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Interest groups, public opinion, and path dependence: how Canada and the U.S diverged on healthcare policy

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INTEREST GROUPS, PUBLIC OPINION, AND PATH DEPENDENCE: HOW CANADA AND THE U.S. DIVERGED ON HEALTHCARE POLICY

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"Courage, my friends; 'tis not too late to build a better world." – Tommy Douglas.

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ABSTRACT

Despite being comparatively similar countries, the United States and Canada have taken very different historical tracks to developing their respective health care systems. While Canada incrementally developed a system of universal coverage through national public insurance, the United States repeatedly failed to achieve universal healthcare reform and infamously maintains its hybrid public-private system to this day. Scholars of comparative politics have produced numerous competing accounts of the conditions under which health care policy change occurs and explanations for the major factors that shaped policy divergence. However, there are few studies dedicated to explaining mechanisms for continued policy divergence and its impacts on public opinion. In this thesis, I comparatively examine the passage of Medicare in the United States in 1965 with the Canadian Medical Care Act of 1966 and present the results of a nationally representative U.S. public opinion survey. I find that a mechanism of path dependence, whereby interest groups and constituencies that participate in policy battles are strengthened or curtailed by their outcomes, weighed disproportionately on the power of the former in the United States. In Canada, path dependence created a stalemate in which early forms of policy entrepreneurship made healthcare expansion and reduction equally

difficult to achieve. The contemporary survey reveals that U.S. public opinion largely favors healthcare reform on matters of principle rather than policy.

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LIST OF ABBREVIATIONS

AMA	American Medical Association
CCF	Co-operative Commonwealth Federation
CMA	Canadian Medical Association
CPSS	College of Physicians and Surgeons of Saskatchewan
FFS	Fee-for-service
KOD	Keep Our Doctors
MCIC	Medical Care Insurance Commission
MDS	Municipal Doctor System
NDP	New Democratic Party
PPACA	Patient Protection and Affordable Care Act
SHIP	Saskatchewan Hospital Insurance Plan

CHAPTER ONE

Introduction

In 1966, Canada took a decisive step in expanding the postwar welfare state by establishing universal public medical and hospital care nationwide through its Medical Care Act. This government policy remains a source of significant Canadian pride and identity three quarters of a century later. However, despite several attempts at doing so, the neighboring United States has still not established a similar program; instead, they implemented public programs for vulnerable sections of the population through Social Security Amendments in 1965 and have made few major leaps in public healthcare provision since. For Canada and the U.S. to diverge in this way on such a significant policy issue is quite unique, considering the parallel developments observed in so many other areas. The two countries are politically, economically, and socially similar; in addition, they share cultural and historical origins, neighbor each other, and are both federalist in structure (Maioni et al., 2014; Sakala, 1990). Furthermore, even in cases where they are meaningfully different, they still maintain more comparable historical trajectories than with any European country. Thus, we would expect them to follow relatively similar pathways in the development of their respective welfare states.

However, this has not turned out to be the case. Whereas Canada provides universal coverage through government-funded insurance, the United States' only public programs are Medicare for the elderly and Medicaid for the poor, while most other Americans are covered through private health insurance or not insured at all (Maioni, 1997). The development of different kinds of healthcare systems seems to be the most

comparatively distinct policy outcome between the two, yet both were achieved through incremental changes with a great number of historical policy battles. What is especially confounding about this divergence is the way it has shaped public opinion. Even under challenges of rising costs and waiting times, Canada's system of universal public health insurance continues to carry strong public support, which continuously blocks politicians and interest groups from engaging in austerity politics. In the United States, however, public opinion demonstrates varied levels of support for public healthcare, an area that is highly vulnerable to issue framing. U.S. Medicare is one of the few healthcare issues that seems comparatively similar to Canada's system in terms of public support. These conditions are compelling grounds to comparatively examine historical developments in the two countries and investigate how they diverged on this issue, as well as why the distinct outcomes of key policy battles remain.

This thesis will attempt to wrestle with this policy divergence and provide a mechanism for its continuation throughout the 20th century to the present. I will examine and compare the events that led up to the passage of Canada's Medical Care Act of 1966 and the Social Security Amendments of 1965, the latter of which implemented Medicare in the United States. I acknowledge and consider several explanatory factors offered by the literature, including the role of interest groups, public opinion, and historical precedent, as well as numerous alternative explanations that address electoral frameworks, institutional barriers, and race. While some combination of these can be used effectively to explain the results of individual policy battles, or to describe the largest barriers to healthcare policy development in both countries throughout the 20th

century, I argue that a broader causal mechanism for their *continued* policy divergence is necessary for understanding the conditions under which policy can either converge or continue to diverge in the future. Understanding the reasons why a specific policy proposal failed in a historical context is valuable if it succeeded elsewhere in a similar timeframe to determine causal factors. However, it is even more useful to decipher how those episodes in policy development carry repercussions for future ones, especially when existing policy conditions, relevant constituencies, and institutional structures become entrenched and legitimized as a result. A mechanism for this sort of historical process could extend its applicability to case studies at any point in the policy development of healthcare systems while also providing cumulative explanatory factors for how the public is conditioned on policy issues. As a result, the tenacity, or potential malleability, of contemporary public opinion provides a window into the long-term effects of continued policy divergence.

Therefore, in addition to a case study analysis of Canadian and U.S. healthcare developments from the 1940s to the 1960s, I have deployed my own public opinion survey in the United States. I expect incremental healthcare policy developments in both countries to be contingent on a "path dependence" mechanism whereby the lobbying power of interest groups opposed to reform and prior policy entrepreneurship by political actors respectively divide or unify public opinion on public healthcare alternatives. Interest groups become stronger by maintaining autonomy in private practice and developing new markets to grow their sphere of influence in policy matters, thus keeping a vested interest in preserving the status quo and dividing public opinion. Meanwhile,

public opinion can be reinforced and made cohesive by policy entrepreneurs who render the effects of public healthcare materially visible as well as viable as an alternative to existing private structures. Policy battles are decided by how well these two groups use their organizational and lobbying power in addition to whether they can convince the public on the benefits of their preferred systems. Thus, without successful initial public policy implementations, public opinion remains vulnerable to ideological framings and manipulation when presented with alternatives to existing healthcare policy, as is the case during ongoing healthcare reform episodes. This mechanism helps to explain why Canada's public healthcare system and the United States' public Medicare program both maintain resiliently high levels of public support, while views on the hybrid U.S. healthcare system and polling on alternatives remains polarized or "inconsistent".

This comparative approach to public policy will provide a more concrete picture of not only the context in which policy develops, but also of how it either becomes self-reinforcing or paves the way for new political opportunities. The method also seeks to apply a theoretical, comparative approach to public policy as established by policy legacy authors. Much of the literature on these two case studies places heavy emphasis on the tactics used by political actors to secure power or pass legislation; however, a "policy-focused" approach to the history of healthcare development instead prioritizes the feedback effects of public policy and how it shapes its own institutions, creating a fuller picture of the long-term processes that lead to contemporary outcomes (Schattschneider 1960; Hacker & Pierson 2014). Rather than thinking of political history as a one-directional causal pathway, we should instead think of its individual moments both in

terms of the ways in which outcomes differ from the past, and how they affect the power of forces which mobilize in response. While not a comprehensive study of healthcare developments in Canada and the United States, this thesis will attempt to contribute to a broader understanding of the dynamics of policy history.

Literature Review

Interest Group Influence

A recurring theme of studies on the differences between Canadian and U.S. healthcare developments is the degree of conflict in the interactions between interest groups and government-led reform efforts. In the United States, private sector interests have had a strong influence on health policy for almost a century. A few decades after Theodore Roosevelt advocated for a national medical care program in 1912, Franklin Roosevelt attempted to include such a plan in the New Deal but failed to do so after facing opposition from insurance companies (Sakala, 1990). The subsequent inability of the Truman administration to adopt a plan, and the conservatism of the 1950s, led supporters of public healthcare to adopt a more incremental strategy that focused on insurance for elderly Americans, which later became Medicare. In the 1970s, organized labor and grassroots activists began to rebuild support in Congress for a comprehensive national program but were derailed by the sudden Watergate scandal, after which support faltered once more (Sakala, 1990). Private insurance and other interests, such as the American Medical Association (AMA), have played a large role in blocking or otherwise decreasing the scope of reform throughout these periods, as well as in dismissing the

applicability of the Canadian model. While the AMA today has dramatically changed their position on reform since the 1960s, the organization still does not support national public health insurance, instead advocating for the government to build on the Patient Protection and Affordable Care Act (PPACA) (AMA).

The strength of U.S. private interests and their consistent mobilization against reform has also historically placed heavy burdens on supporters of reform. While some of the national social movements that emerged in the 20th century generally supported universal healthcare coverage, political actors that ran reform campaigns concentrated on rhetoric defending reform against opposition attacks instead of mobilizing the public. As a result, support for healthcare reform reached high levels at numerous points but did not themselves generate large-scale movements to back up that support, and healthcare never became a mobilizing issue comparable to the other social ills of the times (Hoffman, 2003). When grassroots movements emerged advocating for civil rights, gender equality, workers' rights, or people with AIDS, these movements demanded reform of the healthcare system only on issues concerning the populations they represented and failed to leverage their power on more than incremental changes to it. Consequently, social justice movements never maintained high mobilization levels and comprehensive demands at the same time, despite some eventually calling for universal access (Hoffman, 2003). Incremental approaches became the primary vehicle for public demands in the face of strong private sector opposition.

While Canada encountered some resistance from physicians to a national health plan in the 1940s and 1950s, most supported the idea of publicly funded healthcare and

advocated for a parallel private system to go with it. However, unlike in the United States, private health insurance was a relatively new and growing phenomenon that was not politically strong enough to advocate or lobby against the plan favored by public officials, who believed that providing insurance for poorer and more at-risk citizens, without drawing resources from wealthier and less at-risk ones, was financially unsustainable (Sakala, 1990). Nonetheless, due to a continued lack of pharmaceutical insurance and the presence of private practice, the public nature of Canadian healthcare has faced increasing challenges in the past few decades. The rise of neoliberalism and right-wing think tanks since the 1990s have brought significant government cuts to healthcare spending, as well as a rekindling of the debate as to whether a parallel private insurance system should be permitted (Macdougall, 2009). Brian Hutchinson (2008) argues that the simple existence of private interests in Canada, though not as powerful as those in the United States, generates attempts at challenging the current system by virtue of the capitalist drive to search for new markets and limits the ability of government to expand beyond medical and hospital insurance. The presence of a private medical sector in some form helps to explain why Canada still operates under the fee-for-service (FFS) model, or why it is unique among OECD countries in not having pharmaceutical or prescription insurance. While Hutchinson believes the popularity of public insurance in Canada and entrenched feelings of social solidarity can more easily prevent a hybrid system from developing, this speaks to the ability of the private sector to influence healthcare policy even in a country with universal coverage.

That Canadian healthcare plays a key role in national identity is a view shared by numerous authors. Carolyn Hughes Tuohy (2018) places great emphasis on Canadian healthcare as "a leading, possibly the leading, symbol of Canadian identity". Crucially, Tuohy argues that Canada's current healthcare system was driven by political actors throughout the provinces before becoming a national plan. Despite physician strikes, political actors pushed the "single-payer" model in Saskatchewan, which created a domino effect throughout the other provinces and required minimal action by the federal government beyond consolidating legislation in the Canada Health Act of 1984. Tuohy, like many others, claims that it was these developments which created such a strong foundation for public support. This combination of political actors displaying a vested interest in one public plan and advocating for it early and locally paints a significantly different picture of the relationship between elites and the public than in the United States.

