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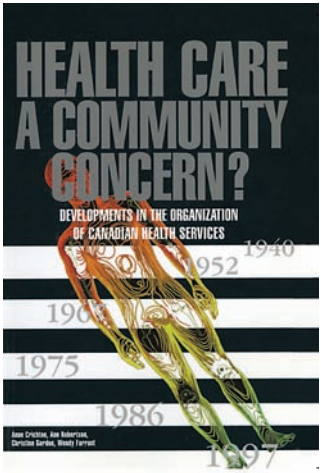


**HEALTH CARE: A COMMUNITY CONCERN?**
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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# PART II

# The Context of Health Policy Development

## CHAPTER 5

# Development of Canada's Welfare State Programs

### Differences between Nations' Approaches to Welfare State Organization

Welfare states set up by most western developed countries as well as the communist states were not alike; what they had in common was some commitment to social redistribution. To give some idea of the differences in this commitment we can review Field's Typology of Health Systems (Field 1989) in which he differentiates Canada's approach from those of the United States and Great Britain (see Chart 5.1).

### The Differences Are Ideological

George and Wilding (1976) have reviewed the ideas of four groups of ideological thinkers who have influenced social welfare development: (1) anti-collectivists, (2) reluctant collectivists, (3) Fabian (democratic) socialists, and (4) Marxists. Social reconstruction models were established between 1945 and 1975 in all western developed countries. Although these models varied to some extent according to a particular nation's commitment to capitalism or socialism, in every case there was a welfare state component. As Canada decided to adopt British models, Canada's post-Second World War federal welfare state was influenced, to a large extent, by the Fabian socialists who had influenced British thinking. Canada's centrist Liberal party was also strongly influenced by Saskatchewan's agrarian socialists,[1] Quebec's Quiet

1 Marchak (1975) has discussed the *counter-culture* of democratic socialism which challenged classical liberalism, the traditional ideology in Canada. The Liberals who were in power for most of the time between 1935 and 1984, were strongly

**Chart 5.1**
**Field's Typology of Health Systems**

| Health system | Type 1<br>Emergent | Type 2<br>Pluralistic | Type 3<br>Insurance/<br>Social Security | Type 4<br>National<br>Health Service | Type 5<br>Socialized |
|---|---|---|---|---|---|
| General definition | Health care as item of personal consumption | Health care as predominantly a consumer good or service | Health care as an insured/guaranteed consumer good or service | Health care as a state-supported consumer good or service | Health care as a state-provided public service |
| Position of the physician | Solo entrepreneur | Solo entrepreneur and member of variety of groups/ organizations | Solo entrepreneur and member of medical organizations | Solo entrepreneur and member of medical organizations | State employee and member of medical organization |
| Role of professional associations | Powerful | Very strong | Strong | Fairly strong | Weak or non-existent |
| Ownership of facilities | Private | Private and public | Private and public | Mostly public | Entirely public |
| Payments | Direct | Direct and indirect | Mostly indirect | Indirect | Entirely indirect |
| Role of the policy | Minimal | Residual/indirect | Central/indirect | Central/direct | Total |
| Types described in the book | | Switzerland, USA | (Canada), (France), Japan, New Zealand Spain, Yugoslavia | Scotland, (Great Britain) | USSR |

*Source:* M.G. Field, *Success and Crisis in National Health Systems.* (NY: Routledge, 1989), 7. Reprinted with permission.

Revolutionaries, and its own social reformers (Kent 1962), but it was at heart a party representing strong capitalist interests, which is to say that it was reluctantly collectivist.

In the 1940s Canada designed its welfare state using the British model Sir William Beveridge had proposed — a model in which priority is given to promoting *Full Employment in a Free Society* (Beveridge 1945), with a backup social security system to provide for those at social risk (Great Britain 1942). There were to be five separate thrusts to correct what Beveridge called the Five Giant Evils: want, disease, ignorance, squalor and idleness. Thus in Britain the National Health Service (NHS) would try to clean up "the pool of ill health" while other departments were working on these other problems. They were seen to be connected, though only in a broad general way. Through providing full employment and by improving education and housing, disease would be reduced and there would be less demand on medical care. Then doctors would have more time to build up good health rather than only dealing with sickness. Marsh, who chaired Canada's social security planning group, had been one of Beveridge's research assistants, and he adapted Beveridge's ideas to the Canadian situation (Canada 1943b).

