no large disruptions in the food supply. Similarly, the reason given for the recent government bailouts of Bear Stearns in the United States was, according to Fed Chief Ben Bernanke, was to protect the smooth operation of 'the market' (CNN.com). Recent exceptions aside, this is precisely the role the Food and Drug Administration serves (nominally at least) in the United States. What is even more striking is the reaction of the farmer over the lack of universal health care coverage.

The farmers publicly chided the government for not taking the same interest in human health as is done for cattle. For these farmers, the explicit support for a Russian model (the most centralized of all the systems of health care both at that time and compared to contemporary systems) is striking and something that could not have taken place in the United States after the early 20<sup>th</sup> century Red Scare. Minus the Red Scare, Canadian farmers found an ideology that was not antithetic to the very ways they lived their lives – with cooperative granaries or equipment that sought to minimize the impact of bad harvests or economies on any one farmer. Acceptance of elements of a socialist model that seeks to minimize the negative aspects of the capitalist system was a natural fit for rural Canadian farmers.

Even without national government support, rural provinces were able to work towards universal health care coverage through strong social democratic leadership. Tommy Douglas in Saskatchewan, realized that “if the average person were checked over by a health clinic at staged intervals and treatment were available before the illness had reached a critical stage, not only would we live longer but the cost of health services in the aggregate would be less than now” (Finkel 2006:172). As premier of Saskatchewan, Douglas oversaw the development of new public hospitals, a universal hospital coverage scheme (1947) and of universal health insurance in 1962. Furthermore, it was the dogged push by Saskatchewan socialist politicians and the Co-operative Commonwealth Federation (CCF) that forced liberal and conservative coalitions in provinces like British Columbia to adopt their own versions of universal health care coverage albeit with more private aspects (Finkel 2006:173).

The eventual adoption of Canadian universal health care coverage was due in large part to the ideologies promoted by socialist parties like the CCF and accepted by pockets of the population throughout Canada. Canadian socialists argued and pushed reform that de-commodified aspects of health care in Canada. Since the development of universal health care coverage in Canada was not a top down reform (e.g. starting at the national level and trickling down to the provincial level), de-commodification was incomplete. Returning to the two-pronged approach to de-commodification from Esping-Anderson, Canada was able to de-commodify the person, but not the services rendered. In Canada’s case, the individual is largely free from commodification in that the payment is outside the individual and use is based on need. However, the services rendered are commodified in that the government pays physicians on a fee-for-service basis, and there is a “contractual autonomy of physicians from the provincial government” (Marchildon 2005; Naylor 1986; Taylor 1987). The creation of universal health care coverage in Canada was a compromise between the social democratic provinces and regimes who gained a de-commodified single payer system, with the more traditionally liberal and

conservative elements that maintained the market system in dealings between the government and the health care providers.

#### 4.2.2 Norway

In Norway, the development of Universal health care coverage was prepared by a centralized structure for medical care (district health officers and public hospitals) that stretched back to the late 19<sup>th</sup> century. Historically, public health and general health care services were intertwined under the oversight of federally employed district health officers. Welfare in Norway has thus been predicated upon socialist ideologies (often referred to as the Nordic model) as an attempt to create a “set of egalitarian institutions which not only give the poor access to a minimum standard of income and social services but also to bring those that would otherwise have been poor closer to the general standard of their societies” (Erikson 1987:vii; Kautto and Hekkila 1999).

Much like Canada, Norway developed universal health care coverage under the auspices of socialist ideology and regimes. Unlike Canada, social democratic parties (namely the Norwegian Labour Party or the *Det Norske Arbeiderparti* (DNA) and Socialist Left Party *Sosialistisk Venstreparti* (SV)) have been the largest political parties since 1927. Whereas in Canada social democratic parties like the CCF and its successor the New Democratic Party have played a crucial role in the development of universal health care but were never an absolute majority nationwide.

Unlike Canada and the United States, Norway has most completely de-commodified its health care system. This is, in large part, predicated on the history of medical services in the Norway. Unlike much of Canada and the United States, the formative years of a comprehensive health care system was done while a majority of physicians was municipal employees on a fixed salary (WHO 2000:33). This has been changing to a certain degree with larger numbers of physicians becoming private contracted physicians who work on a fee-for-service model. Those

physicians, however, are only able to charge the government for services on pre-determined schedule by the National Assembly (WHO 2000:33).