Manipulability of U.S. Public Opinion

There are a few aspects of U.S. public opinion throughout the country's healthcare history which illustrate its inconsistency, manipulability, and sometimes self-contradictory nature. One of these features is the significant drop in public support that takes place over the course of individual policy battles. Before the successful passage of the PPACA, there had been three major proposed plans since WWII: one by Harry Truman in the 1940s, another by Richard Nixon in the 1970s, and a final one by Bill Clinton in the 1990s. These three episodes share commonalities in the public's initial

willingness to support healthcare reform. Shortly before the creation of the Truman plan, 82 percent of U.S. citizens believed the government should assist the public with healthcare costs and 68 percent wanted recipients of Social Security to have their medical bills covered by the program (Blendon et al., 2006). By the time Bill Clinton announced his candidacy for President, a whopping 66 percent of Americans held a favorable attitude towards public health insurance paid for with taxes, and even Richard Nixon's plan was preceded by high rates of policy and healthcare liberalism. However, all three developments also featured significant decreases in support for the proposed reforms as time went on. Opposition to the Truman plan went from 38 percent in March of 1949 to 61 percent in October 1950, while support for the Clinton plan dropped from 59 percent in September 1993 to 40 percent in July 1994. According to Blendon and Benson (2001), three major factors contributed to these rapid drops in support: a lack of trust in government, no major consensus on comprehensive reform, and a public aversion to the costs that health reform would carry. In addition, opposition campaigns by the private sector of the healthcare industry have only made it more difficult over time for these reforms to pass.

What is particularly perplexing about the historical failures of healthcare reform and the drastic shifts in public opinion as policy battles wage on is that Americans consistently show awareness of the failures of their existing system. Public approval rates of healthcare in the U.S. have not increased past 30 percent in decades; furthermore, satisfaction with the national cost of healthcare hasn't exceeded 28 percent since 2001, while only 34 percent rated healthcare coverage favorably as of 2018 (McCarthy, 2018).

When efforts at healthcare reform were reignited during Clinton's candidacy in 1991, a shocking 6 percent of the public believed the system worked well, and an equally surprising 42 percent favored a complete overhaul of healthcare in the U.S. (Blendon et al., 2006). These rates of dissatisfaction are consistently higher than those for citizens in other comparable industrialized countries. It is quite surprising, then, that healthcare reform efforts have failed as frequently as they have throughout U.S. history with such a strong public desire for change.

Given the skepticism with which Americans greet proposals for public health insurance plans, it is thus also surprising that they show robust and continuous support for Medicare, the public insurance option for older citizens. Americans have demonstrated overwhelming approval of Medicare across time, with 72 percent and 88 percent of adults over the age of 65 maintaining a favorable opinion of the program as of 2011. Moreover, support for cutting Medicare to help reduce the national deficit is also consistently low, ranging from 10 to 36 percent across numerous studies despite the false belief held by 62 percent of the public that Medicare spending is on the rise (Blendon & Benson, 2013). The fact that Americans maintain such staunch support for what they believe to be a financially costly government-run program is at odds with many explanations for policy divergence. While the public does not perceive Medicare to be particularly different in terms of cost, quality, or access than private insurance, 61 percent believe that recipients simply aren't getting the care they need, 67 percent think that improving the financial stability of the program should be the priority, and most believe the program is hampered by government mismanagement and health sector excess

(Blendon & Benson, 2013). In other words, the public views Medicare as a successful government program that should be expanded and is exceptionally resistant to rhetoric used by opponents of the program. It is difficult to claim that Americans cannot be supportive of a public insurance program in the face of this public opinion data.

Canada features far more politically stable support for its healthcare system across the board. One of the most significant outcomes of Canada's long-standing and victorious fight for national health insurance is how it has reinforced Canadian civic ideology. Heather Macdougall (2009) argues that social welfare policy, and in particular universal healthcare, is deeply correlated with how Canadians view the role of the state and shared communal responsibilities of a federal society. The author elaborates that efforts at changing Canada's healthcare system throughout the 20th century, and the conflicts that emerged from them, reinforce the belief among Canadians that universal healthcare reflects national social values and a core component of Canadian national identity. Whereas political culture arguments would suggest that Canada's health system emerged from preexisting Canadian values, this article reverses the causal arrow and demonstrates the potent effects of path dependence and long-term policy effects. This means that contrary to public opinion in the United States, Canadian public opinion remains steadfastly supportive of national health insurance despite efforts from the private sector to lobby the government for cuts in health spending and regressive reforms to Canada's universal system.

Some authors seeking to explain the divergence in both outcomes and public opinion on healthcare issues place particular priority on aspects of political life which

they argue to be intrinsic to each country. Seymour Martin Lipset (1990) highlights that Canadians generally tend to be more supportive of state intervention and believe the government carries a greater responsibility to help marginalized parts of the population, while Americans are firmly anti-big government and instead highly charitable in private matters. These seemingly inherent aspects of Canadian and American ideologies make universality and public insurance possible in Canada but not in the U.S. Antoon Spithoven (2011) instead turns to the institutions of healthcare administration of each country, arguing that Canada took Europe's lead in developing their healthcare system while the United States followed its own unique trajectory. While the former has become reliant on careful government budgeting of public funds, the latter relies on both private funding and management, both systems entrenched in these fixed paths. These explanations would require a drastic change in either the collective values or forms of government for the United States to converge with Canada. Arguments like these, however, are highly consequential in that they justify outcomes far more than they explain them. Political culture narratives do not account for the propensity of the U.S. public towards reform or the strong favorability of Medicare; likewise, institutional rigidity may accurately assess historical developments but fail to explain how policy itself reinforces or changes these institutions. Doing so requires placing adequate emphasis on how reform advocates and interest groups interact with one another across different stages of healthcare policy evolution and the political legacies these individual conflicts create for future ones.

Path Dependence

The presence or lack thereof of policy entrepreneurs in the case of Canada and the United States, respectively, had immense repercussions for each country's ability to implement healthcare reform down the line. Katherine Boothe (2012) identifies two major theories in policy development: "path dependence", where policies are continuously self-reinforcing and make it more difficult to pursue alternative policy options, and "punctuated equilibrium", where the status quo endures for a given period until interrupted by some outside event that opens a window for reform. Andrea Louise Campbell (2012) further specifies the mechanisms by which the former occurs, arguing that new constituencies emerge from policies that can then advocate for their interests and mobilize against attempts to change said policies. Iris Geva-May and Allan Maslove (2000) elaborate on critical junctures in policy developments, demonstrating that key political contests where neither interest groups nor policy entrepreneurs secure an outright victory are more conducive to reform rather than when a healthcare system becomes financially problematic. These authors paint a detailed picture of the potency of policy continuity; while there are key points in a country's history that provide opportunities for reform, the circumstances under which healthcare policy was initially framed has long-lasting impacts which frequently determine how those opportunities present themselves.

What makes the effects of path dependence so striking is how public opinion in the United States and Canada started at extremely similar points before diverging in nearly the same manner as their political institutions. Polls taken in the 1940s showed

Canadian support for national insurance at around 60-70%, which the United States mirrored at similar rates. In fact, U.S. citizens were more inclined to support universal healthcare when no alternatives were proposed (Tuohy, 2018). Public opinion in both countries proved subject to influence by policy entrepreneurs, which continued to be the case for years in Canada and still is in the United States. At the time of the 1962 introduction of physician insurance in Saskatchewan by the provincial government, Canadians preferred a public option over a public plan by 55 percent, while efforts in the United States at the time were largely reduced to focusing on supporting what became the Medicare program (Tuohy, 2018). The direction of national healthcare at that point was not decided in either country and the ability of political actors to advocate for public insurance in Canada influenced the very framework by which Canadians now view the role of government in providing healthcare. We will see later that these effects are reflected in the differences between Canadian and U.S. public opinion.

The main advantage in identifying a path dependency mechanism, however, lies in how it distinguishes itself from other explanatory factors by emphasizing cumulative effects of policy and assessing different historical periods without creating a deterministic portrait of history. That is, the outcomes of policy battles at an early stage in the development of healthcare systems heavily influence subsequent ones; however, new opportunities for convergence or divergence present themselves at every stage of the policy trajectory. Furthermore, efforts at reform or preservation of the status quo in different periods can still be affected by exogenous variables and have the potential to tip policy battles in one direction or another. A mechanism for continued policy divergence

would be of little use if it argued, for example, that a few key events in the early 20th decided the institutional bounds of each country permanently or made any changes to their existing systems impossible. Path dependence provides a theoretical basis to explain the significance of historical developments without being prescriptive in assessing future opportunities for policy change.

Alternative Explanations

An alternative explanation for the divergence in healthcare policy lies in the significance of the United States' exceptional history with race in political battles for healthcare reform. Gerard Boychuck's (2008) book identifies 1912-1945 as the crucial era in U.S. politics that determined the causal trajectory of healthcare policy. As he puts it, race is responsible for both the lack of a "conventional left" in the United States as well as the role of southern politicians in preventing any national social welfare program that would change the power dynamics of racial hierarchy in that region. Indeed, the role of Southern Democrats in preventing much of FDR's New Deal from including benefits for Black Americans has been well documented. The author highlights their ability to do this by lobbying against Social Security nationally, while passing off racially inclusive policies such as Aid to Families with Dependent Children to state and local political institutions. In fact, the threat of southern resistance to social welfare programs was so powerful that specific measures favoring physician and hospital interests had to be enacted, resulting in higher long-term costs and a more powerful private sector. Boychuck believes these factors to have been highly influential in the development of

opposition to healthcare reform, which is what has made it so difficult to pass since the 1990s.

Another author points to the contrasting electoral systems of the U.S. and Canada. Antonia Maioni (1995) presents a different kind of historical argument: that the presence of more than two parties provided the differential factor. She argues that the United States' two-party system requires broad coalition-building and compromise, which was particularly necessary for the Democratic Party in the 1940s; in Canada, however, a viable left-wing third party was able to expand the Overton window and advocate for public health insurance. Maioni further argues this in a separate article (1997) with respect to the federal system and the ability of a Canadian social democratic party to develop healthcare reform within the provinces. This was particularly important from 1940-1965, which the author identifies as the point where healthcare policy in both countries diverged. These arguments emphasize how influential the early policy battles over healthcare in the United States were, and how uniquely American features of the political system influenced its development; however, electoral systems and race are both factors that should have created numerous other differences between the United States and Canada down the line. They do not adequately explain how the U.S. hybrid model has sustained itself for so long after those initial periods, nor how public opinion developed as a result.

