

**CANADA AND THE US: PUBLIC HOUSING AND HEALTH POLICIES**

CANADA AND THE UNITED STATES:  
AN HISTORICAL AND NEO-INSTITUTIONAL STUDY  
OF PUBLIC HOUSING AND HEALTH POLICIES

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## ABSTRACT

This thesis seeks to explain the way in which assisted housing and health policies evolved in Canada and the United States during four watershed periods: the mid-1940s, the late 1960s, the late 1970s, and the mid-1980s. To achieve this objective, it discusses the concepts of health, the broader determinants of health, disease prevention, and health promotion; it reviews documents which urge that greater attention be paid to the broader determinants of health during policy formulation; and it examines recent studies which stress the value of linking assisted housing and health policies.

After an overview of assisted housing and health policy development in Europe, the thesis explores the evolution of these policy fields in Canada and the United States up to the mid-1940s, and investigates the reasons why these nations followed the policy paths they did.

Using the neo-institutional approach to explain the complex interplay among the various institutions, actors, and events that affect the public policy process, the thesis discusses eight major institutional and behavioral variables that contribute to the shaping of policy over time. It then studies the influence which these variables had on assisted housing and health policies during the four watershed periods.

Examination of postwar Canadian and US policy trends shows that although housing was treated in both countries mainly as an economic issue and only secondarily as a determinant of well-being, Canada dealt with healthcare essentially as a social issue and adopted a public system, while the US treated it as a socioeconomic issue and relied heavily on the private sector. Despite these policy differences, a potential for linking assisted housing and health policy manifested itself in both countries during the mid-1940s and late 1960s, but declined after the late 1970s.

## PREFACE

This thesis is closely linked with my clinical experience as a physiotherapist. Having worked for nearly thirty years with patients of all ages afflicted with a variety of conditions caused by injury and disease, I have become keenly aware not only of the functional challenges related to the underlying pathology from which these individuals have suffered, but of other obstacles which have also adversely affected the quality of their lives. Indeed, these latter obstacles to healthy living — for example, shelter that does not meet functional needs, transportation that proves physically or economically inaccessible, limitations on the possibilities for gainful and satisfying employment, absence of community support — can be as disabling as any handicap.

In recent years there has been a growing interest in these broader health-related issues and the influence they have on well-being. This interest has spawned a search to prevent problems from occurring in the first place by learning how the onset of disease can best be avoided and how good health can most effectively be promoted. In the process, it has become apparent that the quality of health is closely related to the nature of housing and that, in both areas, it is wiser to adopt proactive and preventive strategies than reactive and adaptive ones.

As a physiotherapist, I have followed the evolution of housing policy over the years in Canada and the United States, where shelter has been treated mainly as an economic issue and not always as an integral part of social policy. I have also found that insufficient study has been accorded both to housing as a broader determinant of health and to housing policy as an adjunct to health policy. As a result, I have dedicated this thesis to exploring the roles of the state and society in providing housing and healthcare, to determining what factors have shaped those roles in each country, and to discovering what opportunities have

existed to fashion closer links between housing and health policies.

I would like to express my appreciation for the guidance given to me by the members of my Supervisory Committee: Professor Michael Stein, Chair; Professor Joan Boase; and Professor George Breckenridge.

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## INTRODUCTION

This thesis seeks to explain the way in which public housing and health policies evolved in Canada and the United States during four watershed periods since the mid-1940s, and how eight determining factors influenced the development of those policies in each nation.

In order to achieve this objective, the thesis is divided into two Parts.

- Part I (Chapters 1-3) provides historical, theoretical, and procedural background which is necessary for the study proper.
- Part II (Chapters 4-8) analyzes the development of public housing and health policies in Canada and the US during four key moments of policy change, specifies the policy strides that were made by each nation, and, as a subordinate issue, monitors the opportunities for linkage that existed between the two policy fields during those periods.

Chapter 1 surveys historical developments that have exposed the relationship between housing and health — a relationship which, for professional reasons, inspired the selection of these two policy fields as the focus of study for this thesis. The chapter proceeds to discuss the concepts of health, the determinants of health, disease prevention, and health promotion. It then reviews important documents which urge that greater attention be paid to the connection between public policy development and the broader determinants of health. This review is followed by an examination of recent representative studies on the subject of housing as a determinant of health. Finally, as a means of seeing Canadian and American policy in a wider context, Chapter 1 provides some examples of public housing and health policy development in Europe.

Building on the discussion of the ways in which these policy fields have been

treated in Europe, Chapter 2 explores the evolution of public housing and health policies in Canada and the United States up to the mid-1940s, and studies the reasons why each nation followed the policy paths they did.

Chapter 3 assesses the neo-Weberian, the class, and the neo-institutional approaches and selects neo-institutionalism as the main guide for the study. This choice was made because the neo-institutional approach appeared to be the most valuable tool for examining the development of social policy in nations such as Canada and the United States, which, though analogous in important respects, are fundamentally diverse in others, and whose policy outcomes, be they similar or different, are the product of distinct policy processes.

The neo-institutional framework embraces historical institutionalism, rational choice institutionalism, and organizational theory/sociological institutionalism. By focusing on eight major variables drawn from these streams — federalism, central government institutions, inherited policy, political culture, ideology, definition of the problem, decision making, and exogenous influences — the thesis brings to light the complex interplay among the various institutions, ideas, and events that affected housing and health policy in the periods under study.

The chapter concludes with a literature review which helps establish the key moments of policy change that will be studied in Part II. Those watershed periods are the mid-1940s, the late 1960s, the late 1970s, and the mid-1980s.

In Part II, the neo-institutional framework is applied to the four watershed periods. Each chapter deals with a different period and, by studying the multifaceted interactions among the determining factors that have been selected, attempts to explain why specific policy choices were made at that time.

Examination of this question shows that housing has been perceived in both countries mainly as an economic issue and only secondarily as a determinant of well-being, while health has been viewed essentially as a social issue in Canada and a socioeconomic

issue in the US. Furthermore, whereas the distinct policy processes characteristic of each nation led to divergent outcomes in health policy, they produced housing outcomes that were in many respects similar. Another similarity was that the potentials for linkage between assisted housing and health policies that were apparent in the first two watershed periods and that stimulated the choice of these two fields as a subject of research in this thesis declined after the late 1960s in both nations.

The study concludes with a summary of the policy differences between these two nations and a brief review of the housing and health policy changes that took place in the 1990s.

## PART I

### CHAPTER 1

#### HOUSING AS A DETERMINANT OF HEALTH:

#### A RETROSPECTIVE

It has long been recognized that the health of populations is dependent on more than the type and quantity of healthcare services that are available to them. Both pre-agricultural and agrarian-based groups developed systems of labor, controls over communal living, and defense mechanisms whose ultimate goal was to protect the health and well-being of their members. When societies became urbanized, the health and welfare of the community remained a primary consideration.

With the advent of the Industrial Revolution, the "vastly enhanced prosperity for Western societies . . . led to better health" (Frank and Mustard 1994, 4). Although there still were few effective medical treatments for most illnesses, the public health measures that were introduced in the late nineteenth and early twentieth centuries significantly reduced the number of deaths that occurred, particularly those that were attributable to waterborne diseases.

The concern about this type of malady is illustrated by the following Canadian example. In 1884, Toronto's Medical Officer of Health declared that poor water supply and drainage in a large number of homes in the city were contributing to a major health problem. This situation, we are told, "imperiled our citizens, causing and promoting disease." In rapidly growing urban centers such as Toronto, the "massing of a vast number of human beings over a limited space, and the unhealthy vapors from stables and factories" was another cause of formidable diseases like typhoid (*Yesterday's Toronto* 1997, 142).

Even before these observations were made in Toronto, efforts were under way in several American cities to replace existing slums and to prevent the growth of additional ones in newly expanding urban centers (Doan 1997). Pioneers in public health, many of whom were women concerned with the worsening conditions for mothers and their children, fought for the passage of city ordinances that would establish standards for space, light, and air in housing. Referred to as "slum worriers," these pioneers had worked for years at the local level with charities and philanthropists to improve housing that was owned primarily by groups and individuals that reaped profits from accommodating "the victims of the slums" (McGuire et al. 1987, 153). Their attempts to influence government action brought the struggle to a new and higher level than before.

Awareness of the appalling conditions that existed in American slums served to heighten the debate regarding government involvement in matters that many people fervently believed should remain in the private realm. Reports indicate that traditionalists put up "a stone wall of resistance" against any government intervention that might undercut the "basic philosophical foundations of the American political structure" (McGuire et al. 1987, 154). Despite such opposition, the effort to ensure adequate housing became one of the most important features of the US welfare system for mothers and their families in the 1920s, and a guiding tenet of the 1937 National Housing Act (Newman and Schnare 1992).

Concern about housing conditions and poor health was not limited to North America, however. In Europe, for instance, city populations grew dramatically and squalor increased in the overcrowded and inadequate urban accommodations that sprang up. By the middle of the nineteenth century, there was a "linking of the phenomenon of urbanization with the sanitary reform movement which was spurred by the widespread occurrences of typhoid and cholera" (Doling 1997, 11). As the Industrial Revolution gained momentum and farm laborers became factory workers in growing numbers, truly appalling conditions

developed in the industrial areas to which the newcomers were attracted. Since factory owners did little to safeguard the welfare of their employees, more and more governments embarked on programs to improve the housing of the working poor and their families.

The concept of public housing<sup>1</sup> as a broader determinant of health carried considerable weight in several countries during the first part of the twentieth century. In Britain, for example, where less than 1% of houses had been built by public authorities prior to World War I, more than 30% of house building was publicly funded after that war (Lowry and Bynum 1991, 6), ostensibly to provide "homes fit for heroes" (Spicker 1989, 11).

In Canada, the concern about housing as a determinant of health, which had manifested itself during the latter part of the nineteenth century and the early part of the twentieth, did not entirely disappear after the Second World War. Thus, it is not surprising to see the publication of two influential federal documents on the subject in the third quarter of the century. The Lalonde (1974) and Epp (1986) Reports emphasized that medical conditions that require treatment by healthcare personnel should be distinguished from non-medical factors which also have an impact on health status. Among these factors were lifestyle (e.g., avoiding cigarette smoking), behavior (e.g., participating in health promotion activities), and physical and social environments (Epp 1986, Pederson et al. 1988).

Later, the World Health Organization (WHO) published *Guidelines for Healthy Housing*. This document maintained that there exists "a strong relationship between housing and health" (1988, 5), and encouraged all governments — but especially those in developing nations and those with large numbers of slums — to create practical, health-related housing policies.

Many of the ailments that the original laws and public health initiatives were designed to combat are still with us, including highly contagious diseases like tuberculosis, and a variety of lesser maladies like scabies, that are frequently associated with overcrowding and unsanitary conditions. But other illnesses related to our current urban

accommodations also challenge the skills of today's medical communities. For instance, in the past five years, researchers have discovered that children's asthma is frequently triggered and/or exacerbated by the presence of cockroaches in the home. In North America, there is a far higher incidence of asthma in urban areas that are infested with this insect and, according to the report, asthma "is the most common chronic illness of childhood and is increasing" (Haney 1996).

### **Health, the broader determinants of health, disease prevention, and health promotion**

In order to effectively approach the subject of housing as a broader determinant of health, it is important to clarify the meaning of *health, the determinants of health, disease prevention, and health promotion*.

As used in this thesis, *health* broadly signifies physical, mental, and social well-being. The fundamental prerequisites for health are listed in the Ottawa Charter for Health Promotion: namely, "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" (WHO 1986).

The term *determinants of health* has a number of interpretations. These tend to reflect the user's professional discipline. For example, a physician would be inclined to see the prevalence of medical management of disease as the key determinant of health. An economist, on the other hand, might see the degree of economic investment in preventive and reactive health strategies as the main determinant. However, our current understanding of determinants of health is becoming much more complex and subtle (Lavis and Stoddart 1994), advancing far beyond the traditional disease/cure and cost/benefit views (Frank and Mustard 1994, Wilkinson 1994). For instance, Evans and Stoddart include social environments, physical conditions, genetic endowments, and individual resilience as determinants, as well as prosperity and access to appropriate healthcare facilities (1990).

Disease prevention and health promotion have been recognized for many years as fundamental to well-being (Pederson et al. 1998). Simply put, *disease prevention* "involves identifying the factors which cause a condition and then reducing or eliminating them" (Epp 1986, 4). Most people associate disease prevention with a variety of public health activities such as immunization and water chlorination.

*Health promotion* goes beyond disease prevention. It is a complex process of enabling people to improve their health (Pederson et al. 1988) through educational, legislative, and economic strategies and through the cooperative efforts of actors other than those who provide health services, in order to ensure that the physical, social, environmental, and economic conditions that influence health are recognized and dealt with (WHO 1984).

However, political and moral dilemmas inevitably arise when these types of strategies are formulated and implemented. For this reason, one of the World Health Organization's working groups noted that there must be a "balance [between] public and personal responsibilities for health" and that the people "involved in health promotion need to be aware of possible conflicts of interest both at the social and the individual level" (1984, n.p.).

These themes were echoed in 1986 when the Ottawa Charter for Health Promotion was presented at the first international conference on health promotion, which was sponsored by the World Health Organization, Health and Welfare Canada, and the Canadian Public Health Association. The Charter was designed to obtain a commitment from the international community to adopt five broad health promotion goals: namely, to develop healthy public policy;<sup>2</sup> to create supportive and sustainable socio-ecological environments; to strengthen community efforts and local actions that focus on health promotion; to develop personal self-care and life skills, primarily through education; and to reorient health services to go beyond merely providing clinical or curative services and to move actively towards the promotion of health.

**The determinants of health in public policy development:  
some representative documents**

The following examination of key documents and reports provides an introduction to the relatively recent interest in assisted housing as a broader determinant of health and to the attention that has been placed by academics on housing and its relationship to health and other policy fields.

**The Lalonde Report.** It was the Lalonde Report of 1974, entitled *A New Perspective on the Health of Canadians*, that started serious academic inquiry into the link between public policy development and the broader determinants of health. The strength of the Canadian document lay in its new and broad approach to old, highly contentious topics associated with the healthcare field. Described as a "very powerful framework" for assembling evidence on the broader determinants of health, it showed that new approaches to understanding the diverse dimensions of health would not only help scholars formulate innovative strategies for analyzing the various aspects of health in relation to public policy development, but would be of distinct value to "providers of care, policy makers, and particularly ordinary individuals" (Evans and Stoddart 1990, 1349).

Marc Lalonde, then Minister of National Health and Welfare, declared that although the healthcare system had served Canadians well and was equal to any other in the world, it was "evident now that further improvements in the environment, reductions in self-imposed risks, and a greater knowledge of human biology are necessary if more Canadians are to live a full, happy, long, and illness-free life" (1974, 6). With respect to *environment*, Lalonde characterized the "lack of adequate housing" as one of the factors that had substantially contributed to societal ills in Canada. He also indicated that "urbanization, and all its effects on physical and mental health, has not been assessed in any comprehensive way. Crowding, high-rise living, and the dearth of intensive-use recreational areas in cities

are all contributors to sickness in Canada" (1974, 18).

A key aim of Lalonde's report was to make Canadians more aware of the importance of adopting a healthy lifestyle, thereby reducing potential health-related hazards and lessening their dependence on the rapidly growing, expensive, curative medical system. However, the proposals made by Lalonde had a consequence that was unintended by their author. Many of the actors who wished to maintain the existing system, as well as others who would benefit from the recommended changes, shifted the debate from attempts to control medical costs to making individuals responsible for their overall health status (Pederson et al. 1988). The result was that both groups "avoided challenging the conventional world of work, income distribution, and control over the environment, or the conventional medical establishment. It was politically much safer to exhort individuals to live better, often implicitly blaming them for their own illnesses" (Marmor et al. 1994, 223).

**Evans and Stoddart.** Since the Lalonde Report was published, numerous studies have been undertaken to further our understanding of the impact of various health determinants. It should be noted that these studies have promoted many types of social and political action designed to raise public awareness. As will be shown below, these research endeavors have advanced our knowledge about health and well-being and, in many respects, have improved our quality of life, thus leaving little doubt that "an ounce of prevention is worth a pound of cure."

Scholars from a variety of academic disciplines, including those in the medical profession, are now going beyond the parameters of the medical model of disease and are conducting research into the broader determinants of health.<sup>3</sup> As a result, important new recommendations are being made about how the principles of disease prevention and health promotion can be put into practice, how those most in need can receive appropriate support, and how healthcare spending can be more effectively allocated in order to ensure that

duplications and deficiencies in health-related services will be avoided. Although other research models now exist for inquiry into the subject of healthcare spending, one framework that seems especially promising for the future is the one designed by Evans and Stoddart.

In their article "Producing Health, Consuming Health Care," Evans and Stoddart assert that, in industrialized nations, healthcare deals primarily with clinical diagnoses, but is woefully neglectful of the detrimental factors that may have contributed to the medical condition in the first place. As a result of following this course, the healthcare system has become overly reactive, overly limited in scope, and overly expensive. The problem, they add, is that "a society that spends so much on health care that it cannot or will not spend adequately on other health enhancing activities may actually be reducing the health of its population" (1990, 1360). In order to avoid this situation, they favor replacing obsolete policy models with frameworks that deal realistically with today's rapidly changing sociodemographic and economic conditions.

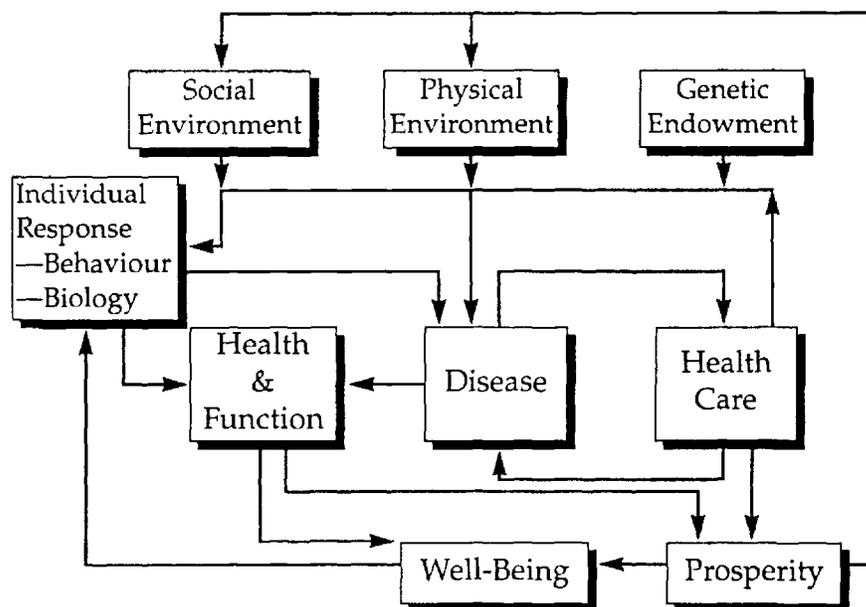
Evans and Stoddart agree with the concept presented by Lalonde and others that, although there have been many beneficial advances in therapeutic interventions for a variety of medical conditions, more emphasis should be placed on "interventions and structural changes outside the health care system" (1990, 1361). They claim, however, that while the thrust of the Lalonde Report was correct, the Report itself had limited success in improving the overall health status of any population because it did not significantly change the practices of healthcare providers who favored using reactive therapy or those of the people who preferred to continue following unhealthy lifestyles.

Evans and Stoddart suggest that what is needed for realistic policy formulation is recognition of a new set of health determinants. Drawing a distinction between *disease* as scientifically defined by the medical community and *health* as understood by the healthcare consumer who is mainly interested in a return to optimal function, Evans and Stoddart maintain that the "patient's sense of 'illness' bears no very close relationship to the

clinician's interpretation of 'disease'" (1990, 1356). In other words, two equally relevant but distinct perspectives coexist. In order to build a bridge between these conflicting views, Evans and Stoddart submit that policy formulators should consider factors such as genetic endowment and the social and physical environment in which we live, since these factors greatly influence our health, function, and well-being.

These researchers also note that, in most OECD countries, healthcare industries are consuming significant percentages of the nation's GDP and are developing increasingly complex links with public, national, and multinational organizations. Evans and Stoddart therefore propose that a portion of the massive amounts currently being spent on health services, particularly in areas where the therapeutic interventions have not proven efficacious, could be reallocated to other health facilitating programs, especially those that have been shown to enhance the quality of life.

The Evans and Stoddart Framework (1990)



Throughout their discussion of the broader determinants of health, Evans and Stoddart emphasize that each of the variables in their framework has multiple, heterogeneous parts, and each contains complex policy issues. Thus, care must be taken

not to offer simplistic policy solutions or prescriptions that may further compound serious problems that already exist in related policy fields.

The above framework is only one of several that have been crafted to explain how the determinants of health might be regarded and, hence, to guide policy makers in designing effective, cost-efficient policy measures for the populations that fall within their purview. These frameworks have produced greater debates about the broader determinants of health, the impact they have on population health, and the politics associated with health policy. Some critics have argued that by cutting health costs, people in need will be further disadvantaged because, in their view, the money saved will not be reallocated by policy makers to ameliorate the underlying illness-producing problems (Burke and Stevenson 1993). Other critics maintain that what has been lacking has been a greater focus on the causal factors of health problems, including detailed examination of the broader determinants of health in society (Coburn et al. 1995). Whichever approach those policy makers or researchers adopt, however, they will have to face several major challenges. Among these are how to understand the broader determinants of health and their impact on people's well-being, how to be objective in their analysis, and how to use a balanced perspective in their efforts to obtain the conditions that promote optimal health.

### **Examples of recent research into the relationship between housing and health**

The following studies serve to illustrate some of the research efforts that have been made into the complex relationship between housing and health. Representative investigations such as those outlined below help reveal why housing and health are becoming more important for understanding the nature of contemporary policy making. In addition, when seen in the context of the Lalonde Report and the theoretical work of Evans and Stoddart, these studies will help explain why the policy fields of housing and health were selected as

the focus of research in the present thesis.

Research has proven that homes which are excessively hot or cold, damp, or infested promote illness and disease (Jones and Sidell 1997). Especially vulnerable to the detrimental effects of poor living conditions are the young, low-income women, and the elderly. Three studies, in particular, may be cited to illustrate the impact that housing quality has on the health of these specific groups. The first, carried out by Sharfstein and Sandel, reports on substandard accommodation and its effects on children; the second, by Wasylshyn and Johnson, focuses on women's health, and the third, conducted by Wister and Gutman, deals with housing and its relationship to the well-being of the aged and infirm. In addition, housing as preventive medicine is discussed by Ambrose, and the subject of "unhealthy cities" is investigated by Whiteis.