Pierson (1991) has described these approaches to welfare state planning as bourgeois.[2] They were built on decisions by the middle classes to

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influenced during these years by the Cooperative Commonwealth Federation (democratic socialist) party.

2 Therborn has presented two typologies of welfare states, the first of which Pierson quoted: (1) In 1986 he differentiated between those with proletarian and bourgeois origins. The first of these was promoted by working men seeking greater social security, the second by the nation's middle classes who were willing to share some of their wealth with poorer people but who also wanted social programs to meet their wants. (2) In 1987 he distinguished, as Field (1989) and George and Wilding (1976) have done between:

| | | |
|---|---|---|
| **Strong interventionist welfare states** | (extensive social policy, strong commitment to full employment) | Sweden, Norway, Austria, (Finland) |
| **Soft compensatory welfare states** | (generous social entitlements, low commitment to full employment | Belgium, Denmark, Netherlands, (France, West Germany, Ireland, Italy) |
| **Full employment-oriented, small welfare states** | (low social entitlements, but institutional commitment to full employment) | Switzerland, Japan |
| **Market-oriented welfare states** | (limited social rights, low commitment to full employment) | Australia, Canada, United States, United Kingdom, New Zealand |

share some of their wealth in order to ensure that the poor were provided with "a social minimum." This is known as the "equality of condition" approach to welfare. At the same time, there was a belief that making *universal* provisions for family support, education, health and employment opportunity were important for the middle classes. The concept of "equality of opportunity" with respect to access to state services was the idea underlying many welfare state programs in which they were interested.

## The Social Division of Welfare

While the policy makers openly discussed the welfare state legislation which provided for improvement of the social minimum and pushed towards establishing equality of opportunity programs, it was not until 1958 that Titmuss (1958), a British academic, challenged the bourgeois welfare state over hidden financial redistribution. He revealed that there was a whole range of financial benefits going to business organizations through "revenue foregone."

His concept of the social division of welfare is shown clearly in a chart developed by Graycar and Jamrozik (1989) to explain the welfare state redistribution system to Australians (see Chart 5.2). Although the federal-provincial divisions of responsibility are different in Australia, the principles are the same. This chart shows that although there has been a move towards sharing the national earnings across the collectivity, it has never been an even redistribution. As Graycar and Jamrozik pointed out, the financial benefits in column 1 are relatively low, the financial benefits in column 2 go as much to the service providers as to the consumers, and the financial benefits in column 3 are likely to be more substantial for upper income earners than for the working classes.

## Focussing on the Social Minimum versus Collective Allocations

One Canadian study would seem to support the point made by Graycar and Jamrozik (1989) that the bourgeois welfare state is likely to profit the middle classes more than the poor. How the economic situation changed in Newfoundland was chronicled by Brown (1981) who provided a useful review of the history of health care in that colony and province from the turn of the century to 1980:

> During this time there were considerable changes in social conditions, political arrangements and the availability of public monies, all of which influenced the development of the health care sector. In general terms Newfoundland's health care system shifted from one involving low expenditures and many British type institutions to high expenditures and American type institutions. The

> evidence suggests that the changes have been particularly beneficial for Newfoundland's merchant class, including the doctors and dentists, although some benefits have also accrued to patients and fishermen. (p. 210)

The Liberal government in Ottawa took some time to get its welfare state in place. There were continuing struggles with Quebec over post-secondary education and Ontario over hospital insurance, but small gains were made throughout the 1950s. However, after a period in opposition the Liberals returned to power in 1963 with new energy and a new determination to pass the legislation necessary to provide for improved collective services and a satisfactory social minimum. The Medical Care Insurance Act, 1966, followed