CHAPTER TWO

Case Study: Canadian Universal Public Health Insurance

Saskatchewan Hospital Insurance

The struggle for and achievement of universal Canadian healthcare began during the 1940s in the rural province of Saskatchewan. The 1944 election of the left-wing Co-operative Commonwealth Federation (CCF) party, led by Premier Tommy Douglas, signaled a widespread desire of the public to expand the role of the provincial government in providing social services. This was especially true after the devastating effects of World War II and the Great Depression on the province's hospital financing system at the time (Marchildon 2009). The party won a sweeping 47 of the 53 seats in the Saskatchewan legislature and secured over half of the popular vote, becoming the first social democratic party to be elected in Canada (Whitehorn 2015). Led by Douglas, the party succeeded in 1947 at implementing the Saskatchewan Hospital Insurance Plan (SHIP), the first universal hospital insurance reform effort in North America (Flood et al. 2018). The plan included public coverage of all hospital services as well as an influx of funds for hospital construction grants, the former significantly increasing hospital use by the public and the latter allowing for an expansion of hospital infrastructure to match it. The number of occupied Saskatchewan hospital beds per 1000 people saw a 31% increase, from 5.1 in 1947 to 6.7 in 1951, as did days of patient care per 1000 beneficiaries, which surged from 1,678 to 2,209. As Aleck Ostry puts it, this boom in hospital infrastructure and the gains made in the ability of hospitals to provide crucial care "were unparalleled in Saskatchewan compared to any other province in the 1950s".

The visible and unprecedented success of Saskatchewan in supporting such a crucial public service had large ramifications for how other provinces dealt with this issue. Although Saskatchewan was alone in the universality and comprehensiveness of its hospital insurance program, four other provinces followed in implementing partially public hospital insurance reform, leading to the coverage of one third of all Canadians by the mid-1950s (Ostry 2009).

It is important to note that the success of these efforts did not come from a vacuum of existing policy or neighboring alternatives. Prior to WWII, Saskatchewan had delegated the responsibility of hospital financing through the development of Union Hospital Districts, which were co-ops formed by rural municipalities that paid for hospital development through local taxes on property owners and individuals. Rural residents of Saskatchewan likewise formed co-ops to pay for healthcare services from doctors known as the Municipal Doctor System (MDS), creating a sophisticated and low-cost pseudo-public infrastructure before the provincial hospital initiative even came to be (Ostry 2009). These local systems provided evidence to the people of Saskatchewan that public funding for healthcare yielded beneficial results, a conclusion not yet reached by the rest of the country. Exemplified by the fact that other provinces only adopted partial coverage plans in the 1940s, the postwar federal government had also begun subsidizing an existing private hospital care system, which was technologically advanced yet incredibly costly in comparison to the rest of the world (Hacker 1998). The parallel development of public insurance policy at the provincial level and private insurance interests stemming from federal policy was a powerful early indicator of healthcare

policy battles to come and the mobilization capabilities of advocates on both sides of the issue.

The success of the Saskatchewan government's hospital insurance policy had enormous spillover effects for both the other provinces in Canada as well as the federal government. British Columbia and Alberta quickly followed Saskatchewan in adopting limited hybrid insurance programs in 1948 and 1950, respectively. Ottawa likewise passed hospital insurance policy conditional on support in sharing costs from the federal government, signaling that a once-provincial healthcare agenda would soon become the basis for significant change in the federalist Canadian power structure (Hacker 1998). The push for the federal government to develop a shared-cost hospital insurance program, and later a national hospital insurance plan, came from several directions in the decade following the implementation of Saskatchewan's policy. Firstly, the CCF government's gains after the war were not solely regional as the national wing of the party began to threaten the Liberal Party's majority. In order to preserve their coalition's advantage over the Conservatives, the Liberal government was forced to adopt some of the CCF's proposals during a national conference in 1945, including healthcare reform (Hacker 1998). Secondly, Saskatchewan had not been the only province to struggle with hospital costs after the war; the economic boom that came after led to growing hospital sectors across the country and incentivized provinces to secure financial assistance. With Saskatchewan providing a hospital insurance program that was both practical for covering marginalized populations as well as politically popular after its implementation, it became a model for other provinces and the federal government (Ostry 2009).

Thus, after the passage of the national Hospital Grants Program in 1948, it did not take long for the federal government to move toward universal hospital insurance. The national coalition considered the different provincial programs and negotiated on a national one from 1955 to 1957, ultimately abandoning the Alberta model's hybrid voluntary subsidy plan in favor of a single payer one guaranteeing universal hospital coverage named the Hospital Insurance and Diagnostic Services Act of 1957 (Flood et al. 2018; Marchildon 2014). This policy faced far more organized opposition than the one adopted by Saskatchewan a decade beforehand. By its implementation in 1958, Canadian healthcare had become far more expensive and subsequently developed a stronger private sector which resisted the government's movement on the issue (Hacker 1998). The national Canadian Medical Association (CMA), which supported a federal public health insurance initiative in 1934, dropped its support in 1949 and did the same for national public hospital insurance in 1956 (Ostry 2009). Despite the success of public healthcare reform at both the provincial and federal levels, organized private interests began to emerge and counter-mobilize through the 50s and 60s at both levels as well.

The Battle for Saskatchewan Medicare

After nearly twenty years in power, Douglass and the CCF won another reelection in 1960 on the promise of extending existing healthcare coverage to physician services (Flood et al. 2018). The election was hotly contested due to the emergence of the organized medical profession in the form of the College of Physicians and Surgeons of Saskatchewan (CPSS), which heavily opposed the CCF government and "spent more

money on electronic and print media [during the 1960 provincial election] than any political party" (Blakeney 2009). In similar fashion to their national counterparts, doctors in Saskatchewan had actually demonstrated general support for government-led public initiatives in the health sector. Doctors had cooperated with the Douglass government on initiatives that helped the poor because it meant greater payment guarantees compared to the Depression when doctors sometimes did not receive payment at all (Simpson 2012). In addition, the aforementioned hospital insurance program had made Saskatchewan doctors the highest paid in all of Canada; however, it had not stemmed private physician insurance, which covered some 288,818 people or 31.6% of the Saskatchewan population by 1960 (Ostry 2009). The result was an emerging and organized constituency with an interest in protecting private practice from government interference. Saskatchewan doctors at the time understood the need for the government to cover some parts of the population in the form of subsidized care and hospitalization but wanted to maintain control over the administration of these subsidies and became increasingly worried that the steadily increasing expansion of public coverage would descend into a government takeover of physician practice and insurance. Nor was public support for the doctors' approach insignificant, as private practice had become somewhat accepted by the populace (Simpson 2012). As was the case in the United States, the buildup of private institutions alongside an incremental government approach to healthcare reform generated a strong interest constituency which would come to use its power to contest policy changes.

What followed was one of the most contentious policy battles in Canadian history. As the CCF government proceeded on developing a plan for public provincial health insurance, a coalition of "provincial Liberals, business interests, pharmacists, dentists… and, of course, doctors" formed what were called Keep Our Doctors (KOD) committees and began mobilizing against the plan. These committees circulated newspaper ads and petitions, organized meetings and protests, and prepared a large-scale strike against the government (Simpson 2012). In 1961, the Saskatchewan CCF government introduced and passed the Medical Care Insurance Act, which was scheduled for implementation in 1962. Although the plan was to be administered by a newly created Medical Care Insurance Commission (MCIC) with the participation of Saskatchewan doctors, the CPSS announced that it would refuse to appoint any of its members to the commission (Blakeney 2009). In the summer of 1962, the CCF government, now under the leadership of Premier Woodrow Lloyd after Douglas removed himself to create the national New Democratic Party (NDP), faced a doctors' strike from organized medicine which lasted 23 days. Although they were coordinated, the government responded by choosing not to mobilize which resulted in disproportionate, negative press coverage of the strike compared to the legislation. Public support for the government's efforts proved to be steadfast due to public approval of the former expansions the CCF had made to healthcare (Simpson 2012). Thus, while interest groups attempted to organize and manipulate public opinion, the visible effects of public policy created constituencies that strengthened future policy proposals.

Once it became clear that organized medicine would not be able to prevent the CCF government from proceeding with its campaign promise, representatives from the CCPS met with provincial government officials and signed what was to become the Saskatoon Agreement (Simpson 2012). While the CCF government had been able to hold strong on its policy goal and establish a universal single-payer mechanism, organized private practice had simply become too strong to ignore completely in the implementation of public health insurance. The agreement preserved a significant degree of autonomy within the profession and allowed doctors to "use physician-controlled private plans as fiscal intermediaries, to bill patients insured by the public plan directly and at rates above those paid to the patients by the plan, and [kept] the profession's preferred method of reimbursement, [FFS] payment", the latter which became institutionalized (Hacker 1998). These features of the compromise, particularly the FFS reimbursement, were "seen as a major capitulation by the CCF government that preserved the power of organized medicine and prevented the emergence of a more preventative approach to health care" (Marchildon 2009). Whereas hospital insurance was far easier to pass a decade beforehand due to a pre-built municipal infrastructure and support from provincial doctors, the new realities of organized doctors and private insurance practices meant that the CCF government became increasingly limited in its ability to meet its initial goals. However, it is entirely possible that a total government capitulation and abandonment of the pursuit of universal healthcare would have completely changed the trajectory of public insurance policy in Canada in the decades to

come. The outcome of this regional policy battle would, in fact, define future clashes between strengthened interest groups and support for public healthcare expansion.

The Canadian Medical Care Act of 1966

In the same way that Saskatchewan became the model for national hospital insurance in the 1940s and 1950s, the rural province would likewise go on to inspire the national plan for universal public health insurance. This time, though, the circumstances had changed; namely, organized medicine proved to be in a much better position to contest the ever-expanding role of government in healthcare. By the time Saskatchewan led the charge on universal public coverage, doctors and private insurance had become politically strong enough to negotiate or exclude key points of healthcare legislation and maintain a foothold in the implementation process at several stages. This was even more true in the case of other provinces that created hybrid public-private systems. In 1963 Alberta had established its "Manningcare" (named after premier Ernest Manning), which subsidized individual citizen purchases of private health insurance and provided a public plan for those who either could not afford or were refused by private insurance. Ontario's plan the same year provided subsidies as well and emphasized voluntary enrollment, while Social Credit Premier William Bennet in 1965 British Columbia developed one building off existing non-profit insurance as well as a public option for low-income and high-risk individuals (Marchildon 2014). As a result of these developments, most provinces were opposed to the adoption of totally public health insurance at the national level, particularly because such a plan would override the ones they had developed

regionally. A coalition of provincial governments, alongside their chambers of commerce, the CMA, and the insurance industry rushed to develop alternative and pragmatic plans as the federal government began to consider new reforms in the 1960s, especially due to the precedent of universality established by hospital insurance reform in 1957 (Marchildon 2009). This coalition also used ideological rhetorical messaging not unlike the kind still heard today to defend private insurance. In 1963 the Ontario Minister of Health argued that "adult people should be left with the right to determine for themselves what they should do in such matters, to accept such things as normal responsibilities, or to reject them should they so choose" and referred to the elimination of private insurance as an "assault on the rights and freedoms of the individual". Ernest Manning in 1965 went on national television and referred to universality as "a compulsory program in which participation is compelled by the state and not left to the voluntary choice of the citizen" and emphasized that taxes would be used to pay for the medical insurance of those who could already afford private services (Marchildon 2014). The Saskatchewan Doctors' Strike had emboldened the ever-increasing opposition to public health insurance, placing the future of healthcare policy expansion in doubt.