**Housing and the health of children.** In 1998, pediatricians at the Boston Medical Center produced a far-reaching report which clearly demonstrates that "[m]illions of American children who live in substandard housing are subjected to conditions that put them at great risk for health problems and injuries" (Sharfstein and Sandel, 14). Citing specific housing factors that contribute to long-term or chronic health problems, the authors assert that the rates of asthma, lead poisoning, contagious infections, and other hazardous medical conditions are far higher for children who live in substandard housing than for the general pediatric population. Furthermore, repeated infections and illnesses are known to affect normal development and frequently have a negative impact on the future health and well-being of the child.

Although the physicians who conducted this extensive study hold that "housing should be considered a health issue," they do not see substandard housing and its consequences as a problem which should be borne by the healthcare system alone (24). Rather than recommending that housing-related health problems be treated after the fact, as

at present, they propose solutions that are preventive. They contend, for example, that if government agencies, medical insurance organizations, and residents collectively do not institute specific strategies designed to remove lead hazards, prevent rodent and insect infestations, ensure adequate heating and water supplies, and provide safe physical environments, children living in substandard conditions will continue to be at risk. They further maintain that the cost of introducing preventive measures at an early stage, although significant, would be minimal when compared with the long-term costs that are required to manage health problems reactively. So convinced are these researchers of the danger of substandard housing to the public welfare that they urge that "[l]andlords who maintain apartments with risks to children should be prosecuted to the fullest extent of the law" (24).

It should be noted that the authors of this study do not limit their research to the impact of housing on children's health in rental accommodation, but also include children who live in shelters and those who are homeless. Indeed, they find that conditions are particularly alarming for those who fall in the latter two categories.

**Housing and the health of low-income women.** Wasylshyn and Johnson's (1998) qualitative study explored the question of how living in a housing cooperative influenced the health and health practices of Canadian women with low incomes. They found that a number of interrelated factors, including the physical and social environment, often had negative effects on the overall well-being of the occupants. The study was based on extensive research into the links between the housing and health of unattached women. Basing their conclusions on their own observations and the investigations of others, Wasylshyn and Johnson contended that "[i]nadequate housing is a particularly important factor associated with poverty and poor health . . . [and] serves as an indicator of both deprivation and health status for women. Public housing projects are often associated with stigmatization which has negative health effects" (1998, 974).

**Housing and the health of the elderly.** Studying the issue of housing as a determinant of health from the perspective of the aged and infirm, Wister and Gutman maintain that "[o]ne of the problems we are facing in attempting to assure adequate housing for an aging population is the lack of coordination of services and shelter" that provide for their changing functional needs over time (1997, 33).

After surveying the different types of accommodation and support that aging people need as their functional levels change, Wister and Gutman affirm that it is no longer acceptable for the old and very old to be institutionalized simply because their mobility has become impaired. Acceptance of this contention is leading an ever greater number of policy makers to recognize the "need to interface shelter and care in more flexible arrangements than heretofore has been the case" (32). As a result, Wister and Gutman conclude that, in the future, policy makers will be formulating flexible new policies for the elderly, which establish closer links than currently exist among housing, health, and social services.

**Housing as preventive medicine.** Other research undertaken in recent years has confirmed that factors which had been excluded or ignored in previous studies also have a direct influence on both the physical and psychological well-being of a home's occupants. Among the most significant points that have been revealed is that where assisted housing is concerned, the design and location of high-rise building complexes, with their overcrowding, limited open spaces, noise pollution and lack of privacy, have contributed to a host of psychological, physical, and social pathologies such as isolation, vandalism, and crime (Sewell 1994).

In an effort to find ways of avoiding situations like this, academics at the University of Sussex have examined the issue of housing as *preventive medicine*. In preparation for their study, they critically reviewed over 300 research projects related to housing and health. The projects they checked were largely multidisciplinary in nature and encompassed

a wide variety of research strategies, including complex longitudinal analyses and individual case studies. Their own qualitative and quantitative investigation consisted of a series of interviews with the occupants of over 100 households in London, as well as physical inspections of the subjects' homes. The researchers also conducted detailed interviews with the physicians, nurses, health visitors, and therapists who were directly involved in the medical care of the occupants.

The results of this study confirmed the findings reported in many of the other projects: namely, that complex and interrelated factors, including income, education, and housing, have both direct and indirect effects on health. It was found that statistically significant factors contributing to the occupants' ill health were overcrowding, infestations, dampness, and other injurious conditions in their homes. The researchers concluded that poor housing is one important cause of illness that urgently needs attention. They maintained that "living with the increasingly heavy costs of an under-invested housing system . . . is surely irrational in the face of mounting evidence" and that politicians and policy makers need to be effectively persuaded that "more quality has to be built into housing construction, maintenance and management" (Ambrose 1997, 59).

The issues of construction and maintenance are of growing interest to groups and organizations in the public, private, and third (voluntary) sectors. More attention is now being dedicated to the development of construction methods and designs that use safe and durable materials. These initiatives are being undertaken in an effort to reduce the illness and distress that has resulted in the past from the dangerous substances and shoddy work practices employed by the housing industry.

**Housing and "unhealthy cities."** In addition to research into the above issues, there are studies which look beyond the relationship between health and the physical environment of housing. The Whiteis investigation of "unhealthy cities" illustrates the

impact of housing on health from this broader perspective.

Whiteis' study shows that the quantity and quality of housing for those in need have been direct causes of many of America's urban ills, and conditions such as housing deterioration expose vulnerable populations to "a wide variety of health, behavioral and social pathologies" (1997, 229). The fact that badly built and poorly managed public housing complexes have become ghettos for racial minorities and the poor is only one part of the problem. Government retrenchment from a number of social assistance programs, along with the proliferation of for-profit healthcare organizations — i.e., the expansion of "corporate medicine" — has compounded an already serious predicament in socially fragile urban areas. One consequence is that many community hospitals that once provided care and employment to the local population are no longer considered to be profitable enterprises by their corporate owners and have been shut down. Not only do these closings leave inadequate medical support for needy people in circumscribed areas, but they also cause related businesses, such as pharmacies, to close or move, thus making access to healthcare even more problematic for those who are already financially and/or medically compromised. As a result, the cycle of urban decay is reinforced.

### **Social policies**

#### **in representative European nations**

Although the primary concern of this thesis is Canadian and US public policy development in the fields of assisted housing and health since World War II, it is instructive to have an understanding of the policy paths that have been followed by other industrialized nations.

In the twenty-three OECD nations, for example, a wide variety of state configurations may be identified. Countries like Austria, Australia, Belgium, Canada, Germany, Switzerland, and the United States have federal systems, and Britain is increasingly

exhibiting quasi-federal features. Over time, each nation has developed a unique pattern of social welfare policies designed to meet the dynamic needs of its citizens. Pierson maintains that in order to fully understand these policy patterns, it is essential to "go beyond the simple (if important) claim that . . . institutions matter for social policy outcomes" (1995, 451). He and other scholars, such as Ashford (1991) and Banting (1995), have emphasized the need for examining additional variables in concert with the types of governing systems which have directly or indirectly affected policy change.<sup>4</sup>

The following discussion of European social policies in general, and British policies in particular, calls attention to some of the many variables that should be included in a discussion of policy change.

From a historical and socio-economic perspective, it is clear that social policy in Europe had its roots well established in several nations by the end of the nineteenth century. In good part, this came about because of the massive upheavals occasioned by the Industrial Revolution. Social policies were introduced to "preserve the benefits of industrialism and to cushion workers against some of its shocks" (Kingson and Berkowitz 1993, 27). The German government was particularly progressive in this regard, and based on principles initially enunciated by Bismarck, by 1884 Germany had two social programs that were designed to help victims of industrial accidents and illness. Even before World War I, eleven other European nations had similar programs in place.

World War II left most of Europe physically and financially devastated. Not only did millions of citizens need aid, but, unlike North America which had not been physically damaged by the war, entire cities and industries had to be rebuilt. During this period of physical and economic reconstruction, governments devised complex national and international covenants designed to restore peace and prosperity. Among the strategies that were embraced were Keynes' economic philosophy and the blueprints for market recovery outlined in the Marshall Plan and the General Agreement on Tariffs and Trade (McCormick

1996).

The majority of European nations developed some kind of support for those in need — albeit for different target groups, with different goals, and in different forms. Ashford reminds us, however, that "[t]hough generally omitted from most historical and political accounts of welfare states, the elevation of societal responsibilities from local to national governments was integral to the nationalization of welfare" (1991, 363). As will be discussed later, one of the key consequences of the transfer of social responsibilities from the local to the national level was the permanent change of societal structures and the institutions that molded them.

Although it is generally accepted that Germany was the "institutional innovator" for government intervention in the realm of social security, Britain became known as its "adapter and propagator" because of the breadth and depth of its social programs, particularly those which were developed during World War II and the early postwar period. The term "welfare state" was born in Britain in 1941 and became firmly linked with the Beveridge Report which was published in 1942.<sup>5</sup> Largely because of the devastating consequences of the war and of the economic austerity measures that were associated with it, there was a general rejection of the long-held sentiments that had been embodied in the Poor Laws,<sup>6</sup> and significant parts of the population began to favor a greater societal commitment to the concepts of fair share and redistribution for those in need. In many respects, the British Westminster parliamentary system did much to facilitate this new policy direction during the postwar era. In contrast to the "joint-decision traps" (Scharpf 1988)<sup>7</sup> that have, in many instances, bedeviled policy development and implementation in federal systems, the unitary form of government in Britain promoted change. It should be recognized, however, that Britain's parliamentary system was not solely responsible for the change in policy direction. History shows that the steps taken by the government through its elected and appointed officials were complemented by the concerted actions of

academics, business leaders, union heads, and other activists, all of whom helped to bring this shift about. In other words, there was a "convergence between institutional development and conceptual change" (Flora and Heidenheimer 1982, 18-22).

Over the years, academics from a number of disciplines have used a variety of tools to analyze the causes and effects of changes in social welfare policy. In particular, Ellen Immergut and Paul Pierson have focused on institutions and on the consequence of change within and among the institutional structures of various governments. These scholars have adopted different approaches to institutional analysis, with Immergut focusing more on the historical and formal aspects of institutions, and Pierson exploring both their formal and informal aspects.<sup>8</sup>

Adopting the historical institutional perspective in her analysis of government systems, Immergut asserts that "institutional rules and procedures, and not the demands and resources of social groups, set the terms for political conflict" (1992). In her extensive examination of the activities of health-related institutions in Sweden, France, and Switzerland, she observes that, over time, different polities have cultivated significantly different strategies for policy formulation. Critical factors such as constitutional rules, electoral participation, and formal and informal processes for dealing with conflict and consensus all affect the frameworks in which public policies are developed. Immergut suggests that "specific institutional configurations establish strategic contexts for political contests that determine those interests that can be effectively expressed and which ones will prevail over others. In this way, political institutions can help to shape the definition of interests and their expression in politics" (1992, 5).

Pierson (1995) believes that, in examining policy shifts, however, it is necessary to consider both the impact of established structures and norms and the influence that is exerted by formal and informal rules of the game. Three points are essential to Pierson's type of analysis: the identification of divergences that exist between the policy preferences

of the different countries, the description of how policy makers have applied those preferences, and the revelation of how the implementation of specific policies results in intended and unintended institutional changes.

Although formal institutions are most often constitutionally defined and are therefore central to the governing process, social groups, private organizations, bureaucrats, and other interests also try to manipulate state systems. According to Immergut, although the rules of the game differ in all nations, interest groups generally become embedded in the institutional process. As new issues emerge, those groups attempt to influence the policies in question. This also causes changes to the institutional frameworks and the policies that are produced.

To enlarge upon Immergut's assertion, we might add that when governments introduce, modify, or cancel specific programs, individuals and groups both within and outside of the institutions respond, sometimes in ways that can be anticipated, sometimes in ways that are unexpected. This is true whether those individuals and groups are allied with the government of the day, with providers and manufacturers, or with the people, organizations, and agencies that support or oppose the change. Policy networks and communities (Coleman and Skogstad 1990),<sup>9</sup> as well as epistemic communities (Haas 1992),<sup>10</sup> tend not to remain quiescent in the face of change, but are disposed to go into action. Often, in the hope of swaying policy makers, these groups conduct research, disseminate information, and organize interested parties. As Sabatier indicates, concord and discord within and among these coalitions may change significantly with the passage of time (1993). Whatever course they take, however, they frequently serve as powerful instruments for influencing the policy process.

**Health policy.** Elola (1996) has found that, in Europe, within the social welfare fabric, national health systems fall into two distinct categories.<sup>11</sup> The first consists of

countries with a National Health Service (NHS). Such nations generally have a universal welfare regime in which the financing of health services is mostly through public taxation, and health insurance is universal. Among the countries that have this kind of healthcare system are Britain, Ireland, Italy, Spain, and Sweden.

The second major category of healthcare is the Social Security variety. This is found in countries such as Austria, Belgium, France, Germany, Luxembourg, Switzerland, and the Netherlands. Financing is mostly through payroll taxes, and multiple health insurance options are available. In contrast to countries of the NHS type, where healthcare is mainly provided through public hospitals, nations with Social Security systems tend to rely on private facilities (Elola 1996, 241).

Such diverse institutional structures have come about in Europe as a direct result of political intervention in response to a variety of economic, social, political, and philosophical stimuli. Heidenheimer et al. note that:

German political leaders from the 1920s to the 1950s transformed their insurance-based arrangements into a *corporatized* system, under which health providers and recipients regulate themselves and one another in accordance with rules prescribed by the state. The British in the 1940s chose to have the national government assume direct responsibility for health care, thus creating a truly *nationalized* system (1990, 58).

Thus, the German "Bismarck type" health system developed close links with the private and public sectors, and health providers and care recipients self-regulated the system in adherence to state guidelines. In contrast, the British "Beveridge type" health system, which was established by a Labour government after World War II, was based on the belief that effective universal health coverage required centralized control (Heidenheimer et al. 1990, 58-59).<sup>12</sup>

The debate about the relative advantages and disadvantages of the "Bismarck" and "Beveridge" systems promises to continue as the institutional players keep up the pressure for change. Although key health indicators such as infant mortality and life expectancy are

not dramatically different between the Social Security and NHS systems in OECD nations, there is a significant difference in public satisfaction with the services provided. In 1994, only 24% of the population was content with NHS care as compared to 43% satisfaction with Social Security care (Elola 1996, 245).

Belief in the need to compare the evolution of health policy in industrialized nations has been triggered by several factors. Among them are the following: First, is the occurrence of a major change in the meaning of *healthcare* from little more than the employment of medical strategies to deal with conditions caused by injury or disease to a combination of disease prevention, health promotion, and the medical treatment of illness (Taylor-Gooby 1996, 203-204; Montanari 1995, 28-35). Second is the realization that the medical model of healthcare usually involves reactive strategies and produces costly and complicated relationships between public, private, and non-profit agencies and organizations. Third is the fact that since many of the member states' health problems are similar in cause and effect, solutions to them might be more efficiently found by cross-nationally linking resources and technologies. Indeed, although health policy has generally been considered a domestic issue, more and more calls are now being made for collaborative international efforts designed to prevent injury and disease, better the quality of life (van de Water 1996, 117), and develop cost-effective actions to improve key health indicators such as infant mortality and life expectancy (Fierlbeck 1996, 530; Montanari 1995, 28-35).

One of the consequences of this movement towards international collaboration is that policy makers are discovering that there is a paucity of meaningful information on comparative health and illness indicators, and that many national policy decisions have been based on tradition, ideology, or incomplete information, rather than on empirical data (Elola 1996, 242-246). As a result, interested agencies and organizations are developing retrospective as well as current clinical measures for the critical analysis and comparison of health and disease in various populations (McCarthy 1992, 75).

Over the years, many nations have spent significant portions of their GDPs on social protection. For example:

Public Expenditure on Social Protection as a Percentage of GDP

	<u>1981</u>	<u>1991</u>
France	25.36	27.26
Germany	26.34	22.94
United Kingdom	23.31	24.03

(Source: OECD 1994)

**Housing policy.** Before World War I, and to a large extent prior to World War II, housing had generally been seen as falling mainly within the purview of the private sector and philanthropic societies. Intrusion by government on any level was minimal.

After World War II, house building became a major activity in all European nations. Some governments, including those in Britain, adopted a comprehensive approach and treated housing as of national importance for all citizens. In general, government intervention was believed to be only a temporary measure to facilitate market development and growth (Boelhouwer and van der Heijden 1998).

One of the features of this period was that lasting relationships were established between representatives and organizations in the public and private sectors (Heidenheimer et al. 1990, 99). Nevertheless, a comparative study of housing policies in industrialized nations shows that, as in the case of health policy, nowhere has there been a completely free market in housing "in which outcomes have been solely determined by the unfettered actions of individual suppliers and consumers. In fact, in comparison with many other goods, perhaps reflecting the fact that all housing is an essential item of consumption, the level and nature of [government] intervention in housing has generally been considerable" (Doling 1997, 20).

In Britain, "the link between housing and health was first made explicit in the nineteenth century when local authorities took action to clear slums and then to build municipal housing for the working classes" (Jones and Sidell 1977, 164). After World War II, the Labour government embarked on national social reform, including legislation which augmented the role of local government in the provision of housing for the general population. Between 1945 and 1949, the "concept of social housing as a social service was consistent with the wider development of the welfare state" (Doling 1997, 13) and over 900,000 council houses were built under the auspices of the local authorities. This was a "golden era of social housing." During the tenure of the Conservative government in the 1950s, however, the private sector played a much greater role in supplying accommodation for those who could not afford to buy homes at the prevailing market prices. The 1960s saw another shift in policy, and under a national Labour administration, government intervention again became more pervasive. With the advent of the Thatcher government in 1979, the private sector regained prominence and local authorities were instructed to sell council houses to their tenants at favorable prices. As a result of the policy shift by the Thatcher government, nearly two million of these government-constructed houses were sold (Boelhouwer and van der Heijden 1998, 161-172).

As in Britain, post-World War II governments in Europe elected to offer supplementary housing to specific groups which were perceived to be in need (e.g., the elderly and handicapped). But all governments linked their housing policies with the private sector. Consequently, a wide variety of policy instruments were fashioned to promote home-building and to provide accommodation to those who could not afford to pay market prices. Supply and demand subsidies, tax credits, and other financing arrangements were introduced over the years with varying degrees of success to balance the demands of producers and consumers (Heidenheimer et al. 1990). As might be expected, the type of publicly financed housing policy that was developed in each country exhibited identifiable

national characteristics, where the interaction between the state, the private sector, labor, and, in countries such as France and Germany, even "family-centered ideologies" influenced the creation of assisted housing policies (Doling 1997, 185).

**Other influences on policy development.** In the postwar years, both health policies and assisted housing policies have been affected by internal factors such as economic events, demographic shifts, and with growing frequency — as most clearly evidenced by the Britain of Margaret Thatcher — changes in ideology which spur governments to reduce their fiscal responsibilities for social spending. These efforts to retrench have had an impact on the populations that require both health and housing support. As a result, as the size of the aging population increases, care for the elderly is becoming a primary issue of contention in most European nations; and, as more women spend time in the work force instead of continuing in their traditional role as family caregivers, more and more calls are being made for additional government spending in other welfare areas (Folkesson 1993, 26-28).

To a certain extent, the current tensions between the major health players in each European nation may be traced to the locus of power and control which each of the players occupies. Although in most instances government institutions were responsible for designing the various publicly funded healthcare systems after World War II, the relatively autonomous physician groups and associations have been the principal gatekeepers of the quantity, quality (Immergut 1992, 12-16), and location of care (Folkesson 1993, 14). The dramatic growth in public expenditures associated with physicians' fees and other medical costs, in contrast to the public's expectations and willingness to pay, has increased the potential for greater conflict among the players. Furthermore, observers such as Mechanic suggest that as healthcare costs escalate and demands for more complex therapeutic interventions rise, the lines between health and social welfare needs blur. In view of this,

all aspects of healthcare provision must be subjected to broad and rigorous examination. (1995, 1491).

As in the case of healthcare, European nations are undergoing significant changes in housing. For economic, demographic, and ideological reasons, rental housing in both the private and public sectors is experiencing a marked decline throughout the region. Not only has a significant portion of government funded assisted housing stock been sold in the last several years, but few new private ventures have been undertaken despite the fact that existing rental accommodations are aging and are in need of repair. The above mentioned determining factors have helped to create serious problems for those in need of shelter (Boelhouwer and van der Heijen 1998,172).

In our study of policy development, it should be recognized that internal factors are not the only determinants of policy change within national states. External factors can also play a significant role. For example, as mentioned earlier, international bodies such as the World Health Organization and the United Nations (UN) have profoundly influenced the evolution of social policy strategies in numerous countries. Agencies of both the WHO and the UN were created to monitor and improve the health status of the world's population. In many respects, they have had unquestionable success in carrying out their mandate. For instance, the WHO has encouraged cooperative ventures designed to improve the quality of life in many industrialized and developing nations, and recently has worked to disseminate information about the detrimental effect that certain genetic, social, and environmental factors can have on people with chronic illnesses (McCarthy 1992, 67).

Increasingly, however, there has been criticism of some of the activities of the WHO and the UN. For instance, Javed Siddiqi asserts that both organizations have become highly politicized and have strayed significantly from their mandates (1995, 1-6). If Siddiqi is correct, then it would follow that, to a certain extent, the very organizations that were attempting to facilitate the convergence<sup>13</sup> of international health strategies were at the same

time contributing to the production of further differences.<sup>14</sup>

According to academics such as Ham, who has for years examined health policy in a variety of countries, "the science of muddling through is deeply ingrained in the psyche of policy makers and policy advisors, suggesting that fundamental questions are easier to avoid than to address head on" (1996, 17). Consequently, in Europe, political solutions to increasingly complex health-related problems are profoundly difficult to find. Deppe recommends that time and effort would be far better spent if policy solutions were sought by people "with a clear idea of others' motives, aims and interests — who is 'for' and who is 'against', and why," and who is able to recognize "what is *not* required and what may go wrong" (1996, 195).