Also unlike Canada and the United States, hospitals in Norway tend to be public with ownership at the local, regional or national level depending on the type of hospital (e.g. teaching, large specialty hospitals, local general care hospitals). This is a sharp contrast to the 95% of hospitals in Canada that are private (though not-for-profit) and the 80% of hospital in the United States that are private (both non-profit and for profit). Thus, Norway's health care system tends to have the most state control over nearly all aspects of health care and therefore the most de-commodified system of health care. The individual and, largely, the services rendered are outside the market place. The individual in Norway is the most significantly emancipated from market dependence.

#### *4.2.3 The United States*

In liberal welfare states (with the United States as a near perfect archetype) generally what has developed are modest, means tested assistance programs (Esping-Anderson 1989: 26). This is derived from work-ethic norms that make entitlements rules strict (and usually stigmatic) and which benefits are usually modest. This results in a "class-political" dualism between two groups – the majority with market-derived welfare (the middle and upper class with employee sponsored insurance schemes) and the minority poor state welfare recipients (Esping Anderson 1989:25). This is clearly seen in presidential nominating political discourse as welfare discussion reflects on middle class issues (high costs of insurance and commodities), but in which very little is said about the poor or those in poverty. The 2008 tax rebate checks are another example, giving the largest rebates to those firmly in the middle range while smaller or no rebates to those earning the least (see I.R.S. Economic Stimulus Payments Information Center <http://www.irs.gov/newsroom/article/0,,id=177937,00.html>).

Furthermore, the effect is virtually no de-commodification of the services rendered or the person in the American health care system. Since de-commodification refers to the extent

that a person is emancipated from the market for basic needs, there is virtually none in the United States. Health care is not a right in the United States. It is not guaranteed except for in certain cases of traumatic injuries in American emergency rooms. The services certain poor persons do qualify for (Medicare, Medicaid and SCHIP programs) are continuously means tested and clients are at the mercy of changing requirement from both the national government and state governments. Secondly, most individuals must still rely on the largesse of their employers for the type of coverage they have, thus for the vast majority of Americans there is a near complete reliance on the market.

Health care provision and policies in the United States are significantly different from those of Canada or Norway. The common bind between universal coverage in both Norway and Canada were the mobilization and leadership of political regimes that were hostile towards market-derived social services. In large part, this was ideological in that it derived from social democratic movements at the provincial level in Canada and at the national level in Norway. The United States largely lacked such a movement and lacked effective political movements that sought to minimize market influences. Furthermore, Canada and Norway both offered government subsidized or government delivered care that was less than universal but that covered a large part of the population early enough to effectively halt the creation of private insurance programs in both countries.

The same could not be said in the United States where there was neither the political will nor widespread public support for universal health care coverage (at least in the early part of the 20<sup>th</sup> century). Though attempts were made during the early 1900's to establish universal coverage, it was derailed by varying activists from the state rights movement, conservative politicians, and from a splintered labor bloc which was never consistently on one side or the other of the issue.

At the heart of the lack of social democratic regimes, is what Daniel Bell referred to in *Marxian Socialism in the United States* (1967). Unlike America, where Marxist parties could not

find a way to be “in and of the world”, Canadian and Norwegian Marxist parties were successful because they negotiated between political realism (by working within the framework of parliamentary democratic government and capital markets) and ideology (Bell 1967, IX). The Socialist Party in America was ineffectual because it chose to be so, choosing to fight for a radical readjustment and was ultimately brought down by the political ineffectualness that engendered. Additionally, the American labor movement (a natural fit for social democratic parties) chose to work within the traditional liberal sphere in order to gain advantages like collective rights over the values of individualism (Bell 1967: X). With labor movements more concerned about collective bargaining related to income and work place issues (e.g. work week), and Marxist based parties effectively marginalized, universal health care was left to market forces and became more capitalistic than in the other industrialized nations.