Ultimately, however, a more powerful pro-public insurance coalition prevailed. In the early 1960s, universal health care had the backing of the CCF government in Saskatchewan, organized labor, several public advocacy organizations, the left-leaning portion of the national Liberal government, and popular support from the Canadian public (Marchildon 2009). The national branch of the CCF allied itself with an increasingly powerful labor union movement and rebranded as the Douglas-led NDP in

1961, forcing the hand of the Liberal party to form a coalition with them in 1963 and placing several left-wing reform advocates in the Cabinet (Hacker 1998). As the new federal government considered the different health insurance plans that emerged from the provinces and additional negotiations, a Royal Commission on Health Services led by Justice Emmett Hall was formed to investigate the potential effects of these options. The Commission delivered its report in 1964, advocating the Saskatchewan model as a basis for national health care due to "the lower costs associated with single-payer administration and the benefits associated with the coverage of an entire population on the same terms and conditions" (Marchildon 2014). The opposition predictably fought this recommendation; when the CPSS appeared before the commission, its representatives said that their members would not practice under the proposed plan and would instead continue to serve their patients under private insurance (Blakeney 2009). Nonetheless, the pressure from the Hall Commission and the insistent NDP led Liberal Prime Minister Lester Pearson to meet with provincial premiers in 1965 to discuss the federal plan. Pearson highlighted four conditions for federal funding of provincial health insurance across Canada; one of which, universality, was only supported by the provinces of Saskatchewan, New Brunswick, and Newfoundland. (Marchildon 2014). In the face of continued pressure from the NDP and public opinion, however, the Liberal Canadian government finally passed the Medical Care Act of 1966, known in Canada simply as Medicare. Once the governing coalition secured party discipline, the minority parties surrendered to the immensely popular plan, resulting in passage of the legislation with only two dissenting votes (Hacker 1998). Once again, the initiative of a single rural

province set the stage for public opinion to fuel the drive for universal public healthcare despite mobilized opposition from the private sector.

It is important to note that these developments were by no means deterministic in the forging of Canada's healthcare system. At the height of several of these policy battles, it was entirely possible for private interests to succeed in preventing universal public health insurance, as indicated by the infamous Doctors' Strike and the plethora of hybrid plans offered by several provinces. Furthermore, the victory of universality and the elimination of private insurance by no means led to the elimination of the opposition. The momentum gathered by organized medicine up until 1966 as well as the increase over time of the cost of Canadian healthcare meant the federal government still had to base the Act on the private, free-for-service model entrenched in existing policy. Likewise, the provinces were responsible for managing the federally subsidized insurance, which "froze into place" the healthcare structure for decades to come (Hacker 1998). Healthcare coverage in Canada since the 1960s has changed very little, covering hospital and physician services yet still excluding prescription drugs, home medical devices, home care, and dental care despite the emphasis early policymakers placed on eventually expanding Canadian Medicare (Flood et al. 2018). Policy battles in the 1960s cemented consistent public defense of universal coverage, but the continuous existence and growth of organized medicine has effectively turned most major policy battles since then into political stalemates (Marchildon 2014). Had interest groups and the other provinces further limited the breadth of Canadian Medicare coverage in the 1960s or had the CCF/NDP succeeded in changing the FFS component of the public models at any point,

there might have been less or greater policy divergence from the United States in the second half of the 20th century. Instead, new policies from early advocates of public insurance generated positive public opinion outcomes themselves and created a domino effect on the other provinces and the federal government, preventing a situation similar to the United States from developing yet only managing to parallel the strength of political opponents in the long-term.

Case Study: Medicare in the United States

Truman's Postwar Healthcare Efforts

In many ways, the state of healthcare policy and opportunities for reform in the United States were very similar to those of Canada during and after WWII. The war had made national public health insurance an incredibly popular policy program, with over 74 percent of the public in support in 1942 (Hacker 1998). Like Canada, the federal government's reach in matters of the welfare state was highly limited and administration was left to subnational entities, albeit with more of them in the United States than its northern counterpart. The states likewise delegated its programs and service deliveries to private actors, including nonprofits, professionals, and for-profit firms (Morgan & Campbell 2011). Federal policy before the end of the war took advantage of this existing structure, with the War Labor Board allowing employers in 1942 to offer limited health benefits to their employees in an effort to increase demand. Employer-sponsored hospital insurance soared as a result, increasing the number of Americans covered by private plans from 12 million to 32 million between 1940 and 1945. Once unions secured

collective bargaining agreements with tax exemption for employee health benefits, that number rose to 76.6 million in 1950 (Hacker 1998). By the time Harry Truman succeeded President Franklin D. Roosevelt in 1945, he was in a strong position to proceed with his predecessor's Economic Bill of Rights and advocate for "health security for all, regardless of residence, station, or race - everywhere in the United States" (Kinney 2015). Backed by organized labor and equipped with a governing majority during his reelection in 1948, the opportunity for policy entrepreneurship in a postwar setting seemed more than plausible. This was particularly true as the national government began to significantly expand the responsibilities that came with the New Deal (Morgan & Campbell 2011). The United States was poised to follow a similar trajectory as Canada in the implementation of limited federal healthcare at an early stage of its policy development.

However, Truman's initiative would come to face too many obstacles and fail where policy initiatives in Canada succeeded. The most pressing political issue came from within his own party; although he held a majority, Democrats were divided between their industrial Northern and conservative Southern counterparts, the latter of which was infuriated by Truman's civil rights advocacy. Southern Democrats formed a cross-party coalition with the Republican Party, effectively blocking not only Truman's universal healthcare policy, but all other government attempts at social and economic reform supported by organized labor and the industrial north. The potency of this coalition was exemplified by the fact that they secured over 92 percent of Congressional votes where the coalition was in alignment (Hacker 1998). The success of New Deal initiatives and

their expansion of government responsibility created a backlash in the postwar years as conservative Congressional figures worked to delay or obstruct the capacity of the federal bureaucracy. This forced the expansion that did occur to rely significantly on the delegation of authority in policy implementation to non-state entities (Morgan & Campbell 2011). In addition, interest groups composed of employers, physicians, and insurance companies that had benefited from a delocalized private healthcare system threw their support behind Congressional conservatives and framed their position as "a patriotic defense of American values of individual freedom and limited government". These groups had characterized compulsory health insurance as an invention of the Germans during WWI and went on to fiercely oppose "communist-inspired socialized medicine" at the start of the Cold War (Starr 2018). The AMA spent a record-breaking multi-million dollar sum on lobbying against Truman's proposal and tapping into emerging fears about socialism (Hacker 1998; Kinney 2015). Organized medicine used its wealth and power not only to work with Congressional leaders, but also to change public opinion. Using anti-communist rhetoric and tying public health insurance to an individualized ideological framework, interest groups blocked federal expansion by "[tapping into] ambivalence in American public opinion toward the federal government" despite initial public support for national public healthcare plans (Morgan & Campbell 2011). With institutional and private sector opposition, no existing public healthcare framework to build on, and vulnerable public opinion, Truman never even got to develop legislation for his proposal and was forced to abandon it after 1950.

Fundamental to the numerous issues faced by Truman and other policy advocates at the time was the lack of previous policy initiatives to bolster public support, while the private model of health insurance grew stronger over time. Where Saskatchewan led the charge at the provincial level in the 1940s and 60s, state-level campaigns for health insurance as far back as the Progressive Era of the late 1910s had all failed. Later, Roosevelt's administration considered but rejected national health insurance proposals on two separate occasions during the implementation of the New Deal (Starr 2018). The absence of existing policy meant two things: that Truman's administration had little infrastructure basis or policy examples to work with, and that there were no visible alternatives to existing systems for the public to benefit from. Public opinion, while similarly supportive of national health insurance to the Canadian public in the same era, became manipulable to negative ideological framings where it could have otherwise proved to be a point of justification for policy advocates and legislators. On the other hand, private and employer-based health insurance was given free license for continuous expansion; frustrated by Congressional opposition to its goals, the labor movement turned to securing greater benefits through collective bargaining with employers and legitimized the "private welfare state" developed through federal subsidies and the tax code. Policymakers, rather than counter mobilizing against the influence of interest groups on public opinion, dealt with the emerging and inconsistent demands of social protections with small government by likewise continuing to give private actors control over healthcare implementation (Morgan & Campbell 2011). Instead, political advocates who were on board with Truman's plan abandoned their goals of universality, instead opting

to pursue a program which would focus on the elderly and hopefully secure opportunities for expansion in the future (Hacker 1998). The disproportionate power of interest groups over public opinion, while not the only factor in this change in strategy, was an overwhelming force that contributed to policy divergence from Canada and the snowballing effect of failed policy battles.

Universal Healthcare to Medicare

By the early 1950s, public insurance advocates realized that they needed to take a distinct approach to healthcare reform. Organized doctors represented by the AMA had secured a lobbying victory and maintained significant control over insurance policy while organized labor gave up on political efforts in favor of negotiating with employers, which helped to protect the preferred system of the private sector. The tax exemption given to employer contributions to healthcare insurance more than doubled private coverage across the country, and there was no policy precedent for public insurance plans of any kind, let alone a universal one. One of the only exceptions to this was Social Security; as a politically legitimate and publicly popular program targeted to seniors, advocates turned to it as a basis for policy expertise and healthcare expansion (Starr 2018). Elderly Americans at the time were a growing population due to higher life expectancies and lower retirement ages, yet they faced significant issues with health insurance due to being a higher risk population that private insurers frequently avoided covering. Existing health insurance plans being tied to employment, combined with the fact that benevolent policies for older citizens tend to be politically easier to pass, made a public health

insurance plan for seniors a viable pathway for reformers (Morgan & Campbell 2011). Thus, when John F. Kennedy ran for president in 1960, he did so with a platform that included health insurance for the elderly by expanding the Social Security system. The proposal, which eventually came to be called “Medicare” and was distinct from Canadian Medicare, was promoted with the same rhetorical logic that Social Security advocates had used under FDR: that the program would be a collective investment made by workers to pay for future healthcare costs once they retired (Kinney 2015). Once Kennedy was elected President, he worked with allies in Congress and organized labor to communicate the struggles faced by seniors in securing access to healthcare. Public opinion seemed far more conducive to this approach than national health insurance, as polls run in the first half of the 1960s showed 60 to 67 percent public approval of the plan (Morgan & Campbell 2011). By decreasing the scale of a public health insurance plan and targeting a specific population, reformers hoped that the new policy could capitalize on public support and be more politically feasible than universality.

Predictably, organized medicine in the United States strongly opposed the new Medicare proposal. The AMA doubled down and referred to the program as a new variation of “socialized medicine” (Kinney 20150). However, the public still demonstrated strong support for continuing the establishment of new social programs in the wake of the New Deal and the Democratic Party was committed to delivering them. Therefore, rather than attempting to shut down the push for Medicare completely, the private healthcare sector instead lobbied to exert considerable influence on how the program would be crafted. Doctors, the hospital sector, nonprofit and for-profit insurance

alike weaponized their alliance with conservative members of Congress and continued making ideologically charged claims about government-run health insurance, forcing reform-minded policymakers to make significant concessions. The resulting proposal created a system of "delegated administration" similar to Canada's FFS model whereby the government would pay for Medicare costs but employ the use of "fiscal intermediaries"; in other words, private nonprofit and for-profit insurance companies would manage the administration of medical bills for seniors (Morgan & Campbell 2011). Constructing Medicare this way enabled policymakers to assuage concerns from the public and organized medicine over "big government" while securing votes from the conservatives to avoid what could have been another catastrophic policy failure. However, this compromise was still a significant policy victory for private interests. Medicare's management system not only preserved the power of private insurance, but also created new private groups known as "government-oriented corporations" which would hold a significant stake in the preservation of delegated policy. Existing private insurers such as the Blue Cross Association likewise suggested that the federal government give them the reins over insuring the elderly conditional on federal subsidies (Morgan & Campbell 2011). Even when their ideal outcome would have been no public insurance options at all, organized medicine found ways to advance its own interests in whatever policy came to pass.