Although almost all European governments have spent far less on publicly funded accommodation than on health services, the multifaceted arguments associated with the design and implementation of assisted housing policy are no less complicated than those in the sphere of health. As Heidenheimer et al. observe in their comparative analysis of housing, "[a]s with health care, policy makers in the housing field are confronted with choices that hinge on the relationship of government programs to private sector alternatives" (1990, 131). This has led to contentious discussions about how best to provide accommodation for those who are in need. On the one hand, advocates of production subsidies insist that because house building is "very capital intensive," government support for construction is essential for ensuring that the housing industry remains a major sector in the nation's economy (Doling 1997, 47). On the other hand, supporters of demand side subsidies assert that government aid for consumers is the most efficient method of ensuring that the target groups' needs for shelter are met. But disagreement exists within this group, too. Some members claim that housing allowances reflect "the fact that housing policy has become primarily an income redistribution issue rather than a shelter issue," and others maintain that the growing number of tax concessions

to those who can afford to buy their own homes represents "a massive subsidy to the middle class" and thus do not directly help those people who are in greatest need (Heidenheimer et al. 1990, 120).

Analysis is not limited to the above mentioned issues, however. Today we find more and more examinations of the impact of assisted housing and health policies in concert with each other (Smith and Mallinson 1997). These studies show, for example, that in Britain, much of the housing stock which is allocated to people with low incomes is in extremely poor condition. There have been major problems with building design, and there are pressing needs for basic maintenance and rehabilitation.<sup>15</sup> As a result, the complacency of the past is causing housing to emerge "as a major public health issue" (Lowry and Bynum 1991, 13).

As stated earlier, in all the large cities of Europe, problems such as these have been compounded by a significant decline in the construction of low income housing, as well as by changes in state policy. These factors, combined with gentrification<sup>16</sup> in urban areas that had once accommodated "low-income indigenous residents and ethnic migrant workers," have led to dramatic increases in the number of homeless people (O'Loughlin and Freidrichs 1996, 14). In spite of this, not all observers share the belief that there is a need for more government involvement in housing. Their argument is that governments have already had too great an influence on what is primarily a market issue, and that while the shift towards subsidizing consumers may have "enabled governments to target their aid more directly to the intended recipients, it may also have contributed to an 'over investment' in housing." Indeed, like government health insurance, "consumer subsidies for housing have inflated prices and encouraged families to consume more housing than they otherwise would" (Heidenheimer et al. 1990, 131).

The above discussion shows that a variety of factors influence policy making and implementation in the fields of health and assisted housing. Among these factors are gov-

ernment systems, including institutions and their formal and informal rules (Immergut 1992, Pierson 1995); the epistemic communities (Haas 1992), policy communities, and policy networks (Coleman and Skogstad 1992) that participate in policy formulation; economic trends; demographic shifts; changes in ideology; and the actions of international bodies.

As we embark on our study of health and assisted housing policy in Canada and the US, let us keep in mind the experience of a nation like Great Britain. According to Smith et al., "As the twentieth century dawned, housing and health issues were inextricably linked at all levels of policy making. It was taken as axiomatic that housing impinged on illness and disease and that housing interventions were a route to better public health. In the intervening years, housing and health policies have gone their separate ways, and since the 1950s there have been few explicit links between the two areas at the level of legislation or in policy implementation." With the reappraisal of housing and healthcare strategies, what has become evident is that, over the years, there has been "enormous potential for harnessing their points of intersection to ensure that sick people have a right to a decent home, and to ensure that people in any residential setting can exercise their right to health care. Sadly, there are few real signs that these points of contact are being developed" (1991, 228).

## CHAPTER 2

### SOCIAL POLICY IN CANADA AND THE US

This chapter examines some of the key factors that contributed to the development of the disparate social policy paths that exist in Canada and the US. The chapter is divided into four sections. The first explains why comparative analysis is important in this type of social science research. The second discusses the two types of federal government systems that have emerged in Canada and the US. The third looks into the ways these federal structures have influenced the nature of social policy in each country. And the fourth examines the inception of assisted housing and health policy in the two nations.

#### **The importance of comparative analysis**

Canada and the US are generally viewed as similar nations. This perception is held because both countries are geographically contiguous, have federal government systems, and, in many areas, share the same language and analogous lifestyles. The similarities, however, are largely superficial, and in reality, many fundamental differences exist between the two nations. Social policy is one area of diversity.

With ever greater frequency in social science research, comparative studies are providing us with valuable insights into the similarities and differences between nations, and what factors trigger change (Collier 1991, Sartori 1994). Erickson and Rustow claim, however, that comparison alone is insufficient and recommend that, to give us a fuller understanding of the facts, researchers should ground comparative analysis in historical knowledge, because "history does not run everywhere along the same track and . . . a society's structure of conflict, rooted in basic cultural experience and values, shapes its broad pattern of political development." Their contention is that historical analysis provides

scholars with "a considerably more powerful set of tools for carrying out research, testing propositions, and developing concepts" (1991, 450).

With this in mind, the following sections offer definitions of federalism and compare the origin and nature of the federal systems that exist in Canada and the United States. It is hoped that this will help explain why the social policies of the two countries evolved in unique ways.

### **The federal government systems in Canada and the US**

In his discussion on federalism and the policy process, McRoberts notes that there "is considerable variation among the definitions offered by scholars, with some being far more inclusive than others" (1993, 150). Stevenson observes that the term "federalism" itself presents challenges for those who wish to define it because of its complexity and because of the array of interpretative lenses that may be used. He maintains that federalism "is a political system in which most or all of the structural elements of the state (executive, legislative, bureaucratic, judiciary, army or police, and machinery for levying taxation) are duplicated at two levels, with both sets of structures exercising effective control over the same territory and population." Since neither level of government can normally obtain supreme jurisdiction, bargaining is one of federalism's inherent characteristics (1985, 8).

Gagnon also provides us with a useful definition of federalism. His view, however, captures the system's dynamic quality to a much greater extent than does Stevenson's. Gagnon sees federalism:

as a political device for establishing viable institutions and flexible relationships capable of facilitating interstate relations (e.g., division of powers between orders of government), intrastate linkages (e.g., representation at the central level), and inter-community cooperation. With an emphasis on process, institutions can be seen as arising out of politics, the genesis of institutions resulting essentially from the conflicts and power struggles of economic, societal, and political actors (1995, 23).

Both definitions are valuable, and several of the concepts contained in each will be

employed in the present study.<sup>1</sup> One of the most basic of those concepts is that the creation of two levels of government in both Canada and the US with respect to responsibilities, jurisdictions, and rights in key areas of social policy is often the cause of more than mere "bargaining," and leads to profound political and social tensions. This subject will be dealt with at some length in later chapters. What is important now is to recognize some of the key factors that have influenced the nature of the federal government systems chosen by the Americans and Canadians, and the impact that their structure has had on the policy making process.

Just as is the case today, world events in the eighteenth and nineteenth centuries had broad political, social, and economic effects on governments and their activities. For example, the Industrial Revolution in Europe created enormous demands for raw materials and new markets, and the quest for commercial dominance had far-reaching repercussions in most nations of the world. Although a variety of international pressures and domestic issues were at play at the time and influenced the direction chosen by the founding fathers, it is obvious that the trade demands exerted by British merchants and the taxes imposed by the governments of the day had a critically important effect on the future national directions of both the US and Canada.

Breckenridge contends that, albeit for radically different reasons and in significantly dissimilar ways, it was necessary for the United States and Canada to adopt federal government systems (1998, 107). According to Simeon and Robinson (1990), the primary goal of the new American nation was to reject the executive dominance that characterized the British system and, in so doing, to establish a federal administration in which the powers of government were seen by all citizens to be separate and constrained, but which provided a greater cohesion between the states than that of a loose confederal arrangement. The result of the deliberations of the founding fathers was the US Constitution, a document which afforded the fledgling nation an administrative structure that permitted central authority as

well as specific areas of sovereignty for each of the states. Breckenridge holds that the three core elements of the US Constitution are the maintenance of the federal system, the separation of powers, and the rights of the individual (1998).

Elazar stresses the fact that, in their effort to create a system that was far different from the unitary British parliamentary system that had dominated the American colonies for so many years, the architects of the American Constitution forged a type of federalism that was based on a "super complex of institutions" which linked federal, state, and local governments. The division and sharing of responsibilities within that complex framework, he maintains, "is the essence of American federalism." (1994, 142).

Simeon and Robinson indicate that the fathers of Canadian federalism had a contrasting goal: namely, "to create a new British North American nation, and to establish a new collective political identity capable of inspiring loyalty to its political institutions" (1990, 20). In 1867, Canada's new Constitution, the British North America Act (BNA Act), incorporated many of the British legal institutions and political conventions. That Constitution did not place its emphasis on *life, liberty, and the pursuit of happiness*, as the Americans' did, but on *peace, order, and good government*. Another difference was that the federal government structure which was created by the BNA Act was designed as a practical mechanism for accepting *national dualism* and "took into account the national, regional, and linguistic diversity that characterized the era" (Rocher and Smith 1995, 9).

In addition to formalizing linkages with New Brunswick, Nova Scotia, Quebec, and Ontario, the BNA Act also helped the nation to defend its political and economic claims to its western territories from increasing US encroachment. The latter issue was of great import in the mid-nineteenth century because the Canadian authorities were concerned about the "potentially dangerous power vacuum in the northern part of North America" (Stevenson 1985, 21) and wished to fill that vacuum by establishing their sovereignty over the vast regions to the west. Although the dispute with the United States was subsequently

resolved, the issue of regional control, which was a key factor during the nation's formative period, has retained its importance — not in international relations, but within Canada itself as a source of the intergovernmental tensions that have become synonymous with the nation's federal system (Stein 1989).

Gray asserts that one of the main reasons for giving a strong centralized structure to the Canadian federation was to prevent any potential for civil strife similar to the devastating conflict that had engulfed the American states between 1861 and 1865. The authors of the BNA Act believed that by specifying which taxation and legislative powers would be allocated to each level of government, the central government would be dominant and the opportunity for conflict would be avoided (1991). However, as history has shown, the relationship between the two levels has changed in response to a variety of factors.

Lipset (1990) maintains that the disparate manner in which Canada and the US were founded has led to divergent notions about government and to distinct sets of values related to societal issues. His contention is that because of the way in which their nations originated, Canadians generally support their government and its institutions, whereas Americans distrust government and espouse individualistic values. In Canada, the political culture has evolved into one which is less individualistic and less anti-statist than that which exists in the US. This may be because, as Elazar notes, the US "was born with federal principles, practices, and political culture already pervasive, including a strong commitment to maintaining the diverse integrities of the various constituents of the union, constitutional forms for doing so, and the habit of working together to achieve common ends" (1994, 142).

The different federal systems in Canada and the US have greatly influenced the institutions that are responsible for public policy and the manner in which such policy is designed and implemented. Despite the earnest intentions of the framers of the US Constitution to minimize the role of the national government, the American federal system has evolved into a strong and highly centralized one. Over the years, this has led more and

more to an intrastate relationship in which national institutions have become the primary vehicle for policy design.

In contrast, the Canadian federal system, which had initially adopted a centralized configuration for governing, has moved in the opposite direction, affording the provinces much greater participation in the policy process through an interstate mechanism (Simeon and Robinson 1990). This shift has come to be one of the main sources of intergovernmental conflict in Canada. Although regional, economic, and, particularly, linguistic-sociocultural issues have always been at the core of political cleavage (Banting 1988), so increasingly are the "allocation of costs, control of expenditures, regulatory powers, or substantive priorities" (Fletcher and Wallace, 1985, 153).

In his analysis of the costs and benefits of the intrastate and interstate mechanisms that manifest themselves in the US and Canada, Breckenridge observes that the American intrastate system has been successful thus far primarily because of the separation of power within Washington itself and because of the interstate type of bargaining that occurs among the various policy actors at the state and local levels. He further suggests that the "American intrastate model has managed to reconcile regional differences with national goals without bringing about the kind of radical institutional decentralization that now exists in Canada" (1998, 121).

Simeon and Willis have noted that "almost by definition, political institutions crystallize and entrench the past. They are thus a powerful force for continuity — and for the continued difference between Canada and the United States" (1997, 186). These scholars believe that the federal institutions of both nations were created and have evolved as a direct result of fundamental principles that are embedded in their respective parliamentary and presidential-congressional systems. Each type of governance has created rules by which the political process can be influenced. But this is not to imply that the governments are static. Important institutional changes have been made over the years and this fact will be at the

core of the study below.

### **Social policy in Canada and the US prior to WWII**

When viewed in comparative context with other industrialized nations, particularly those in Western Europe, Canada and the US have been described as "laggards" with respect to the development of social welfare programs (Stevenson 1985, 156). A number of important reasons have been suggested as contributing to this situation. For example, some scholars maintain that, in the United States and Canada, four factors worked to impede the development of national welfare systems resembling those which gradually took shape at the turn of the nineteenth century in Western Europe: "the absence of feudalism, a democratic political system that emerged prior to a large working class, a relatively low level of status differentiation, and a high per capita income" (Kudrle and Marmor 1982, 81).

Not only did US and Canadian institutions for making social policy differ from those in Europe, but they differed from each other as well. Three basic reasons have been presented to explain this phenomenon: a dissimilarity in the nature of US and Canadian society, differences in the electoral and party systems of each country, and the profound contrasts in their federal government constructs (Kudrle and Marmor 1982, 89). Using this assertion as a starting point, this section will examine the governing arrangements that were in existence in the United States and Canada at the end of the nineteenth and early part of the twentieth century. This information will make it easier to understand why the social policies of each country evolved the way they did before World War II, and how it was possible for them to metamorphose to the point where, particularly after the War, the US system acquired an intrastate character and the Canadian system an interstate character.

At the core of the argument concerning national social policy development in North America is the concept of the manner in which each nation came into being. Leman has

suggested that the US, formed by a spectacular revolution during which a completely new governing system was created, was also distinguished by a "big bang" approach to social policy development. In contrast, Canada, by virtue of its birth through prolonged negotiations and compromise, developed a governing system that promoted an incremental approach to social welfare policy making (1977, 261-291). Maioni adds that:

The presence of a parliamentary democracy ensured that social reform would be implemented in a more coherent fashion than, for example, in the more fragmented American polity. In addition, the extensive responsibility of the provinces in the area of social policy meant that, although certain reforms were delayed due to jurisdictional uncertainty, the innovations in the provinces and the compromises reached by federal-provincial negotiation led to the development of more comprehensive social programs characterized by relatively less regional variation than in the United States (1997b, 176).

The allocation of responsibilities articulated in Sections 91 and 92 of Canada's Constitution Act did not specify which level of government would bear the burden of social welfare (Simeon and Robinson 1990). However, it did assign to the provinces responsibility for the "establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions, other than marine hospitals," for "property and civil rights," and for "matters of a merely local or private nature" (Heiber and Deber 1987, 62). In good part, this was because social welfare in any form during the second half of the nineteenth century was provided to the sick, elderly, or needy by private or charitable organizations in the communities that were starting to flourish across the country (Weller and Manga 1983, 223). However, provincial support was fragmented. As Boychuk notes, in the few provinces where rudimentary aid for the indigent was available, it was only for "those desperate enough to be willing to endure the stigma of the workhouse" (1997, 4). Furthermore, as "creatures" of the provinces, municipal governments were able to provide very limited aid to the needy (Tindal and Tindal 1995, 15). This apportionment of responsibility has contributed to much of the intergovernmental conflict related to social policy that has increasingly manifested itself during the post-World War II era (Boadway 1995).

In Canada, social policy did not emerge as an issue related to federalism for the next several decades and few formal institutions were created. Although the federal Liberal Party recognized the necessity of financial support for the sick, elderly, and unemployed as early as 1919, it was only in 1927 under the leadership of Mackenzie King, with his minority Liberal government and with strong pressure from the political left, that a national system of old-age pensions was created.

Unlike the Canadian governments, all of the US states had adopted many of the underlying principles of the English Poor Laws. To varying degrees, all levels of government provided pensions to Civil War veterans as well as allowances for widows and single mothers (Skocpol 1992), and according to Boychuk, from "1880 to 1910, pension expenditures represented over a quarter of total US central government expenditures" (1997, 4-7). However, few state governments were inclined to embark on social policy legislation.

To a large extent, political and institutional structures also constrained concerted innovation in the development of broader social policies. Banting suggests that "the American combination of congressional government, federalism, and non-cohesive political parties diffuses power [and amplifies] resistance to expansive social programs and especially to redistributive efforts to target the poor" (1997, 282). It was not until 1935, during the Great Depression and under the strong leadership of Franklin Roosevelt, that greater emphasis was placed on developing a national strategy.

### **Public housing in Canada and the US prior to WWII**

Examining Canada and the US from the end of the 1800s until the Second World War, this section explores the roles of the public, private, and third sectors in the provision of housing for those who could not afford decent accommodation. What will become apparent here is that, in many instances, the same groups and individuals who sought assistance with healthcare also had difficulties finding appropriate housing.

**Canada.** Political scientists, historians, and sociologists interested in the development of public housing policy in Canada consistently remind us that "interpretations of the British North America Act have universally placed the lion's share of responsibility for social housing with the provinces" (Klodawsky and Spector 1997, 260). But this is not to say that the Fathers of Confederation made that specific determination. As Banting reminds us, the reality was that housing as a public policy issue was simply not a matter of government concern at that time. "Welfare of any sort was largely left to philanthropic individuals, church organizations, or the provision of minimal relief at the municipal level" (1990, 228). However, as we shall see, all three levels of government eventually did become involved in housing, albeit in different ways.

In the latter years of the nineteenth century, Canada had an extremely high rate of population growth. This led to dramatic increases in land values and, in turn, to rampant speculation. Both old and new communities were soon overwhelmed by the influx of people, and slums and ghettos came into being. With the onslaught of both people and animals, established areas deteriorated rapidly and new buildings, constructed in haste to accommodate the newcomers, were often erected with shoddy and even noxious materials. Overcrowding, coupled with inadequate heating, polluted air, contaminated water, poor sanitation, and hazardous materials were the norm rather than the exception in many communities. Under these circumstances, housing conditions at the turn of the century became a major source of illness and death in Canada (Tindal and Tindal 1995).

The picture was not entirely bleak, however. In response to these conditions, Canada saw a rise in social consciousness, and this yielded some very positive results. For instance, "[m]unicipal public works departments grew out of the public health movement, and so did urban planning, housing, and social service functions" (Tindal and Tindal 1995, 47-9). In addition, some industrialists became ardent supporters of the effort to counter the adverse health effects of poor housing. While certain members of the entrepreneurial class

were directly responsible for endangering Canadians by building health-threatening dwellings, others recognized that putting workers into inferior houses was contrary to their own interests, for poor health among their employees meant that productivity — and hence profits — would be likely to decrease. For these entrepreneurs, it was a short leap in logic to see the relationship between healthy workers and the provision of good housing. As Purdy puts it:

Presaging the later obsession with instilling efficiency in all facets of life, they discerned that there was a direct link between the factories and the homes of workers, a relationship that needed to be reinforced. . . Recognizing that by improving home environments a healthy, contented workforce could be generated, sections of the business community joined reformers in calling for action on the housing question (1997, 31).

This led to an odd alliance between business leaders and many groups of social reformers. The latter firmly believed that there was a connection between society, health, and morality. Indeed, as early as 1906, "[t]he physical scarring of the city was linked explicitly to the slide into moral impurity, adding ideological ammunition to the reform crusaders' attempt to repair the social fabric of the city" (Purdy 1997, 31).

Other factors also worked to improve the quality of housing in Canada at the turn of the century. For example, several outbreaks of cholera motivated the growing numbers of Boards of Health to insist that municipalities enforce the by-laws they had already passed — but usually disregarded — concerning the location, design, and construction of houses. In addition, the frequency of disastrous fires, due in good part to the haphazard and cramped manner in which houses had been constructed, led to public pressure for less flammable dwellings, better access for fire fighters, more sophisticated fire fighting equipment, and increased water pressure (Sayegh 1987).

Until this time, the provincial governments had not interfered to any significant extent in local affairs, since they were primarily concerned with putting their economic houses in order and determining their relationship with the federal and other provincial

governments. In time, however, the areas of responsibility started to blur between local and provincial levels, especially when additional funding was needed to address issues associated with municipal expansion. As time went on, the provincial governments assumed more and more of the responsibilities that had been held by the municipalities. In order to deal with the problem of overlapping jurisdictions, the provincial governments created provincial institutions to facilitate policy coordination. This tended to happen either because municipal governments could not keep up with the number of local problems that demanded solution or, as was most often the case, because issues had grown enough to become of general provincial concern. Matters such as public health and housing helped trigger these changes in government responsibility (Tindal and Tindal 1995).

The federal government was interested in housing from an altogether different perspective. Established in 1909, the Commission of Conservation was given responsibility for examining a wide variety of social and economic issues related to industrialization. The public health branch of the Commission focused on the detrimental effects on Canadians of poor housing and town planning. The work undertaken by the Commission in this regard gradually expanded and, within two decades, the federal administration had a staff of full-time planning experts whose mandate was to offer advice to both provincial and local government officials on matters related to housing and urban development. Influential groups such as the Canadian Manufacturers Association and the Canadian Public Health Association supported this initiative. According to Purdy, the planners had considerable influence and, under the guidance of Thomas Adams, came to play "a central role in providing ideological legitimation for the emerging theory and practice of town planning and helped promulgate its merits to a wide network of reformers, academics and politicians" (1997, 33).

The link that was formed between these influential groups brought about intense discussion on the role of government in housing, specifically, which level should be

ly responsible. After the city of Halifax was devastated by an explosion in 1918, housing became an issue of greater prominence (Anderson 1992). Adding to the urgency of the matter, the 1918 Royal Commission on Industrial Relations reported that overcrowding and poor quality of housing was a significant cause of social problems in Nova Scotia. According to Rose, "the problems consequent upon the disaster [in Nova Scotia] created a need for government intervention to assist disadvantaged families" helped convince the federal government to authorize long term loans to the provinces for house building and to the affected areas (1980, 1). This move led Nova Scotia to create the first provincial housing institution dedicated to housing.

By the Depression years, when local and even provincial governments found it difficult to help the private sector provide accommodation at a cost all citizens could afford, the need for increased federal involvement in housing again came to the fore. The situation was particularly acute in the Prairie provinces. As a result, organizations such as the Progressive Commonwealth Federation (CCF) and the League of Social Reconstruction were born. Included in the latter group was Humphrey Carver, who would later become one of the key actors in the establishment of the Central Mortgage and Housing Corporation (CMHC). Along with other intellectuals who energized the LSR, Carver tirelessly advocated for federal government intervention in the funding and production of housing.