Consequently, health care became more highly commodified in the United States. The federal government abdicated any responsibility to providing health care on the constitutional argument that health care was not a responsibility of the federal government. Although some activists in the early 1900’s pushed for universal health care, it was never really close to becoming a reality. One reason was that universal health care was treading on thin ideological ground in the United States. Since there was never a well-defined publicly supported socialist movement, the prevailing ideology that had made universal health care coverage possible (and perhaps almost inevitable) in Norway and Canada was not available for the reformers to use here. Thus, liberal reformers were stuck trying to explain the purpose for huge government involvement in universal health care without having the logic of a critique of capitalism. The question in Norway and Saskatchewan had been how to protect workers from the inherent inequalities and negative aspects found within the capitalist mode of production. Furthermore, communalism was a natural element of rural life in Canada, thus an interpretation of Marx had provided an answer that the Norwegians and Canadians could use – protect the worker from the capital system as much as possible by providing those welfare services that would limit how

bound workers were to the capital system. There was an inherent distrust (at least in certain cases) to the market economy and an acknowledgement that certain services should not be found within those markets.

The United States had no such predisposition to capitalism cynicism. In fact, America had engaged market capitalism more enthusiastically than any other nation and had created a political system that reflected Adam Smith's embrace of the market as the solution to inequality. Thus, physicians (and later surgeons) were never in the employ of the government in any role to provide for health care. In fact, public health initiatives like local and state health boards were only begrudgingly started (beginning at the local level) and kept a very limited scope of activity focusing on public health care (water and air and communicable diseases) and was devoid of any personal health care responsibility (personal illness). America's health care became a privately operated, privately organized system that had only the most informal protections for poor patients who could not afford care.

Physicians and pharmacists in the United States had, from their earliest inception, established a private fee-for-service health care system. Doctors established private practices that set fees for services and that never had the goal of universal health care. Health care for the poor was limited to the largesse of physicians, charitable foundations, and philanthropists. Reflected within this largely informal and un-institutionalized approach to welfare was the protestant values that had pervaded the United States since its founding, of individualism and Calvinist ideas of one's economic state as a reflection of God's will. Yet, until the late 1920's there were also no private health insurance to speak of, largely because the costs of health care were small (due to low state of medical technology coupled with little public confidence) compared to the major problem which was related to loss of income (Thomasson 2002).

Until the late 1920's health care was a highly commodified and operated entirely within the free market. Services were only guaranteed to those who could afford services based upon a fee schedule set by physicians. Even the creation of the private insurance market was looked

on unfavorably (and delayed) by physicians who feared third party involvement would “restrict their income and limit their ability to price discriminate” (Thomasson 2002). Doctors were fearful of an insurance market that dictated prices for services and that could potentially lower their income potentials.

After the failure of universal health care reform movements in the 1910’s, the growth of the health care services in the United States occurred within the private sphere. First, as private fee-for-service physicians, then through the establishment of private individual paid insurance, and lastly the employer sponsored insurance. From that point on, the United States health care system grew within the private sphere with increasing private insurance coverage up until the late 1990’s, at which time increased price pressures led to declining coverage by employers (especially those predominantly employing low income individuals).

Thus, in the United States the political and welfare ideologies played a pivotal role in the lack of creation of universal health care. These can be summed up as an acceptance of classical liberal ideologies based upon Smith’s view of laissez faire capitalism as the solution for social inequalities. Tied to these classical liberal tendencies (and consequently because of the absolute rejection of Marxist ideologies), the government in the United States largely abdicated any role in the health care arena. This abdication led to health care providers’ dominance of the health care system in ways that allowed them to maximize earning potential and to become the de-facto policy makers in the health care arena.

#### 4.3 The Role of Special Interests: Professional Dominance in the Health Care System

One aspect that has had a large effect on social policies within nations has been the role of professional monopolization. In Weberian terms (and further expanded upon by Berlant in *Profession and Monopolization*), physicians are part of the privately privileged commercial class (Weber 1978:304). They are, according to Weber, typically entrepreneurs, which was the case in both Canada and the United States. Furthermore, the physicians created medical associations that oversee the creation of licensing standards, and through pseudo-

governmental regulatory powers, the admittance of new members to the profession (through training oversight). The monopolization is directed against competitors (in this case various midwives apothecaries, pharmacists, and healers) with the goal of “the closure of social and economic opportunities to outsiders” (Weber 1978:342). The opportunities for profit are open to all members of the monopoly who can compete within the monopoly for economic gain.

Monopolization of health care in Canada and the United States was done through the development of national (and affiliated regional) medical societies. In Canada, the central society was the Canadian Medical Association (CMA), while in the United States it was the American Medical Association (AMA). Both have their origins in the mid-19<sup>th</sup> century and both have effectively made physicians the overseers (to varying degrees) of their respective health care systems.