The Social Security Amendments of 1965

The 1964 national election saw the Lyndon B. Johnson-led Democratic Party win a landslide victory, securing an overwhelming majority in both chambers of Congress and emboldening reformers to act on the Kennedy promise of Medicare. In addition, reformist northern Democrats gained a significant edge over their southern counterparts, meaning the government was almost certain to pass some form of public insurance for the elderly. The initial bill introduced by Democrats in the House only included hospital insurance; however, it was conservative Democrat and chairman of the powerful House Ways and Means Committee Wilbur Mills who suggested including physician insurance out of fear that only covering hospital costs then would lead to future expansion of the program (Hacker 1998). Thus, in 1965 President Johnson signed the Social Security Amendments of 1965, which included the negotiated form of Medicare as well as an expanded version of previous healthcare legislation for the poor known as Medicaid. The final version did operate under the FFS payment system as a direct result of the intense lobbying from organized medicine and fear that they would refuse to participate otherwise (Kinney 2015). Overall, however, the adaptation in strategy from healthcare reform advocates did succeed in creating a popular, publicly financed program, which reduced coverage inequalities for seniors and generally enhanced the economic well-being of a population still struggling after the initial establishment of Social Security (Starr 2018). After several failed policy battles that spanned the course of the first half of the 20th century, the United States had created an opening for public health insurance, albeit with a private delivery system, uneven coverage from Medicaid, and an

incrementally built program for seniors. Rather than continuing to aim for universal public health insurance, the U.S. government instead bore the costs of healthcare for those who tended to need it most; indeed, federal healthcare expenditures would balloon from $10 to $40 billion in the decade after Medicare and go from 2.6 to 9 percent of total federal spending (Hacker 1998). While Canada's battle with organized medicine a year later would end up with a relatively middle-of-the-road compromise between private practice and public insurance, the outcome of healthcare reform in the United States indicated that the private healthcare sector developed and wielded far more disproportionate power, which only grew as a consequence of reform efforts.

While the reformers who advocated for and passed Medicare hoped that doing so might encourage future ones to implement national health insurance, this wish never materialized as the United States still, to this day, maintains a mixed system of hybrid public/private insurance with incomplete coverage. After the passage of Medicare in 1965 and its subsequent implementation in 1966, the substantial increase in cost to the federal government delayed opportunities to advocate for expansion (Hacker 1998). The biggest changes in the late 1960s were the Social Security Act Amendments of 1967. Yet these amendments only expanded the types of healthcare delivery and management services eligible for state partnerships and federal funds, growing the number of constituencies with interests in preserving the existing FFS structure. The continuous reliance on intermediary entities fueled an ever-growing cycle of public funds working through a maze of state and federal government policy only to end up in the hands of a plethora of nongovernmental organizations instead of simply paying healthcare providers

directly (Morgan & Campbell 2011). Although it is true that Canada used a similar FFS structure to implement universal healthcare, the elimination of private insurance combined with the political capital generated from public support provided a buffer to limit the growth and power of organized medicine. The United States, on the other hand, made smaller gains with no such mechanism. Without a major public drive to advocate for continued expansion, nothing less than a hyper-disciplined push for incremental reform could succeed. Liberal Democrats would find this out the hard way; although in the 1970s Senator Ted Kennedy took up the mantle of comprehensive national health insurance built on Medicare and based on Truman's model, economic turbulence generated concerns over the cost of an expansion. By the time Kennedy and other reformist allies began to make the case for universal healthcare as a program that would contain costs, the election of Ronald Reagan spelled the end for the proposed policy (Starr 2018). It was not long before the Democratic Party gave up on the idea of universal healthcare completely as the obstacles faced to pass such a proposal seemed fruitless in the face of challenges that only grew bigger with time.

Studying the divergence in healthcare policy between Canada and the United States in the mid-20th century provides valuable insight into comparative developments of policy institutions. Both countries started with many of the same features and conditions for reform, such as the postwar development of private medicine, seemingly high public support for national programs, comparable federalist structures, and policy entrepreneurs willing to expand the role of the state in the provision of social services. However, the outcomes of early policy battles in both countries generated permanent

shifts in the political landscape at several stages of their respective healthcare developments. These shifts either solidified public support for future reform or entrenched the political power of private sector interests, meaning that seemingly small victories or defeats actually had large ramifications for future policy battles. In the case of Canada, incremental healthcare expansions built on staunch public support solidified the principle of universality but permitted private practice to develop and effectively block future extension efforts. In that of the United States, a similarly incremental approach yielded a targeted public insurance program conditional to and complimenting private practice and insurance due to a lack of early successes. Factors such as electoral frameworks and institutional incentives played a significant and varied role in several of these policy battles, but it is ultimately this mechanism of path dependence that defined the consistent and continued divergence of healthcare policy between the two neighboring North American countries.

CHAPTER THREE

Contemporary Opportunities for Policy Convergence

A natural question that emerges from policy divergence in historical comparative case studies is whether there remains the opportunity for future convergence between the United States and Canada. That is, has public opinion today shifted enough over time to present new opportunities for healthcare reform in the United States? While path dependence does emphasize the continued growth of the private sector in the absence of state intervention, it does not assume deterministic outcomes and is still prone to exogenous variables. Furthermore, any institutionalized public policy, such as U.S. Medicare, can become the basis for policy entrepreneurs to build on when seeking potential reform. These two conclusions suggest that it is not impossible for public healthcare policy to pass in the 21st century United States, albeit with significant hurdles because of decades of failed attempts. In this chapter, I will highlight two factors that could be most indicative of the correct conditions for future healthcare reform: current public opinion and Medicare. The lack of cohesive public opinion on healthcare reform has historically been the biggest barrier to resisting the political power of organized medicine; by extension, Medicare provides the most solid basis of public support for policy entrepreneurs to expand upon. To determine the former, I conduct a public opinion survey that asks Americans their personal views on the U.S. and Canadian healthcare systems. For the latter, I explore several Medicare-based solutions to the lack of universal healthcare coverage in the United States and evaluate them based on a path dependence model.

Lack of Public Opinion Cohesion

As stated before, it is not easy to determine what Americans think should be done to fix existing healthcare problems. When it comes to public opinion, there is a deep chasm in how Americans view the national health system. The U.S. healthcare system is viewed with high disapproval amongst Americans, with only 38 percent maintaining high confidence in the system and an even smaller 31 percent holding confidence in public health leadership as of 2006. The public also consistently believes the United States should spend more on healthcare and is primarily concerned with the high costs of healthcare delivery and services (Blendon et al., 2006). What tends to be the most manipulable and subject to framing is the way Americans understand a national public healthcare proposal. Notably, a 2000 study revealed a 54 percent approval rate for national health insurance paid for with taxes, but a 38 percent approval rate upon specifying that the government would be the sole provider of an insurance plan (Blendon & Benson 2001). Lastly, 74 percent of the public believed in 2003 that reform should be enacted to increase national coverage, but less than half conceded a willingness to help finance this with increased taxes. Americans are generally confused about the communal tradeoffs of public health insurance despite also being highly dissatisfied with existing private insurance.

Another layer of complexity to the healthcare problem is that Americans view their personal healthcare arrangements very differently from the system as a whole. Robert Blendon, Mollyan Brodie, John Benson, Drew Altman, and Tami Buhr (2006)

show that most U.S. citizens perceive their own "healthcare" as their typical interactions with healthcare workers and hospitals, which they view favorably. However, when answering questions about the healthcare *system*, citizens think of the economic insecurity they or others might face regarding medical bills at the time or in the future. These concerns are shared by insured and uninsured Americans alike: 61 percent of those who have issues with medical bills are insured, while uninsured people are more likely to believe that the healthcare system should be significantly reformed. Again, a plurality the public associates its healthcare problems with high costs, especially from doctors' fees and prescription drugs. Blendon et al. also observe significant differences in these perceptions across different levels of income and insurance coverage, indicating that the inherent inequality of private insurance may contribute to the maintenance of existing policy. Stuart Soroka, Antonia Maioni, and Pierre Martin (2013) find comparable differences in perception based on personal and collective framings as well as prospective and retrospective ones.

One major reason to believe that Medicare can still successfully be used as a starting point for healthcare expansion is not only that it serves as the exception to the lack of public opinion cohesion, but that it has enjoyed comparable and sometimes even greater public support since its inception. Mollyann Brodie, Elizabeth Hamel, and Mira Norton (2015) find that polls typically showed around 60-66 percent of the public supporting a potential expansion of Social Security to cover the medical care of elderly citizens in the 1940s and 60s. By the 1990s, Medicare was seen as favorable and personally beneficial by 70-75 percent of the population, and a 1996 poll found nearly

unanimous agreement that Medicare was good for the country. Jill Bernstein and Rosemary Stevens (1999) further explore the nuances behind this staunch support and show that the public tends to believe that problems with Medicare financing come from fraud, excessive charging, and mismanagement from both the public and private sectors; despite this, over two-thirds of both retirees and nonretirees agreed that Medicare is a promise which the government should and must deliver on. This trend continued into the 2000s as Medicare expansion consistently proved to be the most popular method of expanding healthcare coverage, with 60-80 percent of the public favoring lowering the Medicare eligibility age to 55 in the years leading up to the PPACA. The PPACA, for its part, only served to confuse the public further on Medicare. A 2013 poll demonstrated that one-third of the public believed the PPACA to be detrimental to Medicare while 60 percent either believed or were unsure whether the PPACA cut Medicare benefits (Brodie et al. 2015). Despite public misunderstandings over the specifics of Medicare's implementation, its legitimization and favorability has only increased over time and continues to serve as the most popular public insurance program.

Thus, a successful use of public support for public healthcare initiatives would have to involve mobilizing the public on the basis of its existing healthcare problems and deliver messaging that clearly communicates its material benefits. Any attempt at passing such a policy would meet with fierce resistance from the private healthcare sector; however, policy entrepreneurs seeking to wield public support in response should capitalize on the benefits of existing public health policy. Medicare provides a solid foundation for this, as a program that is misunderstood on a technical level yet politically

popular despite repeated attacks. Variations in healthcare polling may be significant when such an agenda is proposed, but they matter significantly less than how public opinion is weaponized or manipulated by political actors.

Policy Convergence Solutions

The trajectory of Canadian healthcare as an initiative launched by individual provinces before becoming a national program, in combination with the difficulty of obtaining enough public support for healthcare reform in the U.S., has pushed frequent discussions over the possibility of Medicare expansion as a venue for achieving universal coverage in the United States. Given that support for Medicare is consistently stronger and more coherent than views on private healthcare, public campaigns at educating the public on its financial workings could enable popular sentiment towards this approach. Michael Intriligator (1993) emphasizes that as a preexisting national program with popular support, it would be far easier to expand Medicare than advocate for a new program to nationalize health insurance. Given the dynamics of path dependence, it would also be significantly more difficult for private interests to mobilize against it. Carol Sakala (1990) similarly argues for this development to take place through state initiatives, which would parallel the development of national healthcare in Canada through an incremental federalist approach.