Millions of needy Canadians sought government assistance to pay for housing. But the private sector, represented by financial institutions, architects, suppliers, and builders, was also clamoring for aid. The governments, still focusing on nation building and economic issues, devised a strategy they hoped would reduce unemployment and bolster housing construction at one and the same time (Dennis and Fish 1972). In 1935, in response to these demands, the federal government introduced the Dominion Housing Act. Passage of the DHA was one of the last initiatives of Bennett's Conservative

ment. Reputed to have been an answer to pressures from left-wing political parties the CCF and an adaptation of US New Deal concepts to the Canadian reality, the Dominion Housing Act was seen as "inaugurating the modern era of Canadian housing policy" as well as "a concession to the lending industry and represented a step by the nascent federal housing bureaucracy to make home ownership the centerpiece of its policy development" (Belec 1997, 62).<sup>2</sup>

In 1938, a National Housing Act was passed. It was "a political and economic act of government hoping to stimulate employment by broadening the terms of the 1935 act" (Rose 1980, 3). However, because of the outbreak of World War II, it was not implemented. In its place, the government passed an Order-in-Council in 1941 which resulted in the creation of Wartime Housing Limited (WHL), a new Crown corporation. The WHL helped provide housing for workers in wartime industries, and, in this capacity acted as a supplementary federal housing agency, one of whose major tasks was direct negotiation with elected and appointed officials of municipal governments" (Rose 1980, 27-28).

Banting maintains that, unlike the DHA, Wartime Housing Limited was a success-story, with the federal government providing "inexpensive housing for workers brought into the cities by the demands of wartime production" (1990, 122). After the war ended, WHL was replaced by the Central Mortgage and Housing (CMHC), a large federal corporation which would become responsible for the design and implementation of future national housing policies (CMHC 1946).

As will be shown in Part II, the postwar years saw the publication of a series of important reports and the passage of additional federal legislation. This confirmed that government intervention was a well established reality in the field of Canadian housing.

**The United States.** Despite the general perception that the federal government had only minimally involved in housing, Congressional records show that it was both

and active in housing matters long before the New Deal era. As in Canada, the powers of the central government were constrained to a large extent by the Constitution. Therefore, that level of government was assigned responsibilities in other areas that were not directly linked to housing.

At the beginning of the nineteenth century, all levels of government embraced the concept of laissez-faire, and expected people to fend for themselves for shelter. Those who needed aid with accommodation could seek assistance from family or friends. If necessary, go to local charities or poorhouses for shelter (Katz 1986). Despite the tenacity of the laissez-faire perspective, reformers worked tirelessly for government intervention especially in ghetto areas where immigrants were often forced to reside and they were ruthlessly exploited both by employers and landlords.

In 1892, in response to these considerations, the 52nd Congress decided to appropriate \$20,000 for a detailed investigation of slums in cities with a population of more than 100,000 (Cong. & Nat. 1965). Because many citizens were as concerned about the impact slums were having on their own quality of life as they were about the welfare of the poor themselves, public support for this research was considerable. The studies in Boston, Chicago, New York, and Philadelphia,<sup>3</sup> encouraged reformers in their push for "government regulation of slum housing" (Drier 1998, 93) and inspired philanthropists to provide money to build non-profit housing as well as limited dividend tenement

<sup>4</sup> While the number of not-for-profit buildings constructed was small, the limited number of housing initiatives grew in popularity, became the preferred form of mass housing in the interested state and societal actors (Bratt 1998), and "had a profound effect on the structure and philosophy of American housing. They germinated ideas relating to structure, management and tenant selection which later shaped the course of the twentieth century housing movement" (Birch and Gardner 1981).

The four-city study of 1892 was part of a growing movement to improve living

ns in American cities. The following year, the World's Columbian Exposition in Chicago showed the public what a well-planned city would look like and was instrumental in starting the "City Beautiful" movement in the US, which, from 1909 on, occasioned International Conferences on City Planning.

At the same time, state and local governments in the US were introducing tenement laws designed to establish minimum housing standards. These laws, such as New York's Tenement House Law of 1901, "consisted of regulations for fire prevention, requirements for ventilation, light and air circulation, reduction of overcrowding, and introduction of proper sanitary conditions" (McGrew and Fabregas 1987, 156). Long overdue, the tenement laws eventually took the form of municipal building codes and by-laws and had a positive impact on the quality of housing. As a result, by the start of World War One, housing conditions in the US, as in Canada, had become noticeably better.

Thanks to rapid advances in science, methods of communication improved, and clubs, groups and organizations in different parts of the nation utilized the new technology to disseminate information with each other and with the various government agencies. For example, the National Housing Association, formed in 1910, provided support for a large number of small, fragmented reformer groups across the country (Drier 1998, 98) that sought or greater government participation in the funding and supply of decent and affordable housing. However, vehemently opposing government intervention in matters of housing were groups representing builders and housing suppliers, and organizations such as the United States Savings and Loans League (established in 1893), the National Association of Real Estate Boards (1908), and the Chamber of Commerce of the US (Drier *Cong. & Nat.* 1965).

Despite this type of opposition, World War I forced the federal government to become more involved in the direct provision of housing. In 1916, the Shipping Act included provisions for supplying accommodation to shipyard workers and their families. In

, the federal Emergency Fleet Corporation and the United States Housing Administration (under the Department of Labor) built thousands of dwellings for people in wartime activities. After the war, these dwellings were sold at half their original price to those who wished to stay (Doan 1997).

The postwar period was a time of opportunity and growth. Immigration had increased, house building had increased, and employment and home ownership were at high levels. Municipal and state governments extended their respective building codes while, for its part, the federal government, through the Department of Commerce, limited itself primarily to promoting the adoption of planning, zoning, and building codes by local and state agencies (Doan 1997).

Although the quality of housing was still of concern to many, the postwar boom had masked problems associated with poor accommodation and, for the most part, they had fallen off the public agenda. With the advent of the Great Depression, however, reappeared a glut of housing that few could afford and, with the dispossessed struggling to find shelter, the specter of overcrowded slums loomed again. Both employers and the labor movement, which had never gained a strong national identity in the US, had been relatively powerless in the face of the economic disaster. Therefore, as in earlier periods of economic stress, reformer groups increased their efforts to bring about greater government intervention in housing. As Drier states, "Until the Depression, housing reformers had been lonely voices in the wilderness. The Depression convinced reformers that the private market and private philanthropy could not solve the economic and housing problems of the poor" (1997, 6).

The pressures from state and local governments as well as from societal actors eventually induced the federal government to take action directed towards alleviating the housing crisis (Goetz 1993). Its initial interventions were focused on stimulating the economy and stabilizing the banking systems. Among the strategies used to accomplish these two

goals and to protect both housing suppliers and consumers were passage of the Home Loan Bank Act in 1932; establishment of the Home Owners' Loan Corporation in 1933; enactment of the National Housing Act in 1934, which created the Housing Administration; and passage of the Housing Act in 1937, which created programs for providing low cost dwellings to people in need.

The various actions taken by government and societal players during and after the World War will be discussed in more detail in Part II, but it is of interest here to note that during the President's 1931 Conference on Home Building and Home Ownership the US Public Health Service urged that housing and health issues must be linked to a significant extent. In 1935, the same federal Public Health Service undertook a national survey on "The health of Americans under depressed economic conditions. The results of the National Health Inventory "did demonstrate conclusively that housing is a factor in bad health and that a correlation exists between poor health and overcrowding, and between health and unsatisfactory toilet facilities even among families with equal economic resources" (USPHS 1951, 392-3).

The next years witnessed a massive shift in government housing policy, and, as we will see in Part II, public opinion about government's role in housing changed as World War II progressed.

### **Health policy in Canada and the US prior to WWII**

Although the need for health policy as we know it today was simply unimaginable when the men who created the Canadian and American federal government systems, this is not to say that government was entirely absent from the healthcare scene in Canada and the US. Both governments at all levels played a part in improving the health of their subjects. On a national level, the governments were primarily interested in economic development. Domestic growth and active trading with other nations did much more than better the

l condition of the population. As incomes increased, so did the availability of s food, more suitable clothing, and better housing.

at the provincial/state and local levels, government sponsored public health s also had beneficial impacts. For instance, by informing the public of the need for sanitation and clean water as a means to lessen the spread of disease, infant y decreased, longevity increased, and the severity of certain illnesses declined. ately, some long-standing infectious conditions linked to poor housing still l.

According to Boase, "[o]verall constitutional, political and administrative structure ular polity will indicate the potential for political action and will influence the f state-societal relationships that will develop" (1996b, 16). With this fact in mind, of Canadian and American historical realities from the late nineteenth century to nd World War will make it easier to understand what potentials were open to and the US where health policy was concerned, and the reasons why different ietal relationships developed in each country.

**Canada.** It is generally accepted that Section 92(7) of the British North America 867 gave the provinces jurisdiction over health policy. The exception was health for native people and military personnel which, under Section 91, were assigned deral government. Selected public health matters, such as responsibility for food ; safety, were also assigned to the federal government.

During this formative period, physicians were establishing their professional als. Most of the practicing doctors in Canada had been trained in Britain and many n previously affiliated with the military. Unlike their counterparts in the US, n physicians saw the benefits of establishing a medical licensing system. Since y and unscientific cures were rampant and anyone could claim to be a doctor, those

medical training believed that their professional status was not being well served by those who did not have similar credentials. Ultimately, the physicians gained control of the domain of medicine. By the 1870s, legislation for licensing physicians was in both Upper and Lower Canada, medical schools had affiliated themselves with the universities, "[h]ospitals became the site for nurse training, and medical control of the hospitals . . . ensured that the occupations that grew up there would remain subordinate" (Boase 1987, 14). By the end of the century, despite the efforts of other healthcare professionals such as nurses and pharmacists to improve their position in the medical hierarchy, the physicians held a position of dominance.

Even though the provinces were responsible for healthcare by constitutional arrangement, in reality health as a public policy field was an area of "benign neglect" (Boase 1987) a situation which remained well into the twentieth century. Governments remained disinterested in economic development and continued to leave healthcare to those who professed to know about it. Demand for health services grew in concert with the influx of immigrants and the economic expansion that took place in all regions of the country. As the railways opened up new communities in previously inaccessible places, population densities increased for those who could profit from providing healthcare. Despite the expansion of health services continued to be offered by local charitable associations and organizations, the role of private groups expanded in the rapidly growing urban centers and fee-for-service facilities became larger and more institutionalized, with physicians still at the top of the hierarchy and in control of the locally financed health systems.<sup>5</sup>

In the post-World War I era, the federal government undertook new health-related responsibilities, but these fell largely within the realm mandated by the 1867 Constitution. For example, the Dominion Department of Health assumed responsibility for administering regulations on food and drug safety, medical patents, narcotics, and public works.

ed on the growing demands for government assistance, the Dominion Council of  
rovided a forum wherein federal and provincial officials could start to coordinate  
tive roles and responsibilities in healthcare policy in a more formal manner (Smith

s a result of the Great Depression, the federal government was pressured to  
nore involved in the development of health policy and the provision of healthcare.  
; the reasons had more to do with economics than with altruism. Not only were  
across the nation devastated by this catastrophic event, but many municipalities  
d bankruptcy. The Prairies were particularly hard hit, with droughts and crop  
aving whole communities destitute. In keeping with the prevalent political culture  
d the desirability of state intervention with the ideals of the social democrats,  
ought government assistance. Ottawa was besieged with calls for aid from  
il and local governments, as well as from groups and organizations representing  
ndividual, and professional interests (Taylor 1987, 4).<sup>6</sup>

he turbulent Depression years fostered a desire for change. Innovative ideas  
p in Saskatchewan, Alberta, British Columbia, and, to a lesser extent, Ontario. In  
vinces, farming groups demanded state-sponsored healthcare, and urban workers,  
ng themselves to be fragmented and incapable of independent action, rallied to  
these demands. As a result, two provincial governments, Alberta and British  
a, introduced health insurance legislation. Neither act was implemented, however.  
s due to the fact that, in Alberta, the Social Credit Party took over government  
g the provincial election of 1935, and, in British Columbia, opposition from the  
profession coupled with lack of federal funding outweighed the power of the  
rs of the provincial health insurance plan (Torrance 1987, 20-24).

n spite of opposition to health insurance by physicians in provinces like British  
ia, the Canadian Medical Association (CMA) chose to support the concept of

health insurance. After conducting a survey in 1933 which indicated that the health of the Canadian population was deteriorating to an alarming extent, in good part because victims of the Depression were unable to pay for medical services, the CMA requested the Conservative government of Prime Minister R. B. Bennett to provide the public with health care assistance. Bennett rejected the CMA's request, affirming that health care remained a provincial policy issue. Bennett came under strong political pressure, and therefore, although refusing to back a national health insurance policy, he did provide greater relief to the provinces by introducing legislation which contained health insurance provisions. But those who favored his solution to the problem of health care were disappointed to find that this plan would not be put into effect: when the Liberals took office after defeating the Conservatives in 1935, they justified their opposition to Bennett's plan by declaring that, if passed, the proposed legislation would be unconstitutional.

Unlike the federal government of the time, some provincial administrations were receptive to the idea of government intervention in the field of health and forged alliances with physicians' groups to adopt limited publicly funded plans. In Ontario, for example, what Taylor identifies as the first "social assistance public medical care plan" was enacted in 1935 to pay doctors for visits to those on relief (1987, 6-7).

In 1937, Prime Minister Mackenzie King appointed the Rowell-Sirois Royal Commission to examine Dominion-Provincial relationships. In the process, the Commission considered the implications of a national system of health and social insurance. In 1940, it reaffirmed the position that health was a provincial responsibility. Nonetheless, it called attention to the possibility that several serious problems related to regional policy and inequality between the regions might arise if each province adopted its own policies. This made it plain that there were indeed important benefits to adopting a national health system (Taylor 1987, 7-14).

Other factors affected public health policy at all levels of government during these political, social, and economic turbulence. For example, repeated demands from influential segments of society (notably the Prairie medical associations and nascent groups with growing political affiliations) pressured the federal government to provide health insurance and to develop formal institutions related to this policy field. Ultimately, the threat of war plus the scarcity of funds undermined any effort to provide healthcare insurance at this time.

**The United States.** From the time the Constitution was signed until the mid-19th century, federal government involvement in social policy was for the most part limited because "the federal government was primarily the province of state and local government" (Rich and White 1996, 17). To a large extent, this was the consequence of the nation's traditional political philosophy of limited government and non-intervention, and according to Robinson, this non-interventionist philosophy stemmed from a political system that was "based on the enduring conflict of individual liberties and property rights versus collective social needs and the definition of rights and responsibilities" (1997, 260).

Although the US "distrust of professional elitism had given rise to the Popular Movement of the 1830s and 1840s, which attacked the medical establishment and demanded the continuation of traditional community medicine" (Coburn 1987, 445), in the US — like those in Canada — were soon established in society as prestigious and necessary professionals who "were able to claim a growing monopoly of knowledge of increasingly esoteric and specialized techniques" (Heidenheimer et al. 1990, 10). Just as in Canada, citizens were generally expected to pay for whatever medical aid was required.

Because costs rose swiftly during the century as professionalism increased and new medical treatments and therapies were introduced, the idea of having access to private health insurance

in popularity among the public. As a result, a variety of prepaid medical arrangement-specific groups was designed. These were the precursors of today's Health Maintenance Organizations (HMOs). They were introduced in the American Northwest at the turn of the century after the railways opened up vast industrial opportunities in the region.

In the decades that followed, groups comprised of union members and employers came together to provide various forms of private and non-profit medical insurance that would alleviate financial distress following injury or disease. These early attempts at health insurance were marked by passionate debate between spokespersons for the reformers who sought to institute some form of prepaid medical insurance plan, and the status quo, who defended the status quo. One of the most effective arguments the reformers used to defend fee-for-service medicine was that the proposals for change would lead to socialized medicine (Starr 1982).

The acrimonious debates continued for years. Critics of public health insurance held that the US should avoid government funded systems of the kind that existed in Europe, and did everything they could to prevent the introduction and acceptance of such systems as an alternative to the existing private pay system. Indeed, the "first bitter campaign against public health insurance, in 1918, convinced advocates . . . that 'the less identification with Europe, the better'" (Heidenheimer et al. 1990, 62).

In particular, the American Medical Association (AMA) — founded in 1847 and nationally integrated in 1902 — vigorously countered any move by public health insurance advocates. After defending their position without compromise for years, the physicians reluctantly approved the formation of Blue Cross, a non-profit health insurance provider. According to Mayer and Mayer, this turnabout took place only because public pressure had grown so great that "organized medicine perceived health insurance as the lesser of two evils" (1986, 591).

Even during these times of rancorous debate, the federal government did not intervene to any degree. In their discussion on US federalism and healthcare policy, Rich and White observe that up until 1945, the federal government worked on the principle that healthcare should be provided in a "market context" and involved itself only when particular groups like merchant seamen, Native Americans, and veterans needed special attention. In such cases, "the basic approach was to meet the medical needs of these groups through separate federal financing and provision of services by creating systems of federal hospitals, most notably the Veterans Administration system" (1996, 18).

As a direct result of the federal government's reluctance to enter the health policy domain during the first part of the twentieth century, a two-tiered health system gradually evolved in the United States. People who were financially able paid health providers on a fee-for-service basis or purchased private insurance; those who were not turned either to charitable organizations or to local or, less frequently, state hospitals. As far as the federal government was concerned, its focus remained on the "predominantly preventive and sanitary preoccupations associated with it in the nineteenth century" (Heidenheimer et al. 1990, 62). As evidence of this fact, Heidenheimer et al. indicate that between 1913 and 1932, federal health expenditures on hospitals increased from 0.4 per cent of the GDP to only 0.7 per cent (1990, 62).

Although the federal government was loath to intervene in state and local government activities in the health policy field, physicians actively sought to increase their power and influence on these levels. As the medical profession's prestige grew, physicians won seats on State Boards of Health and, from there, played an active role in all aspects of health policy decision making. So great did the AMA's power become that it was able to profoundly influence the extent to which state and societal actors affected the future direction of health policy in the nation: for example, the number, size, and curricula of medical schools; which professions could participate in the delivery of healthcare; and what

role would be played by individuals and groups with specialized pharmaceutical and technological expertise in the private domain. In the process, it became closely linked with the political preferences of American conservatives in general, and the Republican Party in particular.

The complex arrangements that were made by state and local governments with physicians, societal actors, and their respective institutions gradually led to the development of an even more "bifurcated model" than had previously existed at the national level. More than ever, the functional and financial burdens of healthcare for those who could not afford to pay were carried by state and, primarily, by local governments, and "[p]ublic hospitals operated by city and county governments acted as vendors of last resort for those who had nowhere else to turn in what was a de facto two-tier system of care"(Rich and White 1997, 18-20).

Although the US federal government was conspicuously absent from direct healthcare policy and provision, like the Canadian federal government, it had other health-related responsibilities. Around the beginning of the 20th century, the US Public Health Service became very active in gathering data and identifying strategies for improving Americans' health status and longevity (Krieger and Fee 1996). Much of the data collected by federal organizations such as the Public Health Service and the Census Bureau was used in combination with information gathered by countrywide organizations like the National Tuberculosis Association. In part, these data were used to support the arguments of advocates of publicly funded healthcare who hoped to improve the lot of Americans who lived in squalid circumstances and were unable to pay for medical care (Krieger and Moss 1996, 383).

Between World War I and the Depression, as American citizens in all sectors of society sought relief from their oppressive circumstances, the federal government saw the need to increase the scope of its responsibilities. As a result, the debate between the levels

of government about health policy, administration, and financing became more intense and promised to occasion important shifts in the relationships between the various levels of government (Heirich 1998).

Although key factors related to the New Deal will be explored in some detail in Part II, it is important to note here that it was the combination of the events related to the Great Depression and Roosevelt's New Deal recovery program that brought about a fundamental change in American attitudes towards the federal government. As Breckenridge puts it, now, after decades of shunning federal intervention, "[f]or the first time, most Americans saw the government in a positive light, as the solver of economic and social problems" (1998, 190).

Even though national health insurance was still not contemplated, steps were taken at the federal level to lessen the burden of health costs. Plans were made to introduce social insurance legislation and federal tax subsidies designed to assist employers with their group health insurance. The primary focus was on helping employers as well as the unemployed. Thus, the stage was set for the future American healthcare system which, based on the chaotic and fragmented organizational structures that existed at the beginning of the century, would still be described in the decades to come as a "malfunctioning patchwork arrangement" (Relman 1986, 1610) reminiscent of the antics in a "four-ring circus" (Heidenheimer et al. 1990, 62-71).

As will be discussed in the study below, general dissatisfaction with this arrangement, as well as the impact of events within and outside of the nation during the 1930s and 1940s, would profoundly affect the future of the federal government's role and its relationships with state, local, and societal actors in the health policy field.

## CHAPTER 3

### THE THEORETICAL FRAMEWORK

This chapter explains the framework upon which the analysis of Canadian and American public housing and health policies will be based. Beginning with an assessment of theoretical frameworks that appeared to be the most appropriate for an examination of assisted housing and health policy development, the chapter proceeds to specify why the neo-institutional approach was adopted for use in this study. Then, to guide the research in an orderly and balanced way, it selects eight variables for inclusion in the framework. It concludes by identifying four post-World War II watershed periods of notable change in assisted health and housing policy in Canada and the US which seemed particularly apt for examination.

#### **Three alternative frameworks**

In his review of comparative research in the social sciences, Sartori (1994) highlights the difficulties that challenge the student in selecting the most relevant framework to guide the research effort. He indicates that, unlike researchers in the natural sciences who routinely employ experimental approaches for their studies, researchers in the social sciences are obliged to use other less rigorous analytical frameworks when undertaking comparative analyses of nations. The challenge is to identify the most appropriate strategy for inquiry. In light of his observations, three methodological approaches were considered for the examination of social policy fields in broadly similar nations.

Given the choice of health and assisted housing in Canada and the US, the primary task was to find a theoretical framework that would satisfactorily explain why the policy process in the two nations produced divergent outcomes in health, but significantly similar

outcomes in assisted housing.