Timing was important to attempts of monopolization. For such research, it is important to go back and look at health care in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries. Medical practices up until the early 20<sup>th</sup> century were primitive and largely ineffective. Therefore, medical services were more diffuse with midwives, physicians, apothecaries and various healers all peddling largely ineffectual wares. Health care was not a significant expense because it did not have the confidence of the population it served (Thomasson 2002). It was therefore difficult for either the AMA or CMA to establish effective monopolies until such time that the demand for medicine created conditions conducive to monopolization. Important advances in bacteriology, medical technologies, and anti-infection techniques made health care in the United States (and throughout the world) safer and more effective in the first twenty years of the 20<sup>th</sup> century (Thomasson 2002). It was that “by the 1920s prospective patients were influenced not only by the hope of healing, but by the image of a new kind of medicine—precise, scientific and effective” (Rosenberg, 1987:150). Though medical associations existed before the 1920’s, it was during this time that their influence grew in relation to the increased prestige and confidence that medicine held.

Indeed, because of the localized and largely entrepreneurial approach to medical system development (in both Canada and the United States), an unaffiliated network of competing health care options developed which made monopolization difficult. Light (2004) identifies five competitive forces physicians faced during the late 19<sup>th</sup> and early 20<sup>th</sup> century: a surplus of doctors, competition from natural healers, free-care at dispensaries, proliferation of cure-all medicines and contract medicine. These five sources of competition were evidenced by average yearly incomes of \$1,200 for physicians – about the same as that of skilled craft workers (Burrow 1977:15). In 1901, the AMA was reorganized to better address these concerns in order to reduce competition and cement physicians' dominance in the health care market. In order to be a member in good standing at the national level, one must be in good standing at the state and the county level (Starr 1982, Light 2004). The incentive for increased membership was based upon county medical associations control over hospital privileges, group malpractice insurance, and other benefits (Light 2004). In light of these reforms, membership rose from 8,000 in 1900 and 70,000 in 1910.

Once the medical associations exerted influence to centralize their powers, they were able to attack systematically the elements of competition in order to effectively monopolize the health care system in America. In order to control 'excess' numbers of physicians, the AMA raised standards and threatened schools with the loss of certification if they did not comply, which had the effect of coercing schools to reduce class sizes. In order to deal with natural healers, mid-wives and other medical alternatives the AMA lobbied for the legislation to outlaw them. They were successful in promoting legislation to limit midwifery by arguing midwives were the cause of high infant mortality rates (Light 2004). Ironically, most medical schools offered little obstetrics training and the infant mortality rate increased as doctors assumed delivery duty in Washington D.C. (Wertz and Wertz 1989).

By the early 20<sup>th</sup> century, the practice of contract medicine was rapidly growing in the United States. In some ways this was similar to municipal physician programs in Canada, in that

an organizing unit (in Canada municipalities) paid a salary or yearly per person fee to physicians in order to cover all medical care for the year. In the United States, the organizing unit was most often employers who negotiated with doctors to provide health care to their employees. Many physicians (similar to those in Saskatchewan) liked the program because of the income guaranteed from low wage patients who might otherwise be unable to pay their medical bills (Light 2004). However, the medical associations were able to discourage doctors from taking contract positions by publishing physicians' names in order to embarrass them and even by threatening members with expulsion or censure if they did not agree to end "price-competitive medicine" (Light 2004:8).

Another route to professional monopolization has been through the ethical standards, which at face value attempt to provide medical care regardless of means. Deriving from Thomas Percival work 1803 work *Medical Ethics* both the AMA and CMA created ethical codes of conduct from Percival that largely shaped medical practices in America. Some standards were clearly created to build a type of *esprit de corps* and to increase physician's prestige. These were standards that encouraged physicians, whenever possible, to concur with patients diagnosis' from other physicians which "discourage criticism and thereby contribute to monopolization" (Berlant, 1975: 72). Additionally, Percival noted the importance of price structures for physicians. One almost counterintuitive approach was towards care for the poor and certain select patients. The select patients were certain civil employees and military personnel (as well as other physician's families) who should be treated free as "acts due to the public..." (Berlant 1975:74). Thus, the people who were free of medical expenses (in the early days of medical associations) were those people with the power to potentially limit the influence of physicians. The poor were expected to pay less for services but were expected to be treated. This sense of developed professional responsibility had the intent for Percival of establishing physician monopolization over the care of *all* patients (Berlant 1975: 75).