Potential Medicare expansion through the states, however, would be significantly different and potentially much more difficult to achieve today than the manner in which Canada achieved its system in the 20th century. David Naylor (2018) argues that

Canada's parliamentary system, both nationally and in the provinces, provided more opportunities for unilateral action at the time and was more resistant to private lobbying. Furthermore, around 45 percent of the Canadian population in 1965 was either uninsured or temporarily covered by "medical welfare", which meant that a proposal for a public framework was not as contested as a public plan would be today. Scholars point instead to healthcare reform in Massachusetts in 2016 as a potential example; this law mandated universal health insurance while expanding subsidies for low-income residents and public programs. Incorporating the individual proposals in healthcare reform that are safer and more popular led to reform that was significantly easier to pass than a more transformative alternative (Blendon et al., 2006). Both the arguments for and against contemporary incremental approaches to healthcare reform are subject to the intense effects of path dependence.

Given the incremental nature of policy trajectories in the United States, it is practically a requirement for any healthcare initiative to build on the foundations set by previous healthcare policy. It is a logical outcome of this path dependence, then, that Medicare is the most accessible policy to use as this basis. The conditions for Medicare expansion, however, would have to be carefully crafted according to political realities and standing public opinion. Whether policy entrepreneurs tackle Medicare expansion at the state level, whether it replaces private health insurance, and how effectively it can be capitalized upon with public support are all key considerations that should be taken into account.

U.S. Public Opinion Survey

Hypotheses

In order to decipher the current cohesion and strength of public opinion on healthcare issues, I devised a survey that asks a nationally representative sample of Americans various questions about their preferences for healthcare systems and reform. I expect public opinion to express dissatisfaction with the current state of U.S. healthcare on a national and personal level but maintain inconsistent support and understandings of healthcare policy alternatives as reflected in previous polling. Ten questions were designed to test this prediction, ranging from "How favorably do you view the US healthcare system?" to "Would you support or oppose a healthcare proposal that brings the US healthcare system closer to Canada's?". Except for one question which asked participants how they receive their health insurance, these questions were formulated to explore their understandings of healthcare systems and potential policy alternatives. In addition, several questions were posed to determine the extent to which the public today connects their material experiences to their political preferences. These two objectives should enable conclusions on not only what American generally think, but also the extent to which they synthesize their views and therefore which steps should be taken by political actors to encourage more cohesive public opinion.

Several distinct and specific hypotheses can be drawn for this approach. Firstly, I expect participants to have an overall negative view of the U.S. healthcare system (Hypothesis 1; H1). As reflected in the literature, the public tends to be highly cognizant about the flaws of national healthcare, and I expect this to be reflected directly in the

responses. This contributes to my second hypothesis, which is that participants will be divided in their preferences for public health insurance and tax-based proposals for expansion despite their personal concerns with paying for health care costs currently (H2). The public may have issues with U.S. healthcare and even struggle to deal with it personally; however, only a fraction of the population is expected to have firsthand experience with the benefits of public insurance, which may even be limited given the limited funding of Medicare and Medicaid. In addition, the tendency of public opinion to hesitate on policy tradeoffs is likely to decrease the favorability of hypotheticals such as higher taxes for lower medical costs. Where I expect public opinion to be cohesive and agreeable is in its favorability of the Canadian healthcare system (H3). While participants may or may not be aware of how the Canadian system functions, there remains a legacy of positive views among Americans towards the system maintained by their neighbors to the North. Some parts of the public therefore may approximate reasons why the Canadian system might be better, yet still misunderstand the individual elements of Canadian healthcare policy which generate those benefits similarly to how they might misunderstand hypothetical policy alternatives. As a result, I predict difficulties in the public's ability to synthesize broader macroscopic preferences with technical policy solutions; that is, if H2 and H3 are both true, the public can be characterized as "inconsistent" (H4). Lastly, I expect respondents to favor the expansion of healthcare coverage towards universality and a tendency to view this goal as a government responsibility (H5). While political culture arguments believe the U.S. public to have a propensity for "small government", evidence of the public's dissatisfaction with the

current system and consistent favorability of Medicare as an entitlement program demonstrate that Americans are quite capable of having big expectations for their government.

In general, I expect this survey to demonstrate cohesive views among participants on the current state of the healthcare system and on broader goals of reform, yet remain divided on the personal benefits of reform and the aspects of policy required to enact them. This combination of traits has historically posed significant problems for policy entrepreneurs seeking reform; however, these questions should reveal which aspects of public knowledge are vulnerable to ideological framing and which aspects are cohesive enough to build on. For example, if participants maintain a positive view of the Canadian system and support healthcare coverage extension, then political actors could mobilize the public on the legitimacy of Medicare in addition to public desire for universal coverage and provide counter-narratives which directly connect reform to material benefits for the public. Thus, this survey seeks to identify whether traditional narratives on U.S. public opinion still hold true or whether preferences have shifted enough to offer opportunities for policy entrepreneurship.

Methodology

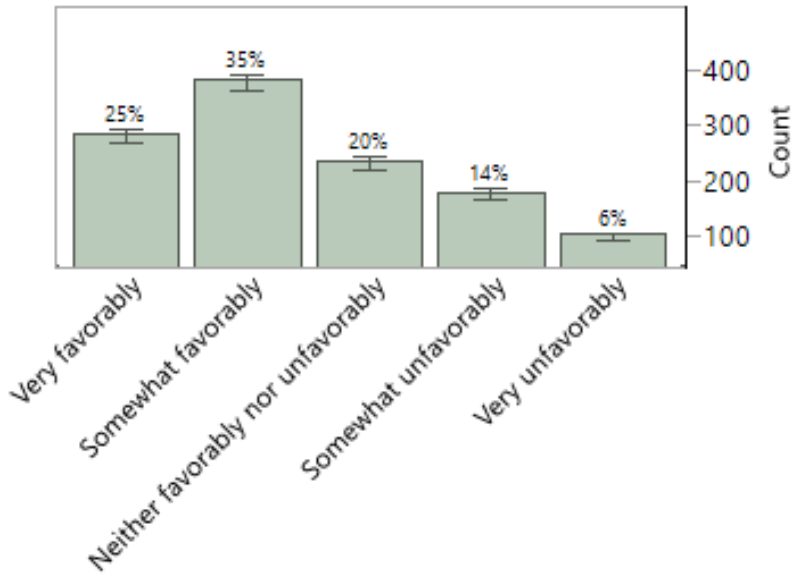
In order to test the assessment of U.S. public opinion as inconsistent over alternates to the current hybrid healthcare system, and to identify the potential for future convergence of healthcare policy with Canada, a survey reflecting characteristics of the national population on gender, age, race, and income was fielded through Qualtrics. The

survey was conducted in March of 2021, receiving 1,043 respondents over the age of 18 who gave information on demographic characteristics and answered questions concerning their opinions on healthcare. The data was analyzed using the SAS Institute's JMP program, and the full survey codebook is provided in the appendix. I present figures reflecting the distribution of responses to these questions in the results and discuss variance based on demographics. While these ten questions cannot possibly cover the full extent of the public's understanding of healthcare systems and policies, they provide a window into how the public thinks about these issues without any priming effects. As a result, these questions should yield a baseline for how prone they could be to ideological messaging and framings during policy battles.

Findings

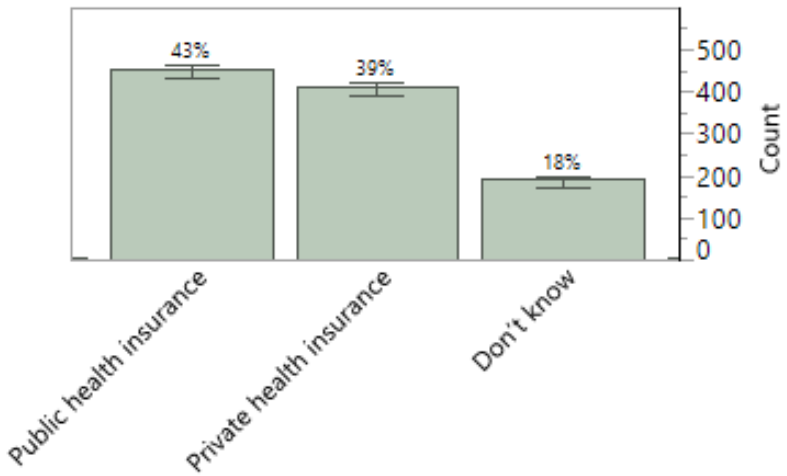
Results

Figure 1 - How favorably do you view the U.S. healthcare system?



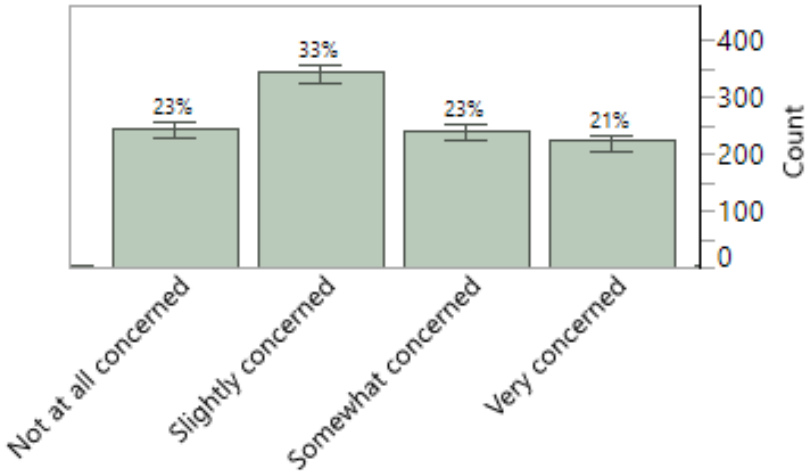
The respondents of this survey gave a positive view of the U.S. healthcare system when asked the question directly. About 60 percent of participants view it favorably, while unfavorability is at 20 percent. Notably, “somewhat favorably” maintains the plurality of responses with 35 percent while one fifth of participants chose neither.

Figure 2 - Which do you view more favorably:



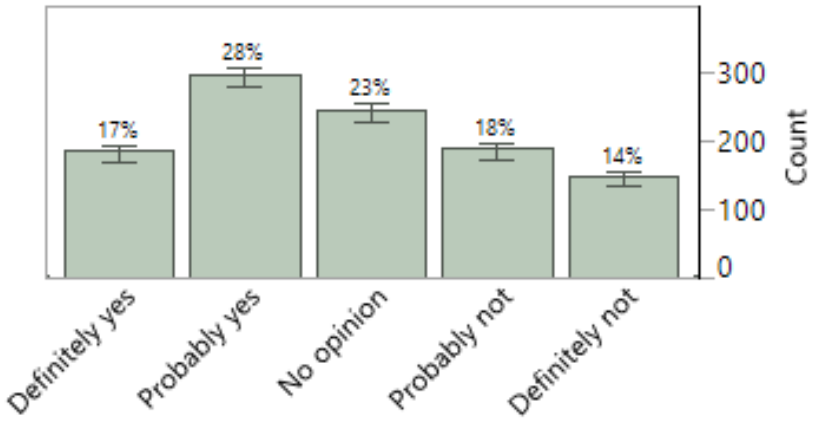
When asked whether they prefer public (provided through the government) or private health insurance (provided through employers), participants were remarkably evenly divided, with the two primary options only differing by 1 percent when accounting for standard error.

Figure 3 - How concerned are you about being unable to pay medical costs for health care?



Responses to concerns about medical costs were distributed more evenly across answers relative to most of the other questions; however, 77 percent expressed at least some concern over their inability to pay their medical bills. Even accounting for the plurality of "slightly concerned" responses, 44 percent were somewhat or very concerned on this issue.