Martz (1994) has indicated that there are difficulties in selecting the most appropriate analytical tool for comparing policies in apparently homogeneous nations. However, important differences between nations do exist and, according to Martz, these may be identified through the careful selection of variables. For example, in his study of Latin American nations, he claims that by enlarging the number of variables and including those which focus on institutional, cultural, and historical elements, the researcher will be able to bring subtle but nevertheless important differences to light.

With this in mind, the following paragraphs describe three approaches that were considered for selection in the examination of these policy fields. Though all were recognized as having important merits, they also proved to have analytical limitations. They are the neo-Weberian model, the class approach, and the neo-institutional framework. The one which held the most promise appeared to be the latter.

**The neo-Weberian model.** The neo-Weberian model, outlined initially by Perrow, claims "to lay out more systematically some of the aspects of bureaucracy that Weber neglected or assumed" (1986, 155). It builds on and consolidates earlier contributions to the study of bureaucracies and organizations, including seminal work related to the organization's structure, processes, and function; its managerial, technical, and institutional subsystems; and its goals, expectations, and choices.

Much of the impetus for examining how public and private organizations functioned and changed over time occurred in the postwar years as scholars from a variety of academic disciplines such as sociology, history, economics, and law, broadened their interest to include the multifaceted aspects of organizational change (Denhardt 1984). During these years, the subject of decision making attracted the attention of scholars and practitioners alike. In particular, Herbert Simon's work became the infrastructure upon which many

researchers built a substantial body of knowledge related to organizational theory. For example, Simon's depiction of the "administrative man," who, rather than exploring and exhausting all options available to him, makes decisions that "satisfice" (1957), promoted extensive scholarly debate and research into the complexities of decision making in both public and private organizations.

Over the years, Simon's work, like that of Weber himself, has been refined as scholars expanded on his concepts of bounded rationality and behavioral theories of choice (March 1990). For example, influenced by these studies and basing their work on economic principles, Cyert and March (1963) articulated their own theory of large, complex organizations. They examined how organizational goals, expectations, and choices are affected by the decisions that are made in response to internal and external variables. Claiming that institutional responses are conditioned by limited rationality, Cyert and March asserted that those responses adapt to a variety of constraints and opportunities which change over time. In this regard, they contended that organizations consist of members who are capable of being influenced not only by other individuals and groups in the organization, but also by individuals and groups in the external environment, and that these multiple and conflicting arrangements create complex and dynamic relationships and preferences.

However, even though the framework provides a cohesive analytical tool for understanding the structures, functions, and processes that influence policy making, the model does not adequately deal with all important factors which directly or indirectly influence policy change. One such factor is particularly relevant in the analysis of assisted housing and health policy: namely, the large-scale events in the broader environment which, although not directly linked to the policy issues under discussion, do have an impact on the policy path. Perrow himself acknowledges that, to a large extent, the neo-Weberian model has treated the environment as a "'given' and unproblematical" (1986,

156). In view of the lack of emphasis which it accords to this factor, the neo-Weberian model, despite its undeniable merits, does not fully meet the analytic needs of the present study.

**The class approach.** Over the years, there has been controversy about the types of welfare states that exist in the industrialized world and the relationships among the forces that have affected class development within those states. Part of the argument has been based on the manner in which the relationship between the state, the market, and society has been examined (Chilcote 1994).

Flora and Heidenheimer maintain that in order to fully appreciate the complex arguments related to class analysis of the welfare state, there must be an understanding of the transformation of the European nations over the centuries. They note that "national differences within Europe in the creation of absolutist states with strong bureaucracies and paternalistic traditions may explain the earlier or later beginnings of the welfare states" (1982, 22). The combination of political and industrial revolutions had a profound impact upon the transformation of several European countries when increased demands were made for mass democracy as well as socioeconomic equality and security. The different structures, functions, and legitimacy of state/societal relations that emerged following these upheavals have been at the core of the Weberian and Marxist traditions. Flora and Heidenheimer claim that these differing analytical perspectives,

that of political sociology in the tradition of de Tocqueville and Weber, and that of political economy in the tradition of Marx and others, do not necessarily contradict one another and may in fact be complementary. They are an expression of the historical constellation in which the European welfare state emerged, a constellation of growing mass democracies and expanding capitalist economies within a system of sovereign national states (1982, 23).

The analysis of welfare state development from a class perspective has included theories which are designed to explore state and societal responses to economic growth,

industrialization, and citizenship rights. Esping Andersen (1990), for example, has contributed significantly to this field of study by exploring in some detail the history and organization of state provision of welfare, and by developing a typology which identifies the main characteristics of each "welfare capitalist regime" (Harloe 1995, 520). As discussed in Chapter 1, Esping Andersen's three types of welfare state are the corporatist, the social democratic, and the liberal. Each shows significant differences in the state's provision of decommodified aid. Both Canada and the US fit into the *liberal* category, which, as "liberal, residualist welfare states . . . depend on the loyalties of a numerically weak, and often politically residual, social stratum" (1990, 33).

The approach espoused by Esping Andersen has important merits and, along with other class perspectives, enhances our understanding of how welfare states emerged and why complex relationships developed between the state, the market, and society. However, while this approach may be most useful in examining welfare state evolution where there were important precedents for the emergence of class struggles, the same approach may not have equal utility for the present study of assisted housing and health policies in Canada and the US. Reasons for this have been advanced by Kudrle and Marmor (1982) who, as noted in Chapter 2, contend that by being exempt from the long historical influence of feudalism and the high level of class differentiation that contributed to many of the class struggles that took place in Europe, Canada and the US have not had the same historical and societal pressures that stimulated demands for welfare state reform in Europe.

With respect to Canada, Haddow notes that from its early beginnings, the welfare state emerged along liberal lines and its programs have been modest when compared with those provided by other industrialized nations. In good part, this is because it developed

in a context of weak working class parties and the dominance of national politics by pro-business parties; there has never been a social democratic government nationally, and the influence of the Co-operative Commonwealth Federation/New Democratic Party, usually on minority governments has been sporadic (1990, 214).

As a result of the emphasis on market interests, there has been a bias against labor and low-income groups. This lack of prominence in the policy making milieu has meant that consumers of welfare programs have, for the most part, been weak and fragmented in organization and have maintained a subordinate position in their ability to influence the policy making process. The Canadian welfare state has reflected this weakness, "permitting conservative politicians to advocate a residual, 'poverty' orientation in social policy" (Haddow 1990, 215).

As for the United States, Lipset indicates that the class structure was characterized by two elements identified by de Tocqueville. These were equality of respect and equality of opportunity. The former referred to an "emphasis on egalitarian social relations," in other words, "the absence of a demand that those lower in the social order give overt deference to their betters," and the latter to an emphasis on meritocracy, that is, "on equal opportunity for all to rise economically and socially" (1990, 24). In combination, these elements gave rise to an explicit rejection of the elitist and class systems already embedded in Europe. This lack of emphasis on class has had a long-term effect on the nature of the US welfare state, causing it to consistently provide limited and targeted programs for those most in need (Boychuk 1997, Banting 1997).

Because Canadian and American beneficiaries of aid in housing and in health have continually been unable to exert great influence on the policy process, the class approach, although valuable, does not provide sufficient analytical scope for this particular study, whose validity must rest on the broader aspects of institutions and ideas, since these appear to carry more weight than social interests.

**The neo-institutional approach.** In his analysis of Canadian and US welfare states, Pierson (1995) observes that the neo-institutional approach simplifies our understanding of the structures and processes involved in social policy development in

industrialized nations due to its ability to reveal the dynamic relationships between state and societal institutions and actors over time. Thus, it helps the researcher "to develop more nuanced propositions about the consequences of institutional arrangements and the interplay between institutions and other variables" (Pierson 1995, 451).

Among the scholars who have commented on neo-institutionalism as a research tool, Lowndes declares that "new institutionalist approaches reflect a common commitment to the significance of institutional arrangements and a common criticism of atomistic accounts of social processes. Beyond these core assumptions, new institutionalism is characterized by a great variety of positions, which are sometimes complementary and sometimes conflicting" (1996, 181). While, individually, each of the approaches can make significant contributions to the social sciences, linking them with other research frameworks promises to produce an even deeper understanding of each issue and, in the process, promote greater discourse between hitherto separate disciplines (Ross 1995).

The debate about neo-institutionalism reflects the dynamic nature of research into increasingly complex policy issues, and also shows the extent to which the study of political science has evolved since the late nineteenth and early twentieth centuries, when academic inquiry was largely restricted to describing the government structures and institutions of specific nations (Baxter-Moore et al. 1994). During the three decades following World War II, the focus on public institutions was superseded by other methods of scholarly inquiry. This search for alternatives was motivated, in part, by the changing role of government in the postwar era, as well as by a growing interest in the actions of groups and individuals that participated in the policy process.

Since the early 1980s, scholars concerned about the relationships between state and society have returned to the question of institutions and their role in the development of public policy. In good part, the reason for this renewed interest is an acknowledgment by researchers that since society is constantly changing and "legacies of the past influence the

present and the future . . . integrating history with social science investigation" can prove to be a most useful analytical tool (Ethington and McDonagh 1995, 85).

Part of the debate within the neo-institutionalist community concerns the question of which theoretical perspectives merit inclusion in the neo-institutional model. For example, in proposing six "vignettes" that capture the "multi-theoretic approach" to neo-institutionalism,<sup>1</sup> Lowndes argues that the conceptual positions from which the vignettes are drawn "differ in the significance they accord to: formal and informal institutional rules; change and stability within institutions; and the role of rational action and norm-governed behavior in creating and sustaining institutions" (1996, 181). In essence, Lowndes' critical appraisal captures the spectrum of ideas that form the neo-institutional framework.

What is becoming apparent is that most scholars who adhere to the neo-institutional approach recognize that there are three dominant theoretical bases that provide the infrastructure upon which neo-institutionalism is gradually being built. These are: historical institutionalism, rational choice institutionalism, and organizational or sociological institutionalism. As will be discussed below, each can be seen as an important contributor to the neo-institutionalist approach to social science research.

**HISTORICAL INSTITUTIONALISM.** In their discussion of neo-institutionalism, Hall and Taylor maintain that historical institutionalists define institutions as "the formal and informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy." These scholars point out that "historical institutionalism developed in response to the group theories of politics and structural-functionalism prominent in political science during the 1960s and 1970s" (1996, 937-938). The joining of historical institutionalism with group theory, however, was not a wholesale attempt to merge the two approaches, but rather, an effort to select, refine, link, and apply what they felt to be the most relevant features of each theoretical perspective in their examination of changes that occurred over time. For example, in group theory, the

historical institutionalists valued the fact that, in many instances, "the institutional organization of the polity and economy structures conflict so as to privilege some interests while demobilizing others." They also recognized the importance that structural-functionalism placed on the dynamic nature of the polity's construct, whose various institutional arrangements had "moving parts." Their conclusion was that by adding features of these two theoretical perspectives to their research toolshed, the product of their own analysis would be stronger (1996, 937).

In adopting this new approach to institutional analysis, the theory's supporters were rejecting the pure description of institutions and were starting to answer the question "do institutions matter?" (Weaver and Rockman 1993). In addition, they stimulated a debate about which institutions were important and why. In the process, they began to explore the relationships and relative importance of formal and informal institutions, the types of influences that affected their behaviors, and the manner in which their structures varied over time (Thelen and Steinmo 1992).

These shifts in focus led historical institutionalists to revise the traditional perspective of the role of the state as that of a neutral agent and to view it as being capable of profoundly affecting complex issues related to all aspects of the polity and as being able to influence the forces acting on it, as well. In her discussion of the state as an integral part of a constantly evolving process, Skocpol (1985, 1995) persuasively argues that state institutions are complex systems that structure both intra- and inter-governmental relationships and also establish vital links with other societal institutions. For these reasons, the state may be viewed as both an institution and a social actor (Evans et al. 1985).

Such conceptual changes in scholarly understanding of the nature of historical institutionalism have led Hall and Taylor to draw the following conclusions about those who utilize this research tool:

First, historical institutionalists tend to conceptualize the relationship between

institutions and individual behavior in relatively broad terms. Second, they emphasize the asymmetries of power associated with the operation and development of institutions. Third, they tend to have a view of institutional development that emphasizes path dependence and unintended consequences. Fourth, they are especially concerned to integrate institutional analysis with the contribution that other kinds of factors, such as ideas, can make to political outcomes (1996, 938).

RATIONAL CHOICE INSTITUTIONALISM. In his review of institutions and rationality in politics, Kato holds that "rational choice studies apply the assumption of utility maximization, or some approximation of it, to the analysis of political actors" (1996, 557). This approach has had an important impact upon our understanding of political processes and outcomes, particularly in the American congressional system (Immergut 1998). For example, prior to rational analysis, key aspects of the complex relationships between bureaucratic interests, political control, and coalition behavior had been poorly understood. What had been lacking, some critics contend, is the institutional context within which the preferences and strategies of the actors operate (Hall and Taylor 1996). Thus, as Kato observes, the "novelty of rational choice new institutionalism lies in the analysis of the effects and influences of institutions, especially the analysis of whose interests or preferences prevail in public policy or social decisions" (1996, 557).

For the most part, Fiorina agrees with this view, suggesting that there is a complementary link between the theoretical approaches adopted by academics in all of the disciplines related to neo-institutionalism. Many rational choice scholars now "see institutions as both causes and consequences. The very fact that institutions can shape behavior and outcomes makes it necessary to explain how they are created and sustained by rational actors who understand their importance" (1995, 113).

Although rational choice institutionalism makes an important contribution to the neo-institutional approach, there are shortcomings which have an impact upon its utility in this thesis. As Hall and Taylor observe (1996), the rational choice framework does not fully explain how institutions originate and change. In this regard, historical institutional-

ism provides a stronger analytical base. Thus, although it is recognized that actors play a role in institutional change, the present study will place much greater emphasis on institutional and ideational factors than on interests.

ORGANIZATIONAL OR SOCIOLOGICAL INSTITUTIONALISM. Of the three methodological approaches discussed here, organizational theory has the most firmly established background in the social sciences. Over the years, political scientists have accumulated a wealth of knowledge about the roles and actions of organizations and the groups and individuals that comprise them (Cyert and March 1965, Thompson 1967). Much of the interest in neo-institutional organizational theory has stemmed from Weber's analyses of bureaucracy as well as later studies which explored the dynamic relationships of groups and individuals within and between organizations (Perrow 1986).

Cohen et al. (1972) claimed that the processes associated with problem identification and resolution, decision-making, and the establishment of organizational goals and procedures are, for the most part, chaotic. Based on work originally undertaken by Simon on decision making, and believing that organizations are akin to "organizational anarchies," Cohen et al. painted a picture of what they understood to be the realities of organizations in action. They referred to their model as the "garbage can"<sup>2</sup> approach. According to Immergut, whereas the concept of "bounded rationality introduced limits on choice procedures, the 'garbage can model' went further by dropping all causal links between problems and solutions, viewing them as meeting randomly" (1998, 15). Cohen et al.'s model was viewed as providing a more radical approach to organizational theory and it stimulated considerable intellectual interest in how organizations function. More recent studies have reexamined this perspective and have sought "a more complete understanding of the impact of organizational settings" on policy change (Hall 1986, 12). Hall and Taylor have added sociological aspects in which complex and often subtle cultural approaches "based on an understanding of culture as shared attitudes or values" are employed in the analysis of

organizational structures, their genesis and characteristics, and the changes to their rules and processes over time (1996, 947). Thus, with the sociological approach to organizational theory, a more expansive view consisting of societal values and attitudes that shape a variety of organizational activities (Lowndes 1996) is adopted in the analysis of institutions (Immergut 1998). This attention to the ideational aspects of institutional formation and change will be emphasized in the present study.

Whatever their viewpoint, proponents of sociological neo-institutionalism are inclined to believe that organizational theory enriches research in several important ways. First, it tends to define institutions more broadly, adding cultural explanations to the examination of formal rules, procedures, and norms. Second, it offers insights into the complex relationships between institutions and individuals. And third, it focuses on explaining the manner in which organizational practices originate and change, and places particular emphasis on "the social legitimacy" of the organization and its participants (Hall and Taylor 1996, 947-949).

The neo-institutional approach has been selected as the most useful analytical tool for the present study because, to a greater extent than either the neo-Weberian or class models, it provides an opportunity to adopt a broader approach to the examination of assisted housing and health policies.

It is apparent that, in themselves, the components of neo-institutionalism are not perfect. As Hall and Taylor note, "in all their varieties, the 'new institutionalisms' significantly advance our understanding of the political world. However, the images they present of the political world are by no means identical; and each displays characteristic strengths and weaknesses" (1996, 950). For example, historical institutionalism by itself does not elaborate on the preferences of state or societal actors, although it does provide a context for action; while rational choice institutionalism alone does not fully explain why institutions change. Even taken together the components of neo-institutionalism may not

always adequately explain the causes and consequences of policy change. To overcome this eventuality, it is essential to make a most judicious and comprehensive selection of variables. When this is done, the neo-institutional framework does provide an opportunity to probe the "state-societal patterns of intermediation" (Boase 1996a, 287) and thus to understand how the structures and characteristics of state and societal institutions work to shape policy over time.

### **The determining factors**

Eight determining factors have been selected to facilitate the study of each nation's public housing and health policies. These factors have been drawn from the three theoretical streams of neo-institutionalism that are discussed above and are a combination of institutional and ideational variables. They allow us to move from the theoretical framework discussed above to a concrete application of the analytical approach.

federalism	the established systems of government in Canada and the US
central government institutions	the institutional structures responsible for policy design and administration
inherited policy	policies that are passed on by previous administrations and that may abet or inhibit policy direction
political culture	the slowly changing, deep-seated values of the populace
ideology	the philosophy and policy preferences of a political party
definition of the problem	how policy issues are perceived and reported by interested groups and individuals
decision making	the interaction between state and societal actors that

	leads to the making of policy choices
exogenous influences	substantial external factors and events which exert influences on policy direction

Federalism, central government institutions, inherited policy, and decision making and exogenous influences may be identified as institutional factors, whereas political culture, ideology, and definition of the problem are ideational issues.

By themselves, these factors offer only partial accounts of the complex process of policy change. Together, they make evident the complex interactions that contribute to an effective analysis of the policy process — one which establishes specific parameters for study, ensures parsimony, and identifies subtle, but significant differences in the policy processes of the two nations, even when, as in the case of assisted housing, there were similar policy outcomes.<sup>3</sup>

**Federalism.** In the present study, federalism is included as a determining factor because of its pervasive impact on all aspects of social policy development. McRoberts observes that "federalism's often intimate relationship with society commends a comprehensive approach that seeks to integrate both state and society into an explanation of public policy" (1993, 169). Academics who have studied the evolution of Canadian and US federalism generally agree that there have been shifts between interstate and intrastate governance over time (Breckenridge 1998), and that the resultant changes in governing relationships and authority have had important effects on policy development, especially in the realm of health and social welfare (Boase 1996a, Rich and White 1996, Tuohy 1993, Ashford 1986). These shifts add to institutional complexity and raise questions about the roles, responsibilities, and capacities of the different levels of government to develop and implement policy (Davidson 1997).

As noted in the previous chapter, despite the fact that Canada and the US both have

federal government systems, each system was formed and matured in a different way. As a result, Canada's parliamentary government with its executive-centered cabinet and concentrated authority stands in contrast to the American presidential-congressional system, which was designed to separate the centers of power (Simeon and Willis 1997). Although the Canadian and US federal systems reflect the "inherent intergovernmental tension and shifting nature of the political balance" that are frequently found in systems with more than one level of government (Boase 1998, 1), they rely on different organizational structures, financial arrangements, and policy instruments for the design, funding, and delivery of public services and programs. These structures, arrangements, and instruments, especially the ones related to social policy, are complex and have frequently led to joint-decision traps<sup>4</sup> between various levels of government (Scharpf 1988).

Policy making and implementation are further complicated by the presence of multiple independent points of access used by societal and state actors who wish to influence the policy process (Banting 1995). Indeed, according to Banting, "the scope of welfare coverage, the proportion of national resources devoted to the task, the balance between public and private programs, the mix of policy instruments utilized, and the redistributive consequences of the welfare state all display fascinating differences, and it is here that political factors, including the institutions of government are undoubtedly important" (1982, 41-43).

Banting adds that federalism also has notable implications regarding the government's capacity to coordinate the programs and the political interests involved. To a large extent, these implications are based on the complex relations that are inherent in multitiered systems of governance. McRoberts observes that "federalism can open up the policy process, by allowing for experimentation and innovation at the province or state level," but it "can also constrain the policy process by impeding the adoption or modification of policies at the national level" (1993, 160). These concepts have been

confirmed empirically. For example, Banting (1995) has shown that, in some cases, institutional fragmentation and complex intergovernmental negotiations necessitated by Canada's federal system have forced an incremental approach to social policy reform.

As discussed in Chapter 2, the Canadian and US Constitutions articulated the roles and responsibilities that the two levels of government would have in each nation. Although from its inception, the British North America Act, like the American Constitution, was amended from time to time, the changes introduced by Canada's Constitution Act of 1982 were more sweeping than previous amendments. According to Simeon and Robinson, the 1982 Charter of Rights and Freedoms has had an important impact on federalism in that "beyond discourse, the Charter gives hitherto disadvantaged groups, particularly those who are not territorially concentrated, a politically powerful new institutional avenue for political mobilization" (1990, 298).

In the Canadian and US federal systems, power also exists in the form of economic control over policy development. As Koebel notes, federal power and the redistribution of resources are a "diverse interweaving of democratic principles and economic concepts" (1998, 7). For this reason, the present study will examine the extent to which the Canadian and US federal governments funded social programs, especially in the areas of public housing and health, during each of the four watershed periods that followed World War II.

As we shall see, both the Canadian and the US federal governments have essentially the same broad strategies for allocating public monies to the provinces and the states. Generally speaking, the mechanisms chosen have been conditional or unconditional subsidies, grants, and/or equalization payments, and funds have been provided either in the form of cash transfers or as tax abatements to the level of government responsible for delivering the various programs (Fallis 1993a, 1993b).<sup>5</sup> However, each country has different methods for determining how and when the funds are to be assigned (Breckenridge 1998).

As with most intergovernmental arrangements, cost sharing and conditional grants

have been both defended and condemned (Norrie et al. 1986). Proponents of cost sharing and the allocation of conditional grants claim that financial arrangements such as these ensure a degree of uniformity for essential government programs across the country (Stevenson 1985). Critics, on the other hand, complain that recipient governments are obliged to spend their funds in their own areas of jurisdiction in ways that are determined by the federal government and that such allocations may be potentially detrimental to the funding of other equally necessary programs. Despite the problems that have been associated with them, however, most analysts would agree that, on the whole, these types of funding arrangements have been highly effective federal policy instruments in both Canada and the US.