If one accepts Weber's argument that virtually all groups engage in economic action (the satisfaction of wants for scarcities), then it is easy to see the motive for a monopolization structure. Physicians' responded to competitors through group organization under the auspices of medical associations. In turn, those medical associations became further exclusionary and sought to "persuade the legitimate agents of force within a political community to recognize and enforce the group's monopolistic claims" (Berlant 1975:48). In the United States, this was done by control over licensing requirements and control over medical school admission (Berlant 1975: 180; also see Milton Friedman *Capitalism and Freedom*).

In the United States, the legitimate agents of force (e.g. the government) have granted a monopoly to the AMA largely because of a lack of national government involvement in health care. Since health care concerns (at least presumably) were state-by-state, due to the federalized structure, a partner was needed to ensure that medical schools were qualified (Yale Law Review 1955). Of course, the state could have developed their own independent structures of oversight; but the underlying assumptions behind American liberalism made turning over oversight a natural extension of a system that was inherently distrustful of government intervention. Even if that led to market monopolization (which was always a wrench in Smith's pure competition model), it would be better if that happened within the private sphere than the public sphere which was, in Smith's telling, inherently incapable. Thus, the government partnered with the AMA to license medical school which being a graduate of is a legal requirement for state licensure as a physician. In turn, "through their reliance upon the AMA to inspect the nation's medical schools, the states tacitly confer upon it the power to set the standards for approval" (Yale Law Review, 1955). In doing so, the AMA was given indirect power to control the number of new physicians available by setting class size standards that schools must follow to retain licensure. Since, state licensure for physicians require graduation from AMA approved programs, the AMA can effectively regulate the number of practitioners which leads to effective monopolization of the health care market. When the AMA issues

warnings (as in the 1932 warning of a “surplus of doctors”), medical colleges tend to comply with voluntary reduction in class sizes, most likely due to the licensing power the AMA has over schools.

One thing was consistent in both Canada and the United States; both countries had a large proportion of doctors that were privately employed, and in both countries, physicians largely opposed the creation of single tax payer insurance systems. Norway was unique because during the formative years of its health system (in the early 1900's), many physicians were in the employ of the government serving as district medical officers and they functioned as coordinators for private physicians within the districts they served. Additionally, during the campaign to stop Tuberculosis public hospitals were created that placed many health care services within the public realm.

Canada differed from the United States since the CMA never achieved the success of the AMA in control over monitoring licensure and education. The control of the CMA was more diffuse as differing organizations were in charge of the varying licensure and educational regimes. In part, this was a reflection of the decentralization within Canada that existed until the creation of Medicare. Control over health care was centralized at the provincial levels and thus varying structures developed relying more on provincial physician medical associations input and control than the national association. Certification is required through one of three bodies: the College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada or the Collège des médecins du Québec depending on specialty and location. In 1979, the Committee on Accreditation of Canadian Medical Schools was established; up to that point, the U.S.-based Liaison Committee on Medical Education (see [afmc.org](http://afmc.org)) accredited medical schools in Canada.

The development early on of differing ideologies within Canada made single powerful interest-group domination unlikely. Unlike the United States where attempts at socialized or universal care were limited by the wide spread predominant laissez faire attitudes of

practitioners, Canada had a diversity of ideological and pragmatic reasons for differing health care models. In Canada, physicians' employment was on a province-by-province basis. Though a large proportion of physicians were privately employed, pockets of publicly financed municipal physicians existed (largely in Saskatchewan though to a lesser degree in Alberta and British Columbia). The development of publicly employed Physicians in Saskatchewan was largely without controversy by the medical associations because it was not mandatory and served physicians well. In agrarian Saskatchewan, struggling through the depression of the 1930's, municipal physicians were in near unanimous agreement that "private practice was no longer feasible" (Houston 2003:36). In fact, the provincial medical associations had become the de facto power holders for physicians in their respective provinces, so much so that in the 1930's the CMA made a campaign for "national reorganization, hoping to pull the provincial associations into closer orbit" (Naylor 1986: 96).

Additionally, there were generally larger roles for government-financed health care throughout the provinces than in the United States. Later, in 1945 the Canadian Medical Association (CMA) supported the creation of universal health insurance with federal-province cost sharing (Naylor 2000:126). However, the limiting factor in implementation was based upon "federal incursions into provincial jurisdiction" (Naylor 2000:127). In the 1960's after successful state sponsored hospital coverage schemes, the Canadian Medical Association (along with its regional partners) did mobilize against state provided medical insurance (in concert with private insurance companies).