Figure 4 - Would you be willing to pay more taxes in exchange for lower health care costs?



The proposal for a tradeoff between taxes and medical costs leans somewhat favorably among the respondents, with 45 percent showing some support for this hypothetical while 32 percent responded negatively. These results, however, are still more spread out across responses compared to other questions and reflect deep divisions despite net favorability. As with several of the questions before, the "no opinion" response hovers at 23 percent.

Figure 5 - Should the federal government guarantee healthcare coverage to all U.S. citizens?

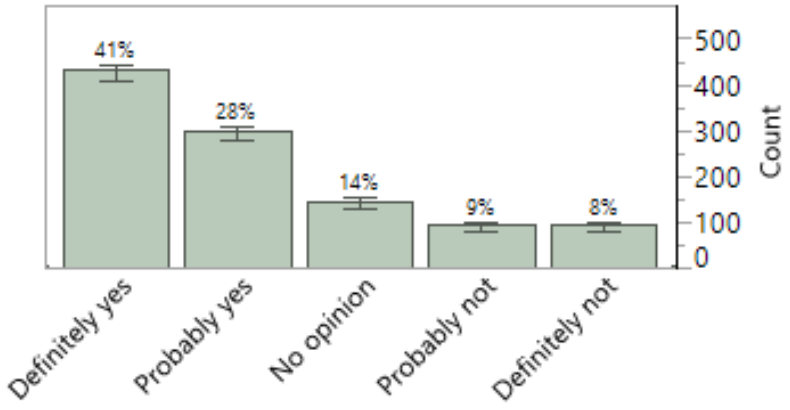


Figure 5, however, demonstrates a much stronger leaning among respondents towards supporting universality in healthcare coverage. A combined 69 percent of participants exhibited a favorable view towards the full extension of coverage, while only 17 percent expressed some opposition. In particular, “definitely yes” was the most popular response at 41 percent, while fewer respondents had “no opinion” on this issue.

Figure 6 - Overall, does Canada have a better or worse healthcare system than the United States?

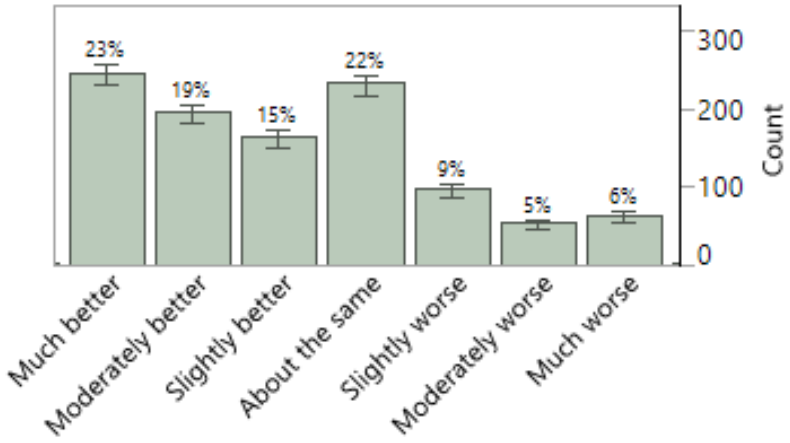
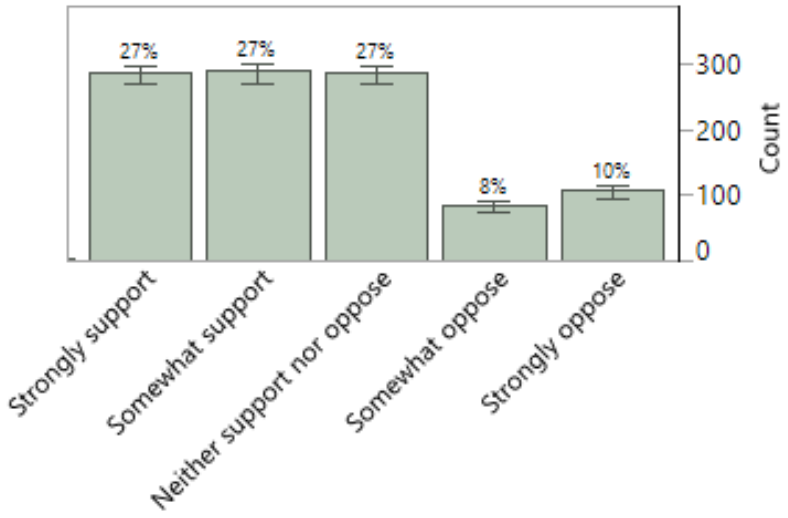
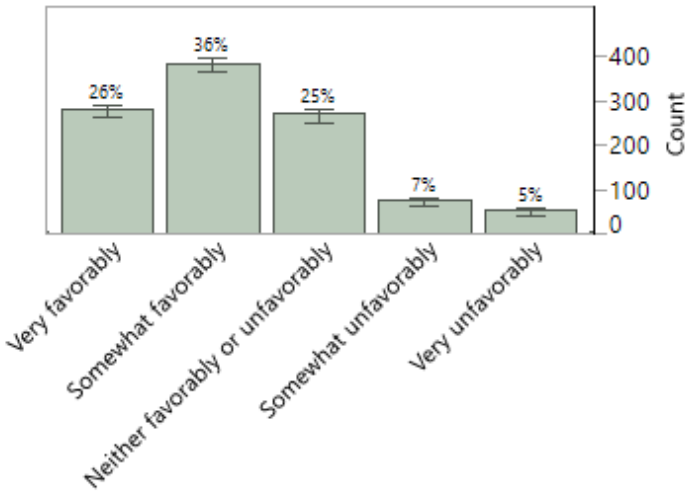


Figure 7 - Would you support or oppose a healthcare proposal that brings the U.S. healthcare system closer to Canada's?



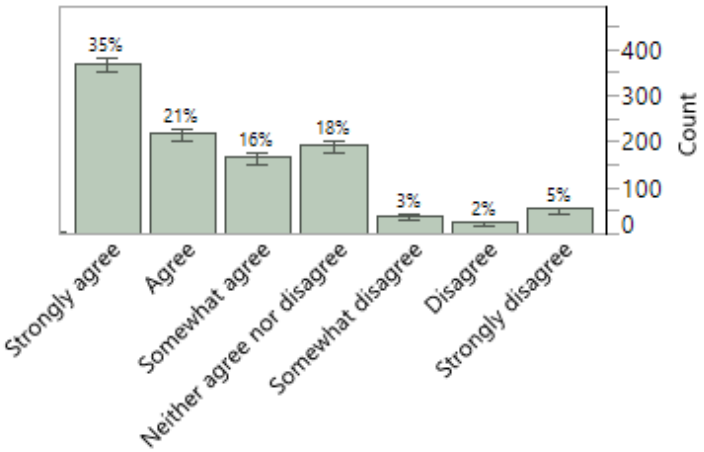
Turning to comparisons with the other country in this case study, respondents maintained generally favorable ideas of the Canadian system. Figures 6 and 7 reveal similar trends in both how they view this system and a hypothetical policy proposal for healthcare convergence. About 57 percent see Canada as having better healthcare and 54 percent would show support for the proposal, while 20 percent perceive the Canadian system as worse and 18 percent would likely oppose the proposal. A notable observation is that there is a three-way plurality between levels of positive support and neutrality concerning the proposal, but more respondents answered neutrally than with any other question.

Figure 8 - How favorably do you view the individual states taking on a greater role in expanding healthcare coverage?



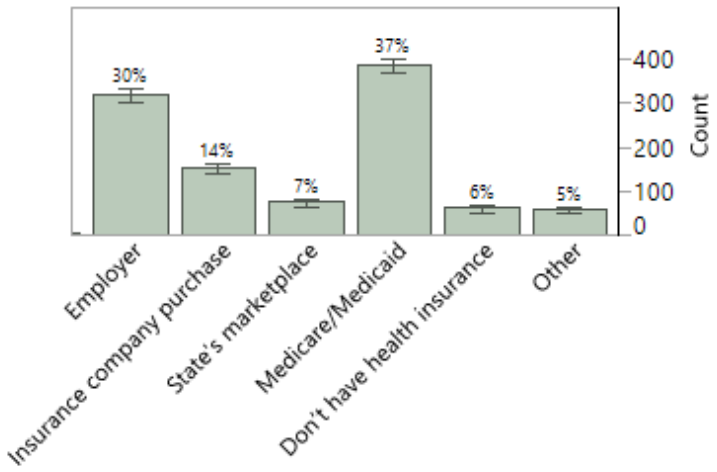
The option of healthcare coverage expansion at the state level was also generally favored by the survey participants. While 62 percent responded favorably, respondents were more likely to choose the "neither" option at 25 percent than they were to answer unfavorably at 12 percent.

Figure 9 - Do you agree or disagree with the following statement: Government should take extra steps to ensure racial equality in health care coverage.



The question on racial equality in health care coverage demonstrated in Figure 9 proved to show the strongest positive support among the respondents, with nearly three quarters agreeing on the principle at 72 percent and only 10 percent disagreeing on some level. Moreover, “strongly agree” maintained a plurality and the “neither” option was on the lower end compared to other responses. One revealing aspect of this question is that it specifically asks about taking “extra steps” to ensure equality, rather than simply asking about general support for the principle, and still featured the most asymmetrical distribution among respondents.

Figure 10 - How do you currently receive health insurance?



The last question, shown in Figure 10, asks participants to name how they receive their health insurance out of the most prominent options for people living in the U.S. generally. The two most common categories were employer-provided health insurance and Medicare or Medicaid. While not nationally representative, this distribution ensures a relatively even split between people who participate in private and public healthcare

programs to reflect variance in public opinion and personal experience across the other survey questions.

Discussion

As expected, U.S. public opinion maintains at least some degree of loyalty to the current hybrid healthcare system. The strongest evidence for this lies in Figure 1, where three times as many survey participants favored the U.S. system as disfavored it. While this finding disproves H1 in some way, there are several ways to interpret the distribution. On the surface, it seems like a fairly powerful mandate for healthcare policy in the United States; if Americans favor their healthcare system, then there may not be a necessity or possibility for policy convergence with Canada. Another possibility discussed in the literature is that survey respondents might have been thinking about their own personal healthcare arrangements, as opposed to the structure, coverage, or cost of current healthcare policy. However, both interpretations are not likely to be fully true as evidenced by Figure 3. Having such a high level of concern over medical costs in tandem with general favorability of the U.S. healthcare system means that at least some portion of total respondents do not associate these concerns with flaws in said system, or at least do not consider them to be defining. The combined distributions of these two questions illustrate the most prominent example of some degree of "inconsistency" in U.S. public opinion.

Figures 2 and 4 present a different kind of challenge for public opinion interpretation. While not nearly as one-sided as U.S. healthcare favorability, the distribution of responses on preferences for public or private insurance and exchanging

higher taxes for lower healthcare costs offer more direct insight into public opinion vulnerability, as predicted by H2. Respondents were nearly evenly split on the public/private line, and while there is slight favorability for the "lower costs" hypothetical, both distributions could be swayed by even a fraction of the participants with no opinion or preferences. Thus, while it might be difficult to convince the public that the U.S. healthcare system is unfavorable, there is far more room for mobilization efforts to convince the public on taxes or the effectiveness of government-run healthcare. These figures suggest that the public is at least somewhat satisfied with their healthcare arrangements and relatively divided on the technical preferences for policy reform.