As will be shown in Part II, funding for social programs has not followed a static course. For example, during the earlier stages of the postwar period, the provinces and states relied heavily on federal funding for most of their social programs. In recent times, however, and mainly for fiscal and ideological reasons, federal transfers have decreased. In some instances, the costs of the programs have been off-loaded to the provinces and states or, as is being seen more frequently now, administrative responsibility for the programs has been devolved to local levels of government. As a result, not only has there been a change in the types of publicly funded programs that are available, but with federalism still a key determining factor, there has also been a shift in the relationships between the federal government and the subgovernments in both countries (Banting et al. 1997).

**Central government institutions.** Neo-institutionalists claim that the role of central government institutions matters to a far greater extent than has hitherto been acknowledged (Hall 1986) and, for the most part, has been neglected in the study of comparative social policy (Pierson 1995). Although these institutions alone do not cause change to occur, they are "structures through which proposals for change must be filtered"

(Boase 1996a, 288-289). As a result, they have an impact on which interests and ideas will prevail in the policy making process.

Krasner (1988) indicates that multitiered levels of governance lead to institutional complexity, and Simeon and Willis (1997) add that the structure and functions of the institutions themselves contribute to policy dilemmas. Atkinson maintains that, in the policy process, central government institutions have the effects of "causality, constraint, and creativity" (1993, 20). This assertion has been confirmed by recent analyses of federal policy making processes in the US. For example, Steinmo and Watts (1995) have shown that institutional structure and complexity have been a major factor contributing to the country's repeated failure to reform healthcare during the postwar years.

In the present study, four key federal institutions will be examined because of their importance in the development of policy. In Canada, they are the Canada Mortgage and Housing Corporation (CMHC), which has overseen assisted housing programs, and the Department of Health and Welfare, which has been responsible for most social policies. In the United States, they are the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS), which are the counterparts of the Canadian institutions.

Over the years, the names, structure, roles, and responsibilities of each of these federal institutions have changed in response to the interaction of several of the other determining factors. These institutional changes have had a direct impact both upon specific public housing and health programs in each nation and upon overall policy direction in the respective fields. Among the interrelated aspects that will be examined in Part II are the mandates of the institutions and their budgets.

**Inherited policy.** With ever greater frequency, political actors are lamenting the lack of opportunities for bold government action to deal with the ills of society. Although

social science literature is rich with inquiries into the underlying causes of these problems and with prescriptions for their cure, what is lacking in many investigations is a focus on the extent to which current options for policy development and implementation in Canada and the US are constrained by the political events and policy commitments of the past.

Policy inheritance and its impact on policy choice in Britain, however, have been comprehensively examined by Rose and Davies. These scholars affirm that, in large measure, government options for current and future policy change are compromised by policies that have been inherited from previous administrations. Placing policies in three broad categories — "those inherited from predecessors; choices made by a particular administration and bequeathed to its successors; and changes made by successor administrations" (1994, 17) — Rose and Davies indicate that these constraints give governments four choices: they can maintain the routine inherited from the previous administration; they can make symbolic gestures where public statements about a policy do not necessarily lead to substantive policy change; they can undertake instrumental adaptations to an existing policy as proof that competent action is being taken; and they can demonstrate innovation by enunciating a new policy goal (1994, 40-43). What is of particular relevance about this type of research is the observation that the limitation of choice in some policy areas may continue for generations, even when significant ideological and economic shifts occur. This, they maintain, reflects societal need for continuity and stability in certain policy fields, especially in the area of social policy.

Weir et al. (1988) agree that the policy direction that is enunciated by the government of the day is almost unavoidably restricted by the realities of the past. It should be noted, however, that not only are the future policy directions of government frequently influenced by legacies of the past, but, in some instances, so are the opportunities for action that can be perceived by the related constituencies. This point is ably demonstrated by Hall (1986) and is underscored by Weaver and Rockman in their 1993 edited study.

Since examination of "the weight of the past" as an influence on actions in the present (Atkinson 1993, 29) is a positive adjunct to a neo-institutional evaluation of public policy, examples of inherited initiatives that influenced the evolution of assisted housing and health policy in Canada and the US will be examined, particularly those initiatives which directly or indirectly prevented linkage between these two policy areas.

**Political culture.** Political culture is the term used for indicating how the citizens of a nation view the role of the state in societal matters. Boase maintains that "state-specific political culture is very complex yet terribly important to the comparative study of politics, although its nebulous nature precludes dependable macro-level descriptions" (1996b, 10). Its examination is useful because it provides valuable information about the relationships that exist between state and society, the ideological fluctuations that emerge from those relationships, and the types of institutional linkages that develop from those ideological changes.

Conflicting elements of need for continuity and pressures for change constantly create tensions and affect state-societal relationships (Simeon and Robinson 1990, 15). Because many streams of individualistic and collectivist actions coexist and influence national values and institutions (Robinson 1997), political culture tends to evolve slowly.

In the Canadian and US federal systems, intergovernmental issues and societal influences are interdependent. They affect both state and societal institutions and, ultimately, influence policy choices. The political culture of the two nations is significantly different, however. According to Lipset, it has its roots in the way each country was created. Lipset reminds us of the following:

The revolutionary Republic was suspicious of state authority and adopted a power-constraining bill of rights, [whereas the] counterrevolutionary dominion followed the Westminster model, with power centered in a cabinet based on a parliamentary majority with no limits on the authority of the state other than those derived from a division of jurisdictions between national and provincial

governments (1990, xiii).

Preston adds that the political culture of the US was further embedded following the Civil War, when "claims to equality of opportunity, a strong economic individualism, a preference for political liberty and an institutional style of republican democracy" became more firmly established (1997, 125). Historical experiences such as these not only shaped state and societal institutions in the US but also affected the manner in which the relationships between them evolved.

Boase (1996b) provides an example of how a nation's roots can condition political culture and from it, specific policy fields. In her comparison of Canadian and US health policy, she discusses how Canada, with its parliamentary system, has been able to introduce health policy initiatives without the same degree of protest that has traditionally blocked their introduction in its southern neighbor. The US, with its fragmented government and multiple points of access by societal interests, has been able to introduce policies only incrementally. According to Boase, these are among the reasons why "Canadian political culture has supported the collectivist notion of a public good such as universal health insurance," whereas American political culture "adheres to a remarkable degree of pluralism, individualism and competition . . . and retains its suspicion of government activity that was the foundation of the system in the eighteenth century (1996b, 33-34).

The power of heritage notwithstanding, political culture does change. Lipset believes that shifts can be identified at specific historical times. For example, he observes that the United States,

faced with the need to come to terms with problems posed generally by industrialization, urbanization, and its emergence as the leading actor in the world system and particularly with the trauma of the Great Depression and the protest wave of the 1960s, has modified its values. It has long given up its unwillingness to use government to deal with social and economic problems or to recognize group rights as distinct from those of the individual (1990, 2-3).

And Inglehart holds that the identification of shifts in political culture can best be revealed

by studies which examine state and society from multiple perspectives and "in longitudinal perspective" (1990, 5). In order to improve our understanding of changes in Canadian and US social policy in general, and housing and health policy in particular, this thesis will avail itself of the contributions of both of these scholars.

**Ideology.** Whereas political culture reflects the way in which the citizens of a nation view the role of the government in societal matters, ideology, as interpreted here, reflects the view of the government regarding its social responsibilities to the citizens, including the provision of assisted housing and healthcare. When analyzing ideology, it is important to consider the strength of the party in office and whether this political reality affected the government's capacity to bring about policy change.<sup>6</sup> In his exploration of the differences between the Canadian and US social welfare systems, Banting contends that the legislative and party configurations in each nation created windows of opportunity<sup>7</sup> for social reform at very different times: "Reform in the United States came at times of great Democratic strength, whereas in Canada reform came at times of Liberal weakness. The times of Liberal weakness were more common than those of Democratic triumph" (1997, 283).

In Canada and the United States, which Esping-Andersen describes as "'liberal' welfare states" (1990, 26), the ideology of the different political parties in each nation may have had a greater impact upon social policy development than previously acknowledged (Kudrle and Marmor 1982). In Canada, for example, this may be attributed to the existence of a third national party (the CCF/NDP) that was more sympathetic than the others to social issues (Maioni 1997a) and to Quebec's influence in national politics (Stein 1989).<sup>8</sup>

Because of its importance as a policy determinant, ideology — including the strength of the government to impose its philosophy — will be studied as a potential influence on Canadian and US decisions concerning the paths that assisted housing and

health have followed during each of the watershed periods.

**Definition of the problem.** Heclo maintains that policy making is "a form of collective puzzlement on society's behalf" (1974, 305).<sup>9</sup> Lindblom (1990) suggests that one way of determining how this collective puzzlement comes about and is subsequently resolved is to examine pivotal reports and documents which provide information about how specific problems are defined.

According to Lindblom, it is frequently the information and misinformation which are presented to policy makers that have contributed to the creation of new policies. Some of these policies have been of questionable benefit to society or have had detrimental consequences for the people that the policy was intended to help (OECD 1994). Lindblom suggests, therefore, that policy makers, reaching out to state and societal groups as well as individuals who possess the requisite knowledge, should take steps to ensure that the information they acquire and share is both relevant and correct.

Schram focuses on the manner in which policy discourse is constructed and conducted. He argues that our present method of policy analysis — what Schram categorizes as the "linear, rational problem-solving paradigm" (1993, 252) — is biased and incomplete, especially when used to examine social welfare policies in North America. Although essential information may be available, it is often overlooked. As a result, old, narrow definitions of social problems are used instead of broader definitions that reflect the diversity of emerging societal issues; scarce resources are not properly channeled to those most in need; and "welfare policy today helps to recreate the problems of yesterday" (1993, 250).

In order to identify why greater linkage in assisted housing and health policies failed to materialize in Canada and the US after World War II, this study will review some of the key reports and documents that reveal how the problems were defined. Although a majority of the documents are from Canadian and US governments sources, influential

reports and recommendations from other sources will also be examined. Because of the volume of material available from a wide variety of state and societal sources, only representative examples will be discussed.

**Decision making.** In their detailed analysis of decision making in modern capitalist states, Ham and Hill (1993) point out that there is a strong relationship between the manner in which decisions are made and the distribution of power within and outside of the government. Basing much of their discussion on Simon's work on rational decision making and Lindblom's research into incremental decision making, they maintain that government decision making processes are highly complex, are influenced by a number of diverse and often apparently unrelated factors within the state and in the broader environment, and are "by no means direct and deterministic" (1993, 187).

Aberbach et al. (1981) and Etzioni-Halevy (1983) believe that among the factors that condition decision making are the locus of power within the state apparatus and the manner in which the political and bureaucratic elites wield this power. These observations have been confirmed by studies that focus on the complex relationships between elected officials and bureaucrats, and the relations these elites have with societal groups and organizations (Skocpol 1985, Haddow 1990). Once a policy issue arises, is seen to require state action, and is defined, each institution perceives the issue from its own perspective and attempts to influence the decision making process in order to meet its own goals (Coleman and Skogstad 1990). In this regard, Simeon and Willis observe that in Canada:

The centralization of authority within jurisdictions — combined with a smaller number of provinces — powerfully supports the executive-to-executive bargaining process of Canadian federalism. In the United States, summit diplomacy, or the intergovernmental lobby, plays a relatively minor role. This diffusion of power leads to a far more fluid and diverse intergovernmental process, which is played out in a myriad of program-oriented policy networks, involving congressional committees, bureaucratic agencies, and state and local authorities . . . This in turn is reflected in intergovernmental fiscal and policy relationships (1997, 175).

The balance of power and authority between government levels in federal systems also has an impact on how policy decisions are made (Aucoin and Bakvis 1988). For this reason, the present study will focus on the relationships between the federal and provincial/state governments and their respective elected officials and bureaucrats (Marshall 1986) in order to determine the degree to which they influenced opportunities for linkage between assisted housing and health policies in each nation.<sup>10</sup>

Social science literature is replete with studies that have explored the dynamic relationships between state and societal interests. Since publicly funded programs are often designed and implemented by representatives from the private and, increasingly, the third sectors, there is also a substantial body of reports concerning corporatism in public sector management. These reports detail how non-government organizations influence and, with growing frequency, even assume responsibility for policy initiatives (Williamson 1989). This has an important impact on policy feedback and influences elements such as institutional structure, interest mediation with other groups, policy choice, and policy impact (van Waarden 1992).

Increasingly, empirical evidence is showing that formal and informal pressure groups (Pross 1992) and advocacy coalitions (Sabatier 1993) also play a part in decision making both within and outside of the public domain and can have a considerable influence on policy development. Thus, when exploring the roles and responsibilities of elected and appointed officials in social policy development, the present study will include an examination of the interaction between some of the policy communities and policy networks that come into play (Coleman and Skogstad 1990).<sup>11</sup>

**Exogenous influences.** Merton (1936) and Dexter (1981) indicate that policy development does not occur in a vacuum and that events and issues apparently unrelated to particular policy matters may enter the picture. Therefore, in the present study, exogenous

factors will be treated as one of the variables which abet or inhibit policy change, or occasion unexpected shifts in the policy path. Exogenous influences may be defined as large scale phenomena that operate on a broad national or international level and in some way influence policy decisions. In view of this, it is incumbent upon us to determine what impact such factors as the Vietnam War of the 1960s and 70s and the economic upheavals caused by spiraling energy costs in the early 1970s had on the overall direction of social policy in Canada and the US, and their specific effects on policy linkage between assisted housing and health.

### **Phases in postwar policy development**

There is an extraordinary amount of literature dedicated to the evolution of social policy in Canada and the US since the end of World War II. The sheer quantity of the material makes it impractical to review it all here. However, four carefully selected examples will illustrate the complex and dynamic nature of policy making in assisted housing and health, which in North America have generally been treated as separate domains, and will help us to identify the main watershed periods that should be examined in Part II of the thesis.

#### **Canada**

**Assisted housing policy — Carroll.** In her research on Canadian assisted housing, Carroll<sup>12</sup> has recognized five phases of federal policy development since the end of World War II. She asserts that the early phases "emphasized social involvement and rational planning." The 1960s and 70s saw an increase in provincial assertiveness as well as program delivery. "The eighties reflected a concern with cost containment and disentanglement. The pattern of development and turnover continued, but in the 1980s, social policy lobbying and province-building combined to produce programs which were both

inefficient and ineffective at meeting needs in a period of financial conservatism. Finally, we have 'rethinking government,' disengagement, and smaller scale, non-government intervention" (Carroll and Jones 1999, 6-7). Carroll's five phases are shown on the following timeline:

1945    1950    1955    1960    1965    1970    1975    1980    1985    1990    1995    2000



1945-1968: ECONOMIC DEVELOPMENT. The primary concern of all levels of government during the postwar period was related to economic growth. Not only were veterans returning from abroad, but people in all regions were in need of jobs and homes. The federal government initiated most of the new housing programs by providing loans and grants. These efforts to promote reconstruction and new growth led to urban slum clearance, the rebuilding of city centers, construction of large publicly funded projects for low income people, and the creation of suburban housing and industrial developments.

These large scale programs had both intended and unintended consequences. For example, although the building industry benefited from the boom in housing, an extra burden was placed on the public sector, which was obliged to provide more land suitable for building as well as an infrastructure of sewers and roads. And although some elements of the population improved their living conditions as a result of the building boom, slum residents were frequently displaced by the growth of commercial enterprises in the city centers and, because of the economic stresses of the time, more affluent people often found that they could not afford to buy their own homes.

1968-1978: SOCIAL DEVELOPMENT. A number of important economic, social, and political factors converged during this phase. These factors had a direct and long-lasting impact on housing policy. For example, problems associated with previous housing policies were identified, the huge "baby boom" generation was seeking accommodation,

and industrialized nations were facing the start of economic upheavals. During this phase, all levels of government linked with community groups and organizations collectively to better housing conditions and supply.

1978-1986: FINANCIAL RESTRAINT. This stage was characterized by serious economic problems and inflation. In their attempt to reduce spending, governments withdrew from a number of policy areas. As far as assisted housing was concerned, the federal government began a process that gave the provinces greater administrative control.

1986-1994: DISENTANGLEMENT. During this phase, all levels of government tried to deal with high deficits. These deficits made it apparent that the public sector could not provide accommodation to all who needed it. As the provinces assumed more responsibility for housing, variations in policy directions in each region developed, one of the most notable being greater partnerships with the private and third sectors.

1994-PRESENT: DIVESTMENT AND DISENGAGEMENT. The federal government withdrew from all assisted housing projects, funding only those that existed under previous agreements. The private sector and, to a much greater extent, the third sector worked with the provincial governments to provide housing for those in need.

**Health policy — Boase.** Boase has written extensively on international health policy with a particular emphasis on the Canadian experience.<sup>13</sup> Focusing on issues related to the complexities of federalism and the relationships between state and societal institutions and actors (1994, 1996a, 1996b, 1998), she maintains that Canada's health policy has relied:

on adjustments within the health care policy community/network that have seen governments move from a peripheral position at the outset to one where they now dominate the policy community and manipulate the networks. The history is one of difficult federal-provincial relations, of controversial government decisions, and of a gradual consciousness-raising in the ranks of the medical professionals and related interests; it illustrates the policy potential of a parliamentary system (even a federal one) despite the resistance of powerful

societal interests, the tenacity of established processes of intermediation and the conditioning effects of past decisions (1996a, 294-295).

In the course of her research, Boase has identified five broad stages in health policy development in Canada:

1945    1950    1955    1960    1965    1970    1975    1980    1985    1990    1995    2000



**PRE-1945: BENIGN NEGLECT.** During this period, there was minimal government intervention, and health services in the free enterprise system were provided on a fee-for-service basis by independent physicians. Thus, health services came under physician control, were hospital based, and created an unintended emphasis on curative care within the confines of health institutions.

**1945-1977: HEALTH INSURANCE.** Both the federal and the provincial governments became more involved in overseeing the execution of health and social policy. This was a time of cooperative federalism characterized by shared costs and conditional grants. During this stage, national medical and hospital insurance and pension plans were introduced. However, there were concerns about the manner in which publicly funded healthcare was being privately implemented by self-regulating professions. In particular, the hegemony of doctors and hospitals increased, and the curative bias in the health care system became firmly embedded.

**1977-1984: GOVERNMENT REGULATION.** With the advent of Established Program Financing (EPF), federal government funding became an important planning issue and government control over national health policy not only became entrenched, but also received broad support from Canadian citizens. It should be noted, however, that with the EPF agreements, the federal government lost a significant amount of control over how federal monies would be spent on healthcare by the provinces. In essence, with EPF, the

process of devolution to the provinces had begun.

1984-1995: INTERDEPENDENCE OF POLITICS AND ECONOMICS. Following the acrimonious debates at both national and provincial levels, which were linked to the passing of the Canada Health Act, the relationship between public, private, and third sector interests changed. The federal government clearly established its expectations for ongoing provincial adherence to the five principles of Canadian health policy: comprehensiveness, universality, portability, public administration, and accessibility. However, it also embarked on a path of devolution of responsibility of health and social services to the provinces (1994, 1996b).

1995-PRESENT: DECENTRALIZATION. The introduction of fiscal changes in the form of the Canada Health and Social Transfer (CHST) by the federal government prompted even greater health and social reforms at the provincial level. It is of note, however, that although the CHST initially appeared to be an abdication by the federal government of its control over health policy, subsequent budgets made it plain that the government was still determined to retain overall control (1998). During this phase, however, the degree of federal authority over other social programs such as the Canada Assistance Program (CAP) was reduced.

### **United States**

**Assisted housing policy — Doan.** Doan (1997) has undertaken a detailed survey of US housing policy from 1880 to the year 2000. Tracing key aspects of public and private sector involvement in American housing production, his work highlights the complexities of this policy field and provides us with a clear insight into how issues and trends changed with the passage of time.

Doan discusses three phases in the evolution of housing production. These are the Pre-modern or Mass Immigration Era (1880-1916), the Transition or War and Depression

Era (1917-1956), and the Modern or Policy Turmoil Era (1957-1990). Within each of these phases, he identifies shorter periods during which significant changes in public and private housing developments occurred. The final decade of the century is treated as a separate section; here future housing policy shifts are anticipated. Only the twentieth century phases will be summarized below.

1945    1950    1955    1960    1965    1970    1975    1980    1985    1990    1995    2000

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1917-1956: THE TRANSITION OR WAR AND DEPRESSION ERA. This period was marked by a notable transition from a laissez-faire economy to one where there was significant federal government intervention in the housing industry. The primary causes of public intervention in housing were the Depression and World War II. This phase made prominent the impact that social, political, and economic factors could have on the quantity and quality of housing.

1957-1990: THE MODERN OR POLICY TURMOIL ERA. Housing during these years was affected both by domestic events and international upheavals. Doan identifies several discrete periods within this time frame and outlines the changes that took place in housing during each. He indicates, for example, that between 1957 and 1965, housing production was "steady" because both supply and demand leveled off (71). He describes the years between 1966 and 1973 as "a remarkable period," a time of "turmoil in the body politic and in housing" (80), when civil rights disturbances erupted and the US became involved in the Vietnam War. During this period, the federal government made "the greatest effort ever . . . to produce subsidized housing for low and moderate income families in large volume and to influence urban development" (81). Between 1974 and 1980, Doan reveals that there was "more turmoil" in housing (101) and that, as economic problems reduced the vigor of the housing industry, the government embarked on a series of new initiatives, one of

whose aims was to resume federal housing programs for "a range of lower income families" (102) Finally, Doan notes that between 1981 and 1990, there was a "return to laissez-faire" in the US economy (111) and a drastic reduction in the federal government's direct role in public housing (117). During this era, because of allegations of corruption and fraud in public housing, Americans' confidence in the public housing system was seriously damaged.<sup>14</sup>

1990-2000: THE END OF THE CENTURY. Housing policy at the federal level was undergoing profound change. Despite the fact that much of the existing housing stock was in need of repair, national support for ongoing federal involvement had been declining. According to Doan, the future will test the ability of all levels of government not only to cooperate among themselves, but to work in concert with the other sectors of society to meet the multifaceted needs of an aging population. As Doan explains it, the situation is likely to worsen on the federal level for the following reasons: "The existing stock of subsidized housing dates back a full generation. Maintenance and replacement costs can only rise. Political support for federal housing programs has clearly weakened. Constraints on the federal budget will no doubt tighten as the government grapples with Social Security and the entitlement programs, particularly Medicare, compounded by an aging population" (1997, 157).