Yet, unlike in the United States the early successes of hospital coverage schemes and further public health initiatives in Saskatchewan and other provinces had led to widespread public support for universal health care insurance – by extension provided by the government. From late 1920's through World War II, because of economic uncertainties, physicians (and their CMA) had a positive view of government involvement in health care services because it moderated losses from individual non-payments and guaranteed income during difficult times.

The CMA support was conditional on physician control of the commissions overseeing public health care, insured fee schedules under the control of provincial medical associations and payments by methods acceptable to the physicians (William et. al. 1995). Thus, the CMA support leveraged their situation in what was a win-win situation guaranteeing professional dominance and income versus giving up minimal control over traditional fee-for-service and insurance schemes. However, the failure in the 1940's to establish a universal coverage system (based on the political structural factors) saw the provincial medical associations establish profession sponsored private prepayment plans (William et al. 1995). In effect, from that point on the medical associations became "private governments" who sponsored, managed, and controlled the health system in Canada. In turn, this led to their retraction of support for public health insurance in favor of the view that the government role should be limited to subsidizing their own private insurance plans for the poor (William et al 1995).

In short, monopolization was not nearly as complete in Canada as in the United States. Provincial medical associations were never brought under the full control of the national medical associations. There, was, inherent in the inter-provincial variation, vastly differing needs in various provinces. This made it more difficult for Canadian associations to build the consensus on a national level, but regional medical associations were quite powerful. The monopolization was never complete in Canada; therefore, doctors did not have the exclusive power to mandate system organization. The same was not true in the United States where the AMA ascended to supremacy as the unifying governing body of physicians. Monopolization was nearly complete and, therefore, doctors' goals became the structural goals of the health care system. This was possible because though states were independent of each other in regards to health care operation, there were no states that were considerably outside the norms espoused by the physicians. In the end physicians, through the influence of the AMA were the primary actors in the creation of the private insurance system.

## CHAPTER 5

### CONCLUSIONS

If it were not for the dogged opposition to universal health care in the United States, it would be easy to conclude that the global trend towards decreased market participation in health care was a wave in which the United States is about to be swept up in. However, the opposition to universal health care in the United States is remarkably organized, remarkably resilient and shows no sign of abating in the near future. The reason for this opposition is complex and by no means does this paper encompass the reasons for failure in their entirety. However, it is clear that a few trends are worth noting that have separated the United States from the other wealthy (and often not so wealthy) nations of this world in relation to the type of health care system we have embraced.

The first aspect of importance relates to the way that reform movements are developed within a nation. There are (as Markoff notes) often developed on the periphery of developed power structures as they were in the poor, agrarian Western provinces on Canada. Alternately, reforms can be instituted from the core of the central power structures if there is the will and ability for that central power structure to implement reforms. This was the case in Norway which had a long monarchical history of centralized authority and in which federal control was based on the principle of unitary government control. Neither method would be fortuitous for the United States. Although there were examples of peripheral reform movement in the United States (e.g. early suffragist success in Wyoming), yet another aspect conspired to reduce the likelihood of such reforms being successful in the United States – the opposition movements.

Peripheral development of universal health care in Canada was largely localized and a reaction to local problems. Even by many physicians' accounts, the unique economic conditions in Saskatchewan necessitated a more communal approach to medicine. Because of this, the

earliest reforms (municipal doctors and universal hospitalization) were often without wide professional opposition. Local physician support made it more difficult for the comparably weaker CMA to oppose such programs even if they were antithetic to its purpose. The CMA as an organization had developed as a less centralized structure that was more a coalition of regional medical associations. This contrasted greatly with the AMA, which in relation to late 19<sup>th</sup> century professional problems (increased competition and lower salaries) led to a top-down restructuring that placed the AMA at the top with indirect control over such local decisions as doctors' hospital privileges. In light of this, physicians in peripheral areas were less likely to support reforms without the AMA's approval as they could be subject to sanctions. Additionally, the AMA showed a willingness to mount vigorous opposition to reforms they felt were against their interests. The growths of universalist movements on the periphery of the United States were unlikely to be ignored as they were by the CMA in Canada.