**Chart 5.2**
**Public Expenditure (Commonwealth) of Australia and Its Beneficiaries**

| Selective in favour *of low income groups* | Universal *provisions* | Selective in favour *of high income groups* |
|---|---|---|
| 1 **Direct allocations** (means tested) | 2 **Collective provisions**[a] | 3 **Taxation expenditure** (revenue forgone) |
| Unemployment benefits | Family allowances | Superannuation concessions |
| Family income supplement | Dependent spouse rebate | Occupational welfare concessions |
| Invalid pensions | Public transport | Assistance to industry |
| Supporting parent benefits | Public schools | Concessions to business |
| Widows' pensions | Public health system | Tax-free dividends |
| Age pensions | Technical (TAFE) education | 'Condoned' tax avoidance[b] |
| Public housing | Early childhood services | 'Condoned' tax evasion[b] |
| | Employment in public sector | |
| | Colleges of advanced education (CAEs) | |
| | Universities | |
| | Culture, recreation | |
| | Private health system | |
| | Private schools | |

*Source:* Adam Graycar and Adam Jamrozik, *How Australians Live: Social Policy in Theory and Practice.* (Melbourne: Macmillan Company of Australia, 1989), 70. Reprinted with permission.

[a] Some of these benefits/provisions entail taxation expenditures, but they are available to recipients on a universal basis, irrespective of income. Some are means tested, most are not.

[b] "Condoned" because the complexity of the taxation system enables some people to take advantage of loopholes and to minimize, avoid, or (illegally) evade payment of tax.

through on the recommendations of the Royal Commission on Health Services, 1964, that there should be matching grants offered for the payment of medical fees, while the post-secondary education grants, 1967, ensured the development of a wide range of community college courses.

## Provision of a "Social Minimum"

So far as providing a social minimum was concerned, Canada made the same decision as Great Britain and the United States to provide income security to workers in its contributory unemployment insurance, pension schemes and other protection programs but this led to the development of a two-tier system of providing for those in need of income support. There continued to be need for local social assistance programs for those who had not contributed to these or benefited from other workers' income support schemes.

Recognizing that there were great differences between social assistance programs in different parts of Canada and between social assistance and social insurance programs, the federal government decided to try to bring more congruity into these schemes by developing a Canada Assistance Plan (CAP) 1966. Its objectives were:

1. The creation of a reasonably consistent national welfare apparatus
2. An extension of assistance to anyone who might need it — need being the only criterion.

Hum (1983) said: "The Canada Assistance Plan dramatically expanded the scope of federal involvement in social policy. In addition to encouraging an integration of assistance programs, CAP extended cost-sharing to a wide variety of social services and to most costs of administration incurred by provincial welfare agencies. However, because responsibility for social programs resides with the provinces and because of certain inherent shortcomings in the CAP legislation itself, these goals remain elusive" (p. 28).

However, the conservative provinces were still very judgemental about social assistance clients. Their reluctance to give generous help was identified in the *White Paper on Income Security* (Canada 1970c). Hum continued: "A fundamental weakness in the administration of social assistance in Canada is the failure to recognize that persons unable to support themselves have a right to assistance.... Judgements of whether a person is 'deserving' or not still enter into decisions about eligibility and the amount of assistance. People are often denied assistance even when the alternative options of employment, training or rehabilitation are not really available" (Hum 1983, 40).

The federal officials recognized that there were shortcomings in the CAP legislation if the objectives of developing an institutional rather than a residual

scheme[3] were to be reached. Working together with the Minister of Health and Welfare they developed proposals for new legislation in the early 1970s (Canada 1973c) but cabinet refused to move further at the time. It was proposed to reconsider the original CAP provisions immediately after a social service review. Johnson (1975) reported on the proposals put to the review. He said that there were already two relatively successful strategies for dealing with income insecurity: an employment strategy and a social insurance strategy. Health and Welfare Canada wanted to introduce three more strategies for tackling the problems of poverty. Johnson described these as:

> *income supplementation strategies* designed to meet, by way of a guaranteed income, inadequacies of income, whether that income came from employment or from social insurance plus private savings. ... The fourth strategy [was a] *social services strategy*. [Under this] the handicapped would receive regional rehabilitation and employment assistance services; single parents with pre-school children would be eligible for day-care services; others might receive, at one time or another, required counselling and job placement services.
>
> A final strategy had to do with the realization of these four policy strategies through a new approach to the development and harmonization of federal and provincial social security programs. This *federal-provincial strategy* ... advanced the proposition that the prime responsibility for setting ... [income] levels should reside with the provinces. (p. 459)

Although provincial norms might vary, the federal government would set the national norms and minima by which the provinces would be bound.