**Health policy — Kingson and Berkowitz.** Kingson and Berkowitz (1993) believe that the study of health policy in the US must encompass an examination of the start of American social security in concert with the evolution of Medicare and Medicaid. Their examination of health within the context of social policy provides us with a detailed review of the complexities of these programs and how they have changed over time in response to a variety of factors. The following are examples of the key periods in US health and social policy development which the authors describe:

1935 1940 1945 1950 1955 1960 1965 1970 1975 1980 1985 1990 1995 2000

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1935: THE SOCIAL SECURITY ACT AND ITS SUBSEQUENT AMENDMENTS. This legislation was the point of departure for all future US health and social programs. Following several important postwar amendments, it became a popular part of the New Deal. Public demands for greater government intervention into health and social services, however, met with vigorous opposition from representatives of the powerful medical and insurance institutions. Over the years, successful lobbying from these private sector groups has profoundly influenced the direction of all aspects of US health and social policy.

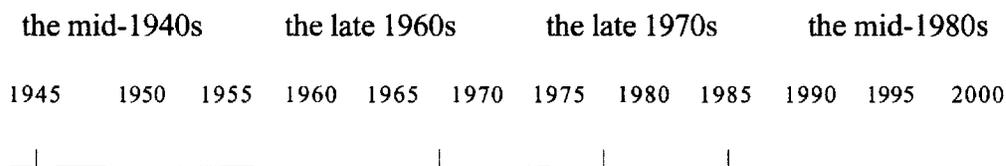
1965: MEDICARE AND MEDICAID. These government health initiatives were introduced during what Kingson and Berkowitz call "the heyday of the Great Society" (1993, 45) and "revealed the complex state-federal, public-private partnerships that characterized Social Security programs" (1993, 46). Their introduction was indeed a remarkable achievement, especially in view of the tensions among representatives of healthcare consumers, providers, unions, and the government.

THE MID-1970S TO THE MID-1980S. Several events heralded changes to health and social policy. National and international economic upheavals caused domestic problems, including a rise in healthcare costs and in unemployment rates. Successive federal governments attempted to deal with stagflation<sup>15</sup> and the concomitant social and political dilemmas that they occasioned. During this period, more and more people and organizations looked to the private sector for health insurance, fearing that the public system would be unable to provide for their future health and social needs. In response to this demand, the private health sector began to experiment with managed care<sup>16</sup> in hospitals and diagnostic-related payment systems.

THE EARLY 1990S. With the change in government, shifts in health policy once again became apparent. Although Kingson and Berkowitz conclude their analysis at this point, it is important to note that the end of the Reagan/Bush era and the beginning of the Clinton presidency heralded significant shifts in both health and welfare. Among these were attempts to overhaul welfare and introduce comprehensive health insurance.

### **Time frames selected for the present study**

Based on the works outlined above, and on other sources from the public, private, and third sectors, the following time frames will be studied in Part II as watershed periods in the fields of assisted housing and health:



These phases have been selected because they reflect significant opportunities for policy change in both Canada and the US. As will be discussed below, during certain watershed periods, some of the determining factors that provided these opportunities had similar outcomes in each nation; others did not. An analysis of these variables will help us discover why there has not been greater linkage between assisted housing and health policy. Since the first of these phases will be used as a baseline for the rest of the study, it will be given an especially detailed assessment.

## PART II

### CHAPTER 4

#### THE MID-1940s

Although the analysis of institutions is a core element in the neo-institutional approach, Pierson reminds us that "institutions alone — which establish the 'rules' but tell the observer only a little about the preferences, identities, and resources of the 'players' — can never fully explain outcomes" (1995, 473). For this reason, Part II adds to the analysis of institutions other key factors which influenced the evolution of health and assisted housing policy in Canada and the US since the mid-1940s. In the course of their study, the following theoretical assumptions are used as a guide:

- Institutional structures create both opportunities and constraints for policy goals, paths, and outcomes.
- Institutions are affected by endogenous and exogenous factors.
- State and societal actors shape and are also influenced by institutions. This process affects the strategies they each employ to promote their interests and also affects the distribution of power between them.
- The relationships between institutions and state and societal actors are dynamic and change with the passage of time.
- Changes in social, economic, and political circumstances affect active and latent institutions and actors, and give rise to new ideas, altered power relationships, different policy goals and choices, and a range of alternative channels and mechanisms by which the actors and institutions promote policy change.

### **Canada and the US in the mid-1940s**

The mid-1940s was an unprecedented time in North America — a watershed period for state and societal institutions in most policy areas. The aftermath of the Depression and World War II placed a heavy burden on citizens and governments alike. Although not forced to rebuild cities ruined by warfare, both Canada and the US still had the enormous task of reestablishing a peacetime society, and governments, for their part, were obliged to undertake complete reviews of social and economic policies that would make it possible for society to function to advantage.

Responsible for crafting viable national policies, the federal governments sought specialists within existing state networks to assist in designing practical peacetime policies. Societal actors also became involved in the policy process, sometimes supporting the government, sometimes challenging it.<sup>1</sup> The diffusion of power between the political, bureaucratic, and societal interests created tensions, the effect of which was to provide opportunities for experimentation in some areas and to constrain new policy options in others (Boase 1996b).<sup>2</sup> In this environment of multifaceted activity, the first incremental steps were taken to form the institutional structures upon which social policy would be built.

### **Canada**

The Canadian liberal welfare state developed in the postwar years in a fragmented, piecemeal manner (Maioni 1997b). In good part, the types of social policies that evolved were based on the characteristics of the Canadian state with its parliamentary system within a federal framework and were the result of the relationships the state developed with established and emerging policy communities (Haddow 1990). In the aftermath of the war, new economic and social challenges appeared, and the Liberal Party's policy direction was influenced to varying degrees by the interactions of the other determining factors. These

will be studied in more detail below.

In housing, change came slowly. As noted in Chapter 2, despite early attempts by urban reformers to make housing conditions a public issue, the question of assisted housing did not emerge as a societal concern until the 1930s. Even during the early 1940s, housing did not appear to be a significant factor in the general shift towards greater federal involvement in social matters. Two reasons might be cited for this. First, housing was still seen by many Canadians to be an economic good and therefore a matter to be dealt with by the private sector. For example, McMahon affirms that in the mid-1940s, influential people in industry were still talking the "language of money" with government officials, rather than making plans with others in society who were speaking the "language of housing need" (1990, 7). Second, Bacher (1993) indicates that the relatively slow development of labor groups in Canada during the Depression meant that there were few intense union pressures on government to supply subsidized housing. But even with the increased union militancy that manifested itself immediately after WWII, the action that was taken by the nascent labor organizations was designed to improve the lot of the worker generally, and did not focus specifically on problems of accommodation.

Within this climate, and as part of the national postwar reconstruction process (Anderson 1992), the federal Liberal government acted on recommendations of the Curtis Report (1944) passing the National Housing Act in 1944 and later creating the Central Mortgage and Housing Corporation to administer the Act (CMHC 1989). This was the start of federal government involvement in assisted housing.

In health and social welfare, efforts to produce a universal health policy failed, despite the fact that reports such as those by Heagerty (Canada 1943) and Marsh (Canada 1943), plus a well-publicized opinion poll, showed that 80% of the public supported the idea of a national health insurance program (Gray 1991). Those efforts did not succeed because of the significant opposition from the provincial governments, especially Quebec

and Ontario, which did not want to have any further federal intervention into their constitutional domain. In addition, other powerful influences in the private sector that would stand to lose by greater federal action, among them insurance companies, also objected to this new policy proposal. As will be shown, however, although health policy failed to be introduced by the federal government at this watershed period, it was destined to become an increasingly important issue of national concern to Canadians and to the governments they elected.

### **The determining factors**

**Federalism.** During the early 1940s, intergovernmental relations had been relatively quiescent because of the combined focus on the war effort. The "classic type federalism," which had been characterized by "the coordinate and autonomous relationship of the central and regional organs," was displaced by "emergency federalism." This was marked by extreme centralization (Mallory 1977, 19). As Gray puts it: "the federal government assumed a range of powers that were normally in the domain of the provinces. This move to 'emergency federalism' was supported by the courts. The peacetime distribution of powers was overridden and, in effect, Canada became a unitary state" (1990, 16).<sup>3</sup>

The challenges facing Canada's unique form of federalism in the mid-1940s were vastly different from any envisaged by the Fathers of Confederation. The main pressure placed on intergovernmental relations at that time was economic in nature. In essence, the provinces, as weak constituent partners in the federal system (Pierson 1995), resented the central government's dominance over economic matters — primarily linked to tax arrangements that had been agreed to during the war and which were shortly to be reviewed — and demanded a larger share of the responsibility for making decisions on how Canadians' tax money would be spent. The resulting struggle for power, which manifested

itself during a series of complex intergovernmental meetings, prompted the government to seek a solution that would satisfy all parties.

The federal Liberal government believed that the problem could be solved in good part by espousing the core tenets of Keynes's economic theory. In the government's view, this approach would enable it to free "the state, politicians and bureaucrats, from the zero-sum logic of the left and right political orthodoxies that prevailed in the interwar years" (Simeon and Robinson 1990, 113).

It must be emphasized that although Canada did gravitate towards the Keynesian philosophy, thus enabling "politicians and bureaucrats to legitimate state economic intervention necessary to meet some of the demands of organized labour without alienating capital" (Simeon and Robinson 1990, 113), it did not embrace Keynesianism fully during this period of economic restructuring. Nevertheless, its shift to a modified Keynesianism was sufficient to give capital and labor opportunities to establish new roles for themselves in the economic, political, and social currents of the postwar era.

Although the federal government did not have the constitutional authority to intervene in all areas, the provinces — "ill-equipped to deal with the problems of urbanization which included housing, community planning, urban renewal, and the like" (Rose 1980, 23) — recognized that the federal government alone had the administrative capacity and resources to spearhead Canada's postwar recovery as well as to assist Canadians through intervention in social policy. The provinces also recognized that federal leadership in conjunction with provincial and local cooperation would meet two fundamental postwar goals: first, the funding of private house building would promote economic development throughout the country; and, second, slum clearance and urban development would help reduce the economic and social burden on provincial and local governments. Therefore, they raised no strenuous objection when Mackenzie King's Liberals embarked on a federal program in support of house building.

Unlike housing, the question of national health policy had become an important intergovernmental issue during the Depression. Indeed, during the late 1930s, because of the increasing influence of the Left, several provincial governments had attempted to introduce innovative strategies that would provide some form of health coverage to their citizens. In contrast, the opportunity for the federal government to establish a national health system was deterred. This was done first, in 1937, by the courts, which "struck down social insurance programs as being beyond the constitutional powers of the federal government" (Banting 1997, 282), and then, in 1940, by the Royal Commission on Dominion-Provincial Relations, which, in its "major review of the federal balance of power" (Gray 1991), recommended that health was to remain a provincial matter (to be discussed in greater detail in "Definition of the Problem").

Despite these obstacles, in the early 1940s the federal Liberals were forced to examine the national government's future role in health policy. To a large extent, this shift was triggered by the growing ideological influence of the CCF, whose views were becoming more and more popular. The threat from the Left led Mackenzie King's Liberals to develop a platform that would ensure their reelection in 1945. Their proposals included "a blueprint for postwar social security that tied health and social insurance reforms to an overhaul of the federal-provincial fiscal relationship" (Maioni 1997a, 416). This move towards a greater direct role for the federal government in social policy would signal the start of a new era in intergovernmental relations. Even though the federal government proposals were checked by the provincial governments during the Dominion-Provincial Conference in 1946, they would have long-term effects in later years when new federal initiatives were designed in the social policy field (Taylor 1987).

**Central government institutions.** The years immediately after the end of the war were characterized by a shift of established federal government institutions from

wartime to peacetime activities. Canada's federal system, with its nascent tradition of intergovernmental negotiations, played a major role in the formation and development of the institutions that would oversee the design and implementation of housing and health policies in the postwar era.

Prior to the Second World War, the Department of Finance was responsible for federal housing policies through the National Housing Administration (CMHC 1946). During the war, the most important vehicle for funding and direct housing provision had been Wartime Housing Ltd. The houses built under the auspices of this agency had been generally considered to be adequate for the needs of Canadians during that time and were also believed to be suitable for Canadians in the postwar period. As a result, the provinces supported passage of the National Housing Act (NHA) in 1944 and, in 1945, the establishment of a new federal Crown corporation,<sup>4</sup> the Central Mortgage and Housing Corporation (CMHC), agreeing that this institution should not only continue with the management of Wartime Housing Ltd. homes, but should also assume responsibility for future national housing and urban policy.

The move to create the new institution was a response to what was seen to be "a national housing crisis of major proportions" (CMHC 1995, 4). The CMHC became responsible for the administration of what was then considered to be "massive mortgage-lending and mortgage guarantee schemes" and for the planning of future public housing projects (McMahon 1990, 6).<sup>5</sup> The complexity of the postwar institutional arrangement for Canadian housing has, for the most part, been underestimated. The demands on CMHC were extensive. For example, although its primary role was to provide mortgage financing and insurance to builders in the private sector as an incentive to construct houses, it also became more and more involved with urban reconstruction and with social issues related to housing. Financial specialists in CMHC were soon joined by people who had expertise in architecture and social issues. It did not take long for CMHC to become well established.

By 1948, CMHC employed 1,345 staff in offices throughout the country and had a balance sheet of \$174,084,266 (CMHC 1948). Of this, \$26,788, 000 was allocated to loans for rental projects for low-income groups (Private communication from CMHC 2000). Thus, the structure and processes of the young federal institution grew in complexity and ultimately set the stage for what was to become a multifaceted public enterprise (Rose 1980, 23-24).

Health and welfare issues also became increasingly important areas of federal involvement. In health, as discussed in Chapter 2, between the First and Second World Wars, Ottawa administered "federal statutes . . . relating to narcotics, food and drug safety, leprosy, medical patents, and public works" (Smith 1995, 319) through the Department of Pensions and National Health. However, in keeping with constitutional stipulations, it had little other direct involvement in healthcare services. This situation changed near the end of World War II. In 1944, a new federal ministry designated as National Health and Welfare (NH&W) was created to replace Pensions and National Health. Its Minister was responsible for health matters and a Deputy Minister assumed responsibility for welfare (Morgan 1961, 138). This new institution was created in response to growing demands by state and societal actors for greater federal government intervention in health policy, in general, and for universal health insurance, in particular. After the war, the new ministry was destined to play an important role in policy development (Taylor 1987).<sup>6</sup>

**Inherited policy.** For several years following the defeat of R. B. Bennett's Conservative government there had been little direct federal involvement in social policy. Nevertheless, during these years there were growing public demands for greater social intervention by the federal government. Mackenzie King's Liberal administration was not oblivious to these demands: increased public support of the CCF, plus the introduction of social initiatives at both provincial and local levels, made it clear that action had to be taken.

Thus, in the mid-1940s, hoping to prevent problems associated with unemployment and postwar readjustment, King's government made a series of socially oriented policy proposals. As Rose and Davies (1994) have affirmed, however, the legacy of inherited policy does not always permit unfettered government action.

Three Acts created the legislative infrastructure upon which all future Canadian housing policy would be based: the Dominion Housing Act (DHA) of 1935, the National Housing Act (NHA) of 1938, and the National Housing Act (NHA) of 1944.<sup>7</sup>

The Dominion Housing Act of 1935 was passed at a time of hardship for many Canadians, and heralded the concepts of joint-mortgage financing between private lenders and the state, as well as long-term amortization. Loans which had been previously limited to 60% were now available for up to 80% of the total amount required and, instead of being restricted to a three year term, could now be repaid over a twenty year period. In addition, as a prelude to the National Building Code, all construction approved under the terms of the DHA had to adhere to specific building standards. Even though this was an era when the private sector was bitterly opposed to any type of government intervention, the Act was finally accepted because key representatives in the building and banking industries understood that the DHA would benefit a relatively small number of mostly middle and upper class households and "was far better than the alternative: social housing" (Belec 1997, 54).

Implementation of the National Housing Act of 1938 was curtailed because of the outbreak of war. Nevertheless, it prepared the way for all postwar federal intervention in housing policy by making substantial loans for new housing units during the time it was in effect (CMHC 1946).

In 1941, Wartime Housing Limited, a Crown corporation, was created by an Order-in-Council with responsibility for overseeing the provision of accommodation for workers whose efforts were needed to produce war materials. This institution is relevant to

the present study for three reasons: first, through it, the federal government became directly involved with housing construction and consulted directly with local governments on matters related to building; second, it was seen to be a "rudimentary federal housing agency"; and third, it confirmed that the federal government had the capacity to provide desperately needed, albeit basic, accommodation for Canadians in a cost-efficient manner (Rose 1980, 27-28).

In 1944, with the end of the war in sight, the federal government introduced a substantially revised NHA. The new Central Mortgage and Housing Corporation was made responsible for its implementation and was required to report to the Minister of Reconstruction and Supply (CMHC 1946). Once again, the emphasis was on loans to stimulate housing construction and urban development across the country (CMHC 1995). It was titled "An Act to Promote the Construction of new Houses, the Repair and Modernization of Existing Houses, the Improvement of Housing and Living Conditions, and the Expansion of Employment in the Postwar Period." This Act fitted with the prevailing Keynesian economic philosophy (McMahon 1990, 7) and, along with subsequent amendments introduced in 1946 and 1949, established the groundwork for direct federal and provincial agreements for the financing and administration of public housing (Hellyer 1969).

In health during this watershed period, federal government initiatives were less extensive than in housing. Recalling Bennett's failed attempt to pass the Employment and Social Insurance Act in 1935,<sup>8</sup> Ottawa sought to have the BNA Act amended so that it could introduce a national unemployment insurance (UI) program. The Act was amended with the agreement of the provinces in 1940, thus giving the government authority to introduce UI as a federal program financed primarily by employer and employee contributions (Muszynski 1995).

Federal distribution of family allowances was another important social policy

initiative in the early postwar era. Introduced in 1944 as a universal program, family allowances were financed by general revenues (Tuohy 1993). However, the program had implications that extended into other areas. Taylor claims that, because the creation of family allowances had been considered a priority by the Liberals and was an expensive undertaking in a time of ongoing austerity, "the effect was to terminate consideration of health insurance as a single program to be developed on its own merits" (1987, 45). As will be discussed below, it was destined to become part of a more complex financial policy package.

Few other pieces of legislation were enacted during the war to affect health and social policy. These laws would have to wait until another watershed period.

**Political culture.** The national spirit that had prevailed throughout the war was based on Canada's traditional adherence to faith in its leaders and its enduring belief in peace, order, and good government. By the mid-1940s, in keeping with the prevailing Keynesian philosophy, the political culture gradually evolved to the point where a substantial number of Canadians also wanted the federal government to play a greater role in meeting the country's social needs (Maioni 1997a). This shift was motivated in part by a general fear that without government intervention after the war, Canada would return to the same conditions that had existed in the 1930s. It was also motivated by certain provincial developments. For example, nearly a decade earlier, the prairie provinces had embraced the idea of greater government control in a number of social policy areas, and this change had fueled the success of the CCF (Gray 1991). The CCF was influenced by groups and individuals who believed that there should be greater government action to "deliver essential services for victims of the market economy" (Purdy 1997, 36). These services included both housing and health.

Pressure for change was not limited to the national scene but came from inter-

national quarters, as well. For instance, Mishra notes that "[b]road postwar Western consensus about the welfare state developed around the idea that systematic government intervention in the market economy — including the provision of a range of public services to ensure prosperity, security, and equity — was both desirable and feasible" (1990, 82).

These changes in thinking were not lost on the federal government. Sensitive to the impact of postwar national and international realities, Ottawa recognized that it would have to expand its participation in matters that had previously been in the private domain (Inglehart 1990) and that the classic federalism which had characterized the nation before the Depression and the war would have to be replaced by a system of greater centralized responsibility (Simeon and Robinson 1990).

**Ideology.** Simeon and Robinson (1990) assert that ideology — in the form of a shift to the left — was to play a significant part in the movement towards a welfare state in the postwar period. Even though the federal Liberal party had enacted unemployment insurance legislation in 1940, it was aware of the growing impact that the CCF and other groups with strong ties to the labor movement were having on the ideological landscape. These political associations were becoming particularly powerful at the local and provincial levels in western Canada and Ontario, and the Liberals knew that they would have to counter the growing popularity of the left in unambiguous ways. Changes at the right of the political spectrum were also under way. The Conservatives, attempting to broaden their appeal among the electorate, renamed themselves the *Progressive Conservative Party*. This opened their "coalition to the so-called democratic populist and 'red' Tory elements" (Maioni 1997b, 179). Determined to remain in power despite these moves from the left and the right, the Liberal party was forced to reexamine its centrist position on a number of policy issues, including housing and health.

Ideologically, the question of housing did not trigger great debate in the mid-1940s.

Although housing was a core issue in the Curtis Report (Canada 1943) and part of the Marsh Report (Canada 1943), both of which will be discussed below, there was no national ideological focus on problems of accommodation. Among the explanations that have been adduced, two stand out. First, Canadians continued to view housing as linked primarily to private initiatives, charitable organizations, and local government (Mishra 1990). Second, because so many Canadians had their living arrangements detrimentally affected during the Depression and war, there was little sympathy for the plight of slum dwellers when other areas of need were seen to be more pressing. As Rose puts it: "Such attitudes towards the poor expressed themselves as opposition to the developing pressure for slum clearance and public housing programs during the last two years of the war and in the early postwar period" (1980, 31).

Unlike housing, in the mid-1940s the question of national health insurance was at the core of ideological debates related to social policy. A small number of members within the Liberal Cabinet advocated urgent planning of an electoral strategy designed to meet postwar domestic demands (Gray 1991). However, most members opposed government intervention in health issues. It would appear that this preponderance of Cabinet opposition to federal intervention in health triggered the CCF's success in Saskatchewan, which led to the design and implementation of provincial hospital insurance in that province (O'Neill 1997).

In response to events such as these, all three parties put health and other social policy proposals on their election platforms in 1945. A national health insurance system was not put in place, however, because among other reasons, the ideological shift in the decision making sphere was insufficient to move delegates to the 1946 Federal-Provincial Conference to reach agreement on the nature or scope of such a system (Taylor 1987).