The next factor in the lack of universal coverage in the United States relates to prevailing ideologies within each nation. Canada and Norway both had an ideological basis (nationally in Norway and regionally in Canada) to support universal health care. Universality, as a health care principle, is inherently related to the 'rights' perspective. This perspective, as enumerated in the 1948 United Nations declaration, declares that health care is a basic human right of which all should have fair and equitable access. The human rights perspective is not necessarily Marxist but will likely flourish in areas in which Marxist ideology is accepted political philosophy. The connection between universal health care and Marxist ideology is a natural fit with Marxian distrust of market mechanisms. At the heart of the debate over classic liberalism and Marxist ideology is the role of the market. In the liberalist society the market is the corrector of inequalities thus there is robust support for market involvement in nearly every sphere of society. Contrast that with Marxist ideology that presupposes the market as the *cause* of inequality. The goal then becomes, amongst Marxist leaning parties (Social Democrats, CCF etc...), to de-commodify those services and goods that are viewed as inherent rights. The

socialist parties in Norway have been the dominant parties (DNA and SV) since 1927 and coupled with a strong centralized structure hearkening back to monarchical reign, enactment of universal care reforms were much easier. In Saskatchewan, the ascendancy of the CCF also created conditions that were favorable to the enactment of universal health care.

The prevailing laissez faire ideology in the United States has made the enactment of universal health care difficult. With strong roots in Adam Smith's reasoning, there is a lingering notion that the involvement of the state in all aspects should be minimal. As a liberal welfare state, the work-ethic norms have helped rationalize a system in which welfare benefits are modest, means-tested, and often stigmatic for recipients. Under this ideological umbrella, health care became a private enterprise with the patients and the services highly commodified. Within this ideology, it has been difficult for reformers to find a cohesive unifying message for which to rally the banner for universal health care. The lack of widely accepted Marxist ideology has made it difficult for universal health care schemes to gain traction; the outright hostility towards Marxist ideologies has made it nearly impossible for universal healthcare to be enacted.

In the end, a robust collection of factors – ideology, special interest opposition, and government structures – have hampered the ability for Americans to coalesce around a unified movement towards national health care. Moves towards universal health care reform are on the periphery of the American mainstream. It is not the healthy, fertile periphery that Markoff writes of, but at the very edge of the American mainstream suspended at the edge of special interest misinformation and lies, citizen fearfulness, and dead and dying ideas.

## CHAPTER 6

### REFLECTION ON THE FUTURE

The lack of universal coverage is once again in the spotlight as another presidential election cycle is in progress. American's are increasingly unhappy with the status of health care coverage in the United States. In part, this may be related to the increasing number of employers who are not offering coverage or are offering increasingly expensive health insurance to their employees. Increasingly, the problems of getting quality health insurance are spreading from the poor into the middle classes. However, the question that remains is how likely is it that the United States will develop a program of universal coverage in the near future?

Unfortunately, it seems unlikely that such a program will be forthcoming. There are a few reasons this is still unlikely. First, there is the role that special interests will play in any debate on the topic. The health care system is still largely dominated by medical professionals (especially physicians) and there is little to indicate that as a collective organization (the AMA) those physicians will support large changes to the health care system. However, individually physicians are leaning towards a universal care scheme it is yet to be seen if that will be reflected in the policy of the AMA. Furthermore, the private insurance companies are a powerful and influential special interest group in their own right. As was seen in the 1990's push for universal health care in the United States, the insurance lobby was able to find sympathetic ears in the government as well as by setting the public agenda through advertising that helped create fear in an already unconvinced American population. There is no reason to think that will not happen again.

Secondly, the ideological basis for universal coverage may not be sufficient in the United States to allow for the creation of a universal coverage scheme. Though people are increasingly dissatisfied with private insurances dominance in the United States, it is unlikely