Nonetheless, there is good reason to believe that the U.S. public maintains some desire for policy change. In particular, survey participants generally responded to questions that dealt with policy *principles* much more favorably. In fact, the public's desire for the extension of coverage to full universality, as demonstrated by Figure 5, proved even more widespread amongst respondents than favorability of the U.S. system. Additionally, more of the responses expressing support for this principle were in the "definitely yes" than "probably yes" category compared to Figure 1, which had a greater proportion of "somewhat favorably" than "very favorably". Likewise, fewer respondents answered with "no opinion" than "neither favorably nor unfavorably" for the respective questions. The cohesive support demonstrated in Figures 5 and 8 thus confirms H5; however, it also demonstrates that public views of government responsibility in extending coverage may be the least divided of any healthcare issue. We can thus infer as much, if not more, public support for universal coverage than the current system.

Another area with response distributions similar to U.S. healthcare favorability is favorability and support for the Canadian healthcare system. Although a greater number of respondents were neutral for these questions, Figures 6 illustrates comparable levels of admiration for the neighboring country's healthcare system despite it being fairly different operationally, confirming the expectations laid out in H3. Figure 7 shows that hypothetical Canada-adjacent healthcare reform shared nearly equal levels of support; however, we can begin to see how these figures run in conflict with the earlier distribution of public opinion on taxes. Based on these responses, the public may view both their own healthcare system and that of Canada's positively yet misunderstand or hesitate to accept the realities of policy alternatives. This analysis confirms that the validity of H2 and H3 necessarily leads to the confirmation of H4, and here we understand another dimension along which the public can be inconsistent.

One area which seems much less prone to contradictions, however, is the sense of equality respondents answered with for Figure 9. Support for initiatives to equalize healthcare coverage based on race demonstrated the firmest support of any question on the survey. Because of the way this question is framed, it is difficult to argue that the stance taken by a large majority of respondents would be easily manipulable even with attempts to manipulate public opinion on ideological grounds. Although the survey doesn't include questions testing the knowledge of respondents on the state of racial healthcare inequality, we can infer that social justice is important to the public in tackling healthcare.

While expectations for this survey were that public opinion would be inconsistent and divided, the results paint a slightly different kind of picture on the behavior of public attitudes. Firstly, a significant portion of respondents could still be fairly attached to the existing state of U.S. healthcare policy; however, an equal or greater portion maintain some degree of economic insecurity with healthcare costs and a propensity for convergence with Canada. Although this could be attributed to the characterization of U.S. public opinion as inconsistent, it does not line up with the view that the public is averse to policy alternatives. A far more plausible explanation may be that Americans are largely unaware as to what policy alternatives would look like for them, and therefore are less likely to connect personal problems to existing systems. This framework helps to potentially explain the "inconsistency" between attachments to the current hybrid system and the public's desire for change.

Secondly, this survey makes clear that while the public tends to be more divided on issues of a technical policy nature such as changes in taxes or public ownership of health insurance, they are far more united and supportive of policy reform on matters of principle. Questions concerning universality or racial justice are ones that get at how respondents think broadly on the moral way to tackle healthcare issues as opposed to the best bureaucratic methods for healthcare management. Given that public opinion is typically assumed to have incomplete knowledge of the full scope of policy issues, it is likely that the attitudes in the public are far more resistant to attacks on issues of principle than they are to attacks on specific details of policy alternatives. This provides more plausibility for the idea that personal experience with the material benefits of public

health insurance becomes a powerful basis for public support, and that is it far easier to communicate the benefits of policy alternatives when the public has firsthand knowledge of them from similar programs beforehand.

These results are by no means conclusive metrics for the potential success or failure of healthcare policy reform. However, they do indicate a solid bedrock upon which policy entrepreneurs could build a case for healthcare reform. Resilient public support for the aforementioned principles could lead to successful initiatives conditional on the frequent appeal to the moral consequences of policy. In addition, it is far easier to educate the public on issues they might be confused or misled on, such as net material benefits of reform, especially if they are directly tied to moral appeals. Figure 8 also provides a starting point for potential reform; although a quarter of respondents were neutral on the question, a large majority of them still express favorability for a reform pathway that would mirror the way Canadian healthcare came to be. Although contemporary policy and healthcare institutions have progressed much farther today than they had by the mid-20th century, there is no shortage of public opinion angles from which to approach and develop a case for reform.

CHAPTER FOUR

Conclusion

While Canada and the United States shared similar origins in the development of their respective healthcare policies, the ability of policy entrepreneurs to capitalize on public support in the face of opposing private sector interests decided key policy battles and carried ramifications for future ones. In Canada, strong public support stemming from regional precedent in Saskatchewan enabled the federal government to draw on strong public support and enact universal national public health insurance while preserving the administrative autonomy of private medical care. In the United States, in contrast, the lack of existing policy structures left public opinion vulnerable to manipulation and ideological framing, rendering it inconsistent and causing policy entrepreneurs to turn to Medicare as a public program for vulnerable populations. These key differences carried significant implications for the continued growth of organized medicine. In Canada, political actors eventually secured national public health insurance by building on public support for and policy precedent from the regional Saskatchewan plan, yet preserving the power of private providers under the FFS model. These events created an ongoing political conflict whereby private interests have been unable to scale back public insurance yet have also prevented it from being expanded on to other types of medical care. In the United States, the failure of early policy initiatives on hospital and medical insurance caused political actors to change their strategy away from universality towards programs for marginalized populations that were vulnerable to particularly high healthcare costs from private insurance. The lack of policy precedent to mobilize the

public not only preserved the FFS model, but allowed private insurance and organized medicine alike to continue to grow and become overwhelmingly powerful contenders in future policy battles for healthcare reform as well. While both countries featured similar public opinion support for universality in the early stages of healthcare development, bold policy entrepreneurship led to cohesive public support and fueled the ability of public health insurance to remain as a more competitive policy alternative in one country and not the other. Early developments in both incremental approaches thus set the stage for the political dynamics of healthcare reform, rendering existing systems very difficult to change in both cases but also generating more robust support from public opinion where universal public health insurance succeeded. The path dependence mechanism for healthcare policy development highlights not only how policy battles become influenced by the consequences of historical precedent, but also how they in turn shape the conditions which lead to future reform opportunities or prevent meaningful change. Data drawn from the original survey presented in this work also suggests that public opinion demonstrates more robust support for reform which appeals to broader moral and political principles or draws from visible alternatives. While exogenous factors could change the direction of policy divergence, it will require careful consideration of public opinion and a reliance on past policies for healthcare reforms to succeed in the future.

APPENDIX: Survey Codebook

Q11: What gender do you identify as?

- ○ Male (1)
- ○ Female (2)
- ○ Non-binary / third gender / other (3)
- ○ Prefer not to say (4)

Q12: What is your age?

- ○ Under 18 (1)
- ○ 18 - 24 (2)
- ○ 25 - 34 (3)
- ○ 35 - 44 (4)
- ○ 45 - 54 (5)
- ○ 55 - 64 (6)
- ○ 65 years or older (7)

Q13: What racial group best describes you?

- ○ White (4)
- ○ Black or African American (5)
- ○ Asian American (6)
- ○ Native American (7)
- ○ Other (8) _____

Q62: Are you of Hispanic, Latino, or Spanish origin?

- ○ No, not of Hispanic, Latino, or Spanish origin (4)
- ○ Yes, Mexican, Mexican American, Chicano (5)
- ○ Yes, Puerto Rican (6)
- ○ Yes, Cuban (7)
- ○ Yes, another Hispanic, Latino, or Spanish origin (8)

Q14: What is the highest degree or level of education you have completed?

- ○ Some High School (1)
- ○ High School (2)

- ○ Some College (3)
- ○ College (4)
- ○ Master's Degree or Higher (5)

Q15: What is your annual household income?

- ○ Less than $25,000 (1)
- ○ $25,000 - $50,000 (2)
- ○ $50,000 - $100,000 (3)
- ○ More than $100,000 (4)

Q21: In which state do you currently reside?

▼ Alabama (1) ... I do not reside in the United States (53)

Q19: Generally speaking, do you think of yourself as a Republican, a Democrat, an Independent, or what?

- o Republican (1)
- o Democrat (2)
- o Independent (3)
- o Other (Please Specify): _____(4)

Display This Question:

If Generally speaking, do you think of yourself as a Republican, a Democrat, an Independent, or what? = Independent

Q22: Do you think of yourself as closer to the Republican or Democratic Party?

- o Closer to the Republican Party (1)
- o Closer to the Democratic Party (2)

Display This Question:

If Generally speaking, do you think of yourself as a Republican, a Democrat, an Independent, or what? = Republican

Q23: Would you call yourself a strong Republican or a not very strong Republican?

- o Strong Republican (1)
- o Not Very Strong Republican (2)

Display This Question:

If Generally speaking, do you think of yourself as a Republican, a Democrat, an Independent, or what? = Democrat

Q24: Would you call yourself a strong Democrat or a not very strong Democrat?

- Strong Democrat (1)
- Not Very Strong Democrat (2)

Q1: How favorably do you view the US healthcare system?

- ○ Very favorably (1)
- ○ Somewhat favorably (2)
- ○ Neither favorably or unfavorably (3)
- ○ Somewhat unfavorably (4)
- ○ Very unfavorably (5)

Q2: Which do you view more favorably:

- ○ Public health insurance provided by the government (1)
- ○ Private health insurance provided through employers (2)
- ○ Don't know (3)

Q3: How do you currently receive health insurance?

- ○ Through my employer (1)
- ○ By purchasing from an insurance company (2)
- ○ Through my state's marketplace (3)
- ○ Through Medicare or Medicaid (4)

- ○ Don’t have health insurance (5)
- ○ Other (6)

Q4: How concerned are you about being unable to pay medical costs for healthcare?

- ○ Not at all concerned (1)
- ○ Slightly concerned (2)
- ○ Somewhat concerned (3)
- ○ Very concerned (4)

Q5: Would you be willing to pay more taxes in exchange for lower healthcare costs?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ No opinion (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q6: Should the federal government guarantee healthcare coverage to all US citizens?

- ○ Definitely yes (1)
- ○ Probably yes (2)
- ○ No opinion (3)
- ○ Probably not (4)
- ○ Definitely not (5)

Q7: Overall, does Canada have a better or worse healthcare system than the United States?

- ○ Much better (1)
- ○ Moderately better (2)
- ○ Slightly better (3)
- ○ About the same (4)
- ○ Slightly worse (5)
- ○ Moderately worse (6)
- ○ Much worse (7)

Q8: Would you support or oppose a healthcare proposal that brings the US healthcare system closer to Canada's?

- ○ Strongly support (1)
- ○ Somewhat support (2)
- ○ Neither support nor oppose (3)
- ○ Somewhat oppose (4)
- ○ Strongly oppose (5)

Q9: How favorably do you view individual states taking on a greater role in expanding healthcare coverage?

- ○ Very favorably (1)
- ○ Somewhat favorably (2)
- ○ Neither favorably or unfavorably (3)
- ○ Somewhat unfavorably (4)
- ○ Very unfavorably (5)

Q10: Do you agree or disagree with the following statement: Government should take extra steps to ensure racial equality in health care coverage.

- ○ Strongly agree (1)

- ○ Agree (2)
- ○ Somewhat agree (3)
- ○ Neither agree nor disagree (4)
- ○ Somewhat disagree (5)
- ○ Disagree (6)
- ○ Strongly disagree (7)

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