But these proposed changes came to naught because of the OPEC crisis and the economic recession of the mid seventies. At the same time as the Established Programs Financing Act, 1977, was brought in (limiting the open-ended matching grant programs), plans for increasing social assistance support were cut back. And in 1978 block funding was reduced, putting many hitherto secure programs at risk (Van Loon 1979). Splane (1987a,b) has argued that the days of the reformist bureaucrats who first conceptualized CAP were ended with the appointment of more conservative thinkers.

## The CAP Welfare Services

The CAP Act, 1966, committed the federal government to paying one half of any increase in provincial expenditure on welfare services[4] for "the lessen-

3 Guest (1980) has explained that institutional schemes meet the needs of *all* applicants while residual schemes apply judgemental criteria.

4 Welfare services are a subgroup of the provinces' personal social services provision.

ing, removal or the prevention of the causes or effects of poverty, child neglect and dependence on public assistance. Eligible services include services related to rehabilitation; casework; counselling; assessment and referral services; adoption services; day care and homemaker services; and community development services" (Hum 1983, 70). This monetary support enabled the provinces to provide a wide range of supports for those who previously had been institutionalized and for the prevention of the institutionalization of others.

In 1975 the conference of welfare ministers had agreed:

> first, that social services should no longer be looked upon as attached solely to 'people in need or likely to become in need'; secondly, that it should be recognized that the degree of universality of social services — their availability and the charges made for them — will change over time and, thirdly, that the priority accorded to social services, both to assist people in entering into employment of 'useful endeavour', and to enable them to manage at home instead of being placed in an institution, should be greatly increased. (Johnson 1975, 463)

Van Loon's (1979) explanation of the proposal was: "Welfare services [should be] divided into categories according to whether they should be universally available without cost to the user (crisis intervention and referral), free to those who needed them because of some long standing problem (rehabilitation) or income-tested (residential care, day care or some forms of home care)" (p. 489).

In 1977 the Minister of National Health and Welfare was expected to introduce a new social services act to extend federal matching grants, not only in respect of social services being provided to people on guaranteed incomes, but to the public generally. The first priorities were to be day care services, homemaker services, child welfare services and a greatly expanded range of rehabilitation services. However, the financial crisis, ever deepening, put an end to this proposed federal action. These moves to improve the administration of minimal income support programs and to reconsider the funding of social services by the federal welfare state were ended.

## Health Services

The development of health services will be discussed further in Part III. There was not the same negative feeling towards health and post secondary educational developments — two universal programs — as there was towards social minimum programs at this time, though they were brought under tighter control by the introduction of block grants rather than open-ended grants under the Established Programs Financing Act in 1977.

## Summary

There are identifiable differences in the way in which nations chose to set up their welfare states. This chapter considers some analyses of these differences:

1. Canada's welfare state appears to be "reluctantly collectivist" in a nation with strong capitalist interests
2. Canada is a welfare state built on the decision by the middle classes to share their wealth — a "bourgeois" welfare state
3 Three sectors of the social division of welfare were analysed by Titmuss: providing for a social minimum, enacting universal programs of social redistribution, and helping businesses to create more wealth. It has been argued that the bourgeois welfare state helps professionals and businessmen more than poor people
4. Efforts were made to improve the provision of the social minimum (through revising the Canada Assistance Plan) until the mid 1970s but this collapsed when there was an economic recession
5. There was not the same feeling about the need to curtail the universal programs of health and post secondary education at this time, only to bring their financing under tighter control

Canada's attitudes to this division have been changing over time. Just after the war the emphasis was upon improving the social minimum, now it is upon helping businesses to survive. Probably the middle classes have profited most from the universal programs of the welfare state.