when interests group air out public insurance schemes that it will come out appearing as anything other than socialized medicine. Unfortunately, the application of the label of socialism to any program of universal coverage is very likely to be the kiss of death for that program. There is a long and lingering distrust of anything Marxist in America, and I see little reason for there to be any change in the near future. In the end, the compromise coverage solutions being proposed by Clinton and Obama are probably unworkable. They essentially offer the possibility of a public system while retaining the private system of health insurance. This is unlikely to be acceptable for the ideological reasons, there will still be enough 'socialism' for special interests to attack I suspect. Additionally, the benefit of a true universal insurance scheme (in single payee systems like Canada or in more centralized programs like Norway) is the ability to control costs more effectively than private insurance systems. There are many preventative health measures (e.g. regular check-ups, immunization programs, proper disease control) that a nationalized system could institute that could bring down costs associated with non-treatment issues that are prevalent in the United States. Without a national program, any new system is unlikely to do much to control medical inflation, which means that the government would essentially be picking up the tab for the millions of uninsured while the private insurers would remain to treat the lucrative patients. The candidates' present a system that is palatable but unrealistic. From a political standpoint, there is little evidence that the coalition necessary for such a large-scale reform would be able to be created, since right now, the issue is pretty clearly delineated with Democrats generally supportive and Republicans almost universally opposed. Therefore, in addition to the ideological chasm that would need to be bridged, there are practical elements within the political structure that would need to be overcome.

This leads to the next difficulty, which was the inherent difficulties in the federal system of government that make universal health care important. Since, in the United States, the parties are well defined and their positions nearly immutable it is difficult to see how change would come. One structural hurdle, the role of the national government, has been largely

overcome with successive government since F.D.R. It is no longer a structural issue since the national government has increasingly gained in strength since the 1940's. A recent example of this can be seen in the realm of education which has nearly always been a state issue and concern – but which with increasing addition of national standards and control culminating in bipartisan No Child Left Behind legislation been placed under the effective control of the national government. The arguments against universal health care are no longer posited within the doctrine of federalism – though it is not impossible to see that argument also returning, but more than likely as a convenient argument of anti-universal health care coalition building than true doctrinal support.

The struggle for universal health care (and more broadly for a more de-commodified) welfare state will seemingly continue for the near future. There are a few lessons to be learned, though, which can lead towards the enactment of a universal health care program. First, a broad coalition of open partners should be courted towards the goal of developing universal health care. This coalition should include consumers, physicians, business leaders and politicians. However, seemingly antithetical business may hold a crucial role in the development of a universal health care. Businesses have absorbed a large cost of the inflationary prices of providing health care. A national system *could* free them from the burdens of yearly re-negotiated insurance schemes that they bear the cost burden of. In fact, globalization maybe a key ally in this battle. Many businesses, certainly the largest and most influential, already operate with employees in many nations. These businesses are well aware of the operation of national insurance schemes as many of the overseas employees are on them. As they are increasingly hit with the probability of providing less insurance for more money (and thus insurance could stop being an effective retention benefit), the possibility of government sponsored universal insurance schemes will not seem so bad.

It is likely that physicians will have to be brought on board outside of the AMA, at least at first. As was previously noted physicians increasingly support the concept of universal

coverage. These physicians need to be brought into a coalition to help promote the ideals of universal coverage. There are already physician groups sprouting up to promote universal coverage (and very optimistically, many of those are young physicians). What is needed is more coordination at the national level amongst these groups.

Tied to this we will need strong national, regional and local political support to make this a reality. Politicians will need to take this issue on with the dogmatic determinism that some showed towards various civil rights. In that aspect we can, all make a difference by encouraging our politicians to view this in just that way. Health care needs to be brought back in the public forum as a right – inherent and natural – that is beyond simple remunerative considerations. For this we will need the same coalition plus informed citizens, commentators and social activists

Lastly, though this may be too much to hope for we need the same people to open the political debate to look deeper into the social and political assumptions that we as a nation are operating under. European Labour leaders, especially those from the United Kingdom like Tony Blair, are warmly welcomed and highly regarded in our nation. France bashing aside, Americans does not necessarily view Europeans as inherently less than us. It is time for politicians, activist and citizens to open up the dialogue as to type of government and nation we want to live in. At some level, socialist (or social democratic) doctrines will need to be examined in our own context. Political liberal groups will need to open that door. The paucity of such discussions is at the heart of the very inequalities (health care and otherwise) that America has and will struggle with for a long time to come.

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## BIOGRAPHICAL INFORMATION

Christopher Biedenbach is a graduate student completing a Master in Arts in Sociology at the University of Texas at Arlington. He will be pursuing a Doctorate in 2008 at Kent State University. He hopes to continue his studies with focuses on social theory and inequality, and would eventually like to publish within those realms. Chris has served in the U.S. Army, has taught high school in Alaska and Texas, but looks forward to spending the next few years working towards a PhD as a full-time student.