**Definition of the problem.** During these critical years of change, the manner in

which international and national reports defined housing and health issues helped determine the development and influence of both state and societal institutions. The most influential documents will be examined briefly below.

On the international scene, the Beveridge Report (1942) became "the blueprint for the development of welfare states throughout Europe" (Baldwin and Falkingham 1994, 1). Embraced by the British Labour government as the optimal direction for postwar social policy, it "formulated clear principles of state intervention and spelled out the institutional framework that would make a reality of state intervention for maintaining the minimum standards of life". Together with Keynesianism, it promised to "make liberal capitalism more productive economically and more just socially" (Mishra 1990, 84). Its principles resonated not only throughout Europe, but in Canada as well.

Four reports that were generated in Canada also exerted influence on federal housing and health policy during the 1940s. These were the Rowell-Sirois Report (Canada 1940) on federal-provincial relations, the Marsh Report (Canada 1943) on social policy in general, the Curtis Report (Canada 1944) on housing, and the Heagerty Report (Canada 1943) on health.

The Royal Commission on Dominion-Provincial Relations, or the Rowell-Sirois Report, was responsible for examining intergovernmental issues related to costs and constitutional responsibilities. This document concluded that the provinces had jurisdiction over health insurance, social insurance, and unemployment insurance because of their constitutional responsibilities for hospitals, local matters, and workplace relations. However, it "suggested that the federal government could have a role to play in social policy through the use of federal spending power or by the provinces' delegating authority to the federal government" (Maioni 1997b, 179). By drawing this conclusion, the Rowell-Sirois Report was pivotal and ultimately set the stage for Canada's future welfare state.<sup>9</sup>

The Report on Social Security for Canada, better known as the Marsh Report, has

been described as "Canada's own Beveridge Report" (Maioni 1997a, 415) and "the charter of the Canadian welfare state" (Mishra 1990, 84). This document, a publication of a subcommittee of the Advisory Committee on Reconstruction, established an important direction for federal policy on social welfare, social security, and family allowances. Indicating that many Canadians had undergone tremendous hardship in recent years and urgently needed financial assistance, Marsh affirmed that family allowances were "the 'key to consistency' in a social security policy" (Morgan 1961, 138). As a result, in 1944 the federal government introduced family allowances as a universal program funded by the federal government out of general revenues (Tuohy 1993).

Because of Cabinet's concern about the upcoming elections, the government was reluctant to introduce other new, expensive programs (Gray 1991). It should be observed, however, that due to the growing popularity of the CCF's election platform, the Liberals did make plans for broader health and social policy initiatives that might be taken in the future.

The Curtis Report focused on housing standards and the nature of urban planning. In its final report, the Curtis Subcommittee on Housing and Community Planning stated that the physical standards and overcrowded housing conditions for many Canadians were "extremely unsatisfactory." Determining that "the formation, institution and pursuit of a policy of adequate housing should be accepted as a social responsibility" (Curtis et al. Canada 1944, 34-35), the Subcommittee called for a recognition that government, principally the federal government, should "ensure minimum standards in housing" (Mishra 1990, 83) and in this way help promote the health of Canadians. By proposing the establishment of a comprehensive low-rental housing program to meet the needs of low income citizens, many of whom lived in substandard and overcrowded dwellings (CMHC 1989), the Curtis Report became the catalytic agent for amending the NHA.

The Heagerty Report on Canadian health policy was one of the most extensive

reports in the federal government's effort to review policy in the postwar period and, because of the anticipated costs to the federal government, one of the most contentious. Examining health service in Canada and elsewhere, it "recommended a universal system of compulsory health insurance" and suggested that "the federal government should offer to share the costs with the provinces . . . by means of a grant-in-aid" (Gray 1990, 31). The report's proposals were presented at the Dominion-Provincial Conference as part of a complex set of social policy plans.

However, instead of backing Heagerty's original health insurance proposal, the federal Liberals espoused a plan to consider health insurance "not as an independent program but as part of what was being developed as a broad range of reconstruction proposals and financial changes" (Taylor 1987, 45). Even though the plans for a national health program had been substantially amended, they were still unacceptable to many of the conference participants. As a result, when the meetings ended, "the health insurance proposals were, if not dead, at least in limbo" (Taylor 1987, 67).

**Decision making.** Decisions concerning the direction of future social policy were made in the mid-1940s by the combined efforts of elected officials, bureaucrats, and representatives from special societal interests (Haddow 1990). It was a time of remarkable change when decisions had to be made in a multi-tiered system of governance about "what to regulate and at what level to regulate" (Pierson 1995, 452). Canadian federalism required negotiation between government representatives, as well as legislative changes at both levels in order to develop national social policy (Boase 1996b). As advocates of the neo-institutional approach contend:

federal institutions encourage three distinctive dynamics: they influence the policy preferences, strategies, and influence of social actors; they create important new institutional actors (the constituent units of the federation); and they generate predictable policy dilemmas associated with shared decision-making (Pierson 1995, 449).

The decisions reached in the mid-1940s profoundly affected both the institutional structures and the complex processes associated with social policy development in general (Boase 1996a), and housing and health in particular. In order to understand the situation more clearly, two questions must be answered: 1) Who were the primary decision makers and 2) Under what circumstances were the decisions made?

Belec (1997) maintains that by the end of the 1930s, basic decisions concerning future federal housing policy in Canada were being made. He notes that the DHA of 1938 "was a concession to the lending industry and represented a decision by the nascent federal housing bureaucracy to make home ownership the centre-piece of its policy development" and even with the amendments of 1944, "the objective of federal policy remained the same." Belec further states that "the classic partnership between the state and finance capital . . . was not an abstract relationship where impersonal bureaucracies and institutions operated in concert due to a vague perception of mutual advantage" (1997, 62). Indeed, according to Bacher (1993), the most prominent policy making bureaucrats were directly linked to Canadian finance organizations and made the final decisions about the design of housing legislation with them.<sup>10</sup>

Subsequent policy decisions were made by other actors who had been closely linked to housing in various capacities for years. For example, David Mansur, an erstwhile insurance industry executive, was named CMHC's first president (CMHC 1946). Mansur joined forces with Humphrey Carver, an architect and former member of the League for Social Reconstruction (Purdy 1997), who, as a longtime advocate of social housing, strongly supported the idea of government intervention (Carver 1975). Carver, in particular, recognized the need to advance public housing in concert with other social policy initiatives by encouraging direct government grants to the private building industry (1948, 1975). Together, Mansur and Carver played a crucial role in establishing federal participation in housing by directing the impact of other actors on the policy process, including

those on other levels of government and in the private sector.

The policy dilemmas associated with decision making in multitiered systems of government were further compounded by the influence of local administrations. These were more vocal than their provincial counterparts in objecting to many of the proposed new housing policies. They complained that the legislation was simply federal macro-economic policy that made urban problems worse by encouraging low density suburban sprawl without resolving issues related to urban decay. In addition, local governments asserted that by providing the physical infrastructure for the builders, they had "become the servants of the development industry that they were supposed to regulate" (Tindal and Tindal 1995, 72). These objections were largely overridden by the federal government, whose primary focus was on the broader postwar issues articulated by the Advisory Committee on Reconstruction, its Subcommittees, and the Rowell-Sirois Report.

Thus, as the planning for postwar housing began, the key federal decision makers were powerful representatives from national building and finance industries. With the establishment of CMHC as a Crown corporation and support from the Liberal Cabinet, these decision makers were able to move ahead with Canada's postwar housing policies without significant intervention from other state or societal actors who, according to Bacher (1993, 23), were unable to match the influence of the state and corporate elites.

The decisions related to health were far more contentious than those related to housing. There were many different and strongly held views concerning government intervention in this area which, as discussed earlier, had been controlled primarily by private and non-profit interests. Prior to the war, both state and societal actors vigorously promoted their respective positions either for or against future state involvement. However, recognizing that Canadians were generally supportive of health insurance, groups that stood to gain or lose by the change in status quo, worked to "maximize their influence over its development and implementation" (Tuohy 1995, 7).

In 1942, by an Order-in-Council, an interdepartmental Advisory Committee on Health Insurance was established. During the course of its formal activities, the Advisory Committee received written and oral submissions from hundreds of groups and organizations. The most powerful representations were sent by the Canadian Medical Association, the Canadian Dental Association, the Canadian Nurses Association, the Canadian Life Insurance Officers' Association, the Federated Women's Institutes of Canada, the Trades and Labour Congress, the Canadian Labour Congress, and the Canadian Federation of Agriculture. Sir William Beveridge also made a presentation. The outcome of these extensive deliberations was a plan for a national cost-shared health insurance program (Taylor 1987).

In the wake of the Advisory Committee's recommendations, the Liberals, aware of labor's growing demands and also "of the reticence of business interests and potential jurisdictional conflicts . . . proceeded with caution" (Maioni 1997b, 179). The plan they presented at the postwar Federal-Provincial Conference failed to be accepted, most notably by the Premiers of Ontario and Quebec. The primary reason for its rejection was that amendments to the federal proposal now linked health with other fiscal arrangements which were considered unacceptable by the provincial premiers (Taylor 1987, Tuohy 1995).

**Exogenous influences.** The two major exogenous factors that affected the development of both housing and health policy were the Depression and the War. Indeed, had these catastrophic events not taken place, one wonders if either housing or health would have become public policy issues at all in the mid-1940s.

Unlike Europe, which would receive assistance for reconstruction under the Marshall Plan, Canada was financially responsible for its own domestic programs. However, new international economic cooperation was achieved by the 1944 Bretton Woods Agreement. Here, plans were made for "a stable and prosperous postwar world"

through "an Anglo-American proposal to promote free trade, nondiscrimination, and stable rates of exchange — goals that were underpinned by the creation of GATT, the International Monetary Fund (IMF) and the World Bank" (McCormick 1996, 33).<sup>11</sup> Although the latter institutions did not directly affect decisions related to postwar social policy development in Canada, they represented important shifts in international relations that would have long-term influences on the Canadian economy and its ability to deal more effectively with the housing and health needs of its citizens.

### **Summation**

In examining the eight variables of the neo-institutional framework to identify their impact on the development of Canadian housing and health policy in the mid-1940s, we find that few other points in modern history produced such profound changes in the relationships between state and societal institutions and actors. These shifts affected many Canadians who, because of the Depression and World War II, lacked good quality housing and full accessibility to an economical system of healthcare based on the most recent advances in medical science.

The above discussion shows that, in many ways, the climate for establishing national housing and health policies in Canada was favorable at this time. Not only were state and societal actors ready to meet the new housing and health challenges, but also the potential for creating and linking these two policy fields was significant. It must be noted, however, that the forces that worked in this direction were outweighed by negative forces within each of the factors. These negative forces not only affected the policy decisions that were made in the mid-1940s, but also future decisions. They did this by influencing the preferences of state and societal actors, by molding the structures and processes of institutions, and by establishing discrete policy paths for housing and health.

The following paragraphs highlight the pressures that operated on each of the

determining factors. Although some of those pressures favored the formation of a national policy that would recognize the complementary aspects of housing and health, and would incorporate housing as a broader determinant of health, the strength of the inhibiting factors ultimately prevented this outcome.

**Abetting factors.** Federalism was the most important of all the factors. Canada's Constitution gave the central government a structural basis for designing and implementing national policies. Furthermore, through complex agreements it had reached with the provincial governments during the war, the federal government wielded considerable authority related to taxation and fiscal control. Under these circumstances, it appeared that the peripheral position in housing and health which it had held in the prewar era, dictated primarily by the Constitution, could change to one where it exerted greater authority over policy direction.

The economic and social upheavals caused by the war — the main exogenous influence of this period — showed that Canadian citizens needed help with acquiring decent accommodation and affordable healthcare. Since the provinces lacked the administrative capacity and financial resources to undertake reconstruction alone, the federal government offered assistance in these areas, creating a federal institution for housing (CMHC) and seeking to make agreements with the provinces on a national health insurance plan.

Attempts to define the problems that would later face the nation began before the war's end. For example, an Advisory Committee on Reconstruction was created in 1943. Members of the Committee as well as several key decision makers, both elected and appointed, recognized that Canadians would need increased support from the state when the war was over. Some of their reports, including those written by Marsh and Curtis, contained recommendations that advocated such support, including linkages between the provision of publicly funded housing and other social programs, including health.

When making decisions, the government could count on a bureaucracy in Ottawa comprised of elites that, for the most part, possessed the necessary skills to undertake complex public policy planning and implementation. In addition, it had the ability to select which societal actors would participate in decision making and to harness the specialized knowledge of selected individuals who could make contributions to the policy process. In housing, the government elicited support from policy networks associated with Canadian financial and building institutions. In the case of health, the situation was different: instead of allowing specific health-oriented coalitions to dominate the decision making process — including the powerful physicians' associations that vehemently opposed a change in the status quo — it consulted with a wide variety of state and societal representatives, many of whom held different opinions about the future role of the state.

The political culture of this period also abetted state intervention in the creation of social policy. Traditionally pro-statist and now fearful of a return to the hardships of the Depression, Canadians looked to the federal government for an expansion of the policies that had been introduced during the war. In response, Ottawa expressed a willingness to undertake such responsibilities.

A greater role for state action was further encouraged by the ideological shifts that had taken place both internationally and domestically. Several governments, notably the Labour party in the UK and the Democrats in the US, were introducing a wide variety of policy proposals designed to enhance the social and economic well-being of their citizens. A new ideological picture was also being painted by Canadian workers and farmers who no longer accepted the dominant role of capital in the policy making process. New parties, principally the CCF, representing labor and other coalitions which previously had been minor players on the political stage, were gaining strength with their own ideological tenets, urging greater state action in the social policy sphere.

Under these circumstances and unfettered by major policies inherited from previous

administrations, Mackenzie King's Liberals were able to make plans for their involvement in housing and health, policy fields which hitherto had been considered separate and largely private concerns.

The newly created central government institutions, CMHC and NH&W, while still having limited jurisdiction over housing and health matters, now became an important focus of attention as the federal and provincial governments conferred about the extent to which the state should become involved in these policy areas.

**Inhibiting factors.** While the above mentioned forces promoted greater federal intervention in housing and health, others worked against it. The provincial governments constituted one of the strongest of the negative forces. Despite the incapacity of the provinces to implement extensive social policy programs of their own (as evidenced by the federal government's creation of unemployment insurance and family allowance programs), their reluctance to sacrifice their autonomy to the federal government in other constitutionally defined areas of social responsibility, specifically that of health, was an essential contributor to the failure of the forces working in favor of national policy development. The ability of the stronger provincial constituents, specifically Ontario and Quebec, to obstruct policy change highlights the complexity of the constitutional issues that the Canadian federal system had to grapple with.

Although the return to peace was primarily an abetting rather than an inhibiting exogenous factor, the manner in which postwar problems were defined impeded the creation of broad national policies. For example, the Rowell-Sirois Report stated that health policy should remain a provincial matter. Furthermore, the highly focused perspective of key specialists who advised the government led decision makers to keep health separate from other policy issues.

The proliferation of societal coalitions with their own preferences also affected the

decisions that were made. By promoting their particular interests over those of society as a whole, they made consensus impossible. For example, insurance groups vigorously opposed what they believed to be threats to their autonomy if a national health policy was established.

When examining Canadian political culture at this critical moment, it is ironic that of two identified areas of need — housing and health — federal intervention in housing, which was not a high priority issue with the public, did become institutionalized, while a national health plan failed to materialize despite broad public demands for universal insurance.

Ideologically the Canadian Liberals adopted a largely centrist policy path but, with an election looming, Mackenzie King's Liberals made gestures to incorporate several of the CCF's popular social policy ideas into their agenda. After the election, however, they made substantial amendments to their proposal for national health insurance and included the universal health plan with other financial issues that were to be discussed at the postwar Dominion-Provincial Conference.

In the mid-1940s, greater government involvement in housing and health was not greatly constrained by inherited policy, since previous federal legislation that related to housing was mainly restricted to the production of new homes, and, for constitutional reasons, health legislation dealt primarily with public health issues. What was constrained by inherited policy at this time, however, was the potential for a linkage between housing and health.

The structural complexity of the new institutions that were created within the federal system at this time also restricted opportunities for a linkage between housing and health. Part of the reason for the lack of creation of a coordinated housing and health policy during this period was that the CMHC was created as a Crown corporation. As such, it was removed from direct government intervention and remained beyond the direct and detailed

control of Canada's parliamentary Cabinet. With its primary focus on housing as an economic issue, the matter of providing public housing was not a high priority on its agenda. As far as national health was concerned, after the federal and provincial governments failed to reach agreement, the new Ministry of Health and Welfare focused more on its specific mandate than on broadening its scope of activity and establishing ties with other government institutions. Had the two government bodies effected greater linkages at this time, coordination of services for people with housing and health needs would have been more likely.

### **The United States**

During this watershed period, housing and health were important issues that faced the nation. However, powerful actors within the state and society disagreed about the advisability of expanding the role of the government in these fields.

At the end of World War II, three related problems required attention: unemployment, slums, and the need for affordable accommodation. Home building offered a partial solution to all three problems. In light of the nation's experience during the Depression, more and more people came to believe that federal intervention was acceptable at this juncture. Consumer groups and proponents of assisted housing saw government action as the most effective way of "expanding the planning vision of the New Deal" (Flanagan 1997 269). On the other hand, representatives of powerful building and banking groups maintained that housing was primarily an economic good and not a problem to be solved by state involvement. However, when it was recognized that "the general welfare and security of the Nation and the health and living standards of its people require housing production and related community development sufficient to remedy the serious housing shortage, the elimination of sub-standard and other inadequate housing through the clearance of slums and blighted areas" (*Cong. & Nat.* 1965, 481), and when it became obvious that the private

sector alone was incapable of meeting all of these challenges, a National Housing Act was passed. This did not take place immediately, but in 1949.

Similar debates took place about future health policy. In 1945, President Truman proposed a federal government plan for national health insurance. Speaking in support of aid for all Americans and, in response to those who cautioned that government health plans would lead the US to communism, Truman declared that Americans would not "be frightened off from health insurance because some people have misnamed it 'socialized medicine'" (1945, 11). National health insurance was not to become a reality at this time, however. Unlike Canada, where a majority government would have been able to introduce its policies, Truman's plans were not approved in Congress, despite the fact that the Democrats held majorities in both the House and Senate. Once again, the powerful interests that were opposed to state interference used opportunities provided by the fragmented US federal system and thwarted the public's desire for health insurance.

Despite this fact, a number of important measures were introduced. As will be discussed below, during this watershed period, the federal government passed legislation that would foster greater federal activity in housing (the Wagner-Ellender-Taft Bill) and in health (the Hill-Burton Act which promoted hospital construction).

### **The determining factors**

**Federalism.** Boase points out that because of its "weak tradition of party discipline and interventionism, and an impermanent and diffused bureaucratic structure," the US often deals with controversial policy issues in a reactive manner (1996b, 8). This seems to have been the case with respect to the development of social policy during and after the Depression and the war.<sup>12</sup>

Following Roosevelt's success in the 1936 elections, the Supreme Court in 1937 "quietly backed away from its restrictive interpretation of Congress's legislative authority.

The result was to remove virtually all constitutional barriers to federal legislation on economic and social issues" (Breckenridge 1998, 112). With this restriction removed, the federal government was able to embark on a policy of cooperative federalism and became more active in several new fields.

The activities of the federal government in the 1940s helped alter the relationships it had with state and local governments. The response to the President's State of the Union address in 1944 exemplifies this point. Roosevelt called for effective, cooperative planning to improve the standard of living of all Americans. Representatives of state and local government subscribed to this idea and agreed that "[t]he role of the federal government as an underwriter of minimum national standards in such fields as social security, health, education, housing, and transportation facilities and as conservator of natural resources can be made effective, in our federal system." However, they emphasized that this could be done "only with the utmost cooperation from state and local governments " (The American City 1945, 94).

Once put into effect, the vastly expanded role of the federal administration in economic and social policy areas during this period introduced permanent changes in the roles, responsibilities, and configuration of government. For the most part, the policies and programs that were introduced at the federal level were implemented at the state or local level (Rich and White 1996).

In addition to its constitutional separation of power, the US federal government system is characterized by the ability of interests and alliances to influence the political process. In particular, the southern Democrats held key positions on Congressional committees and were able to form powerful coalitions. These forces worked in concert to oppose many of Roosevelt's New Deal initiatives (Weir et al. 1988).

Finally, as was the case in the other industrialized nations during this period of restructuring, US federalism was affected by global events. For example, Keynesianism

was a significant influence on the evolution of US national economic and social policy.<sup>13</sup> Although the *laissez-faire* tradition was far from forgotten, endogenous and exogenous forces changed the "interests and activities of the constituent units" within the federal government itself and notably altered the positions of other state and societal actors as well. (Pierson 1995, 444-455).

Prior to war's end, the Social Security Board of the Federal Security Agency recognized that there would be a period of adjustment as people demobilized from the armed forces and as industry reconverted after the war. Realizing that housing was not only an economic issue, but a social one as well, the Board urged the federal government to increase the grants-in-aid that it gave to the states to support those in need. One of the Board's concerns was with the inconsistency of aid in the different regions. It showed, for example, that in "1944-45, the 12 states lowest in per capita income had 21 per cent of the country's population but received only 15 per cent of the Federal funds for assistance" (1945, 6).

The Board's fears were well founded. When the war ended, reports indicated that of the "nation's stock of 37 million houses, shown in the 1940 census, half were lacking in some plumbing facilities or otherwise deficient" (*Cong. & Nat.* 1965, 459). The federal government's response was to provide financial aid to state and local governments as well as support to the private sector in order to stimulate home-building directly and indirectly. Although most states welcomed this assistance, many voiced concern about the growing federal presence in their constitutional areas of responsibility. Thus, as Doan observes, the end of the war signaled the beginning of intergovernmental disputes about federal government control over housing, particularly public housing (1997, 53).

The evolution of federal health and, increasingly, other social policy activities in the mid-1940s was also influenced by the war. In November 1945, in the wake of wartime cooperation between key elements of the military, business, and labor, President Truman

saw an opportunity to introduce a broad-based national health package. Working in a positive climate of "patriotic fervor and renewed prosperity" (Heirich 1998, 26), he recommended "that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts, each of which contributes to all the others." These were: 1) construction of hospitals and related facilities; 2) expansion of public health, maternal, and child health services; 3) medical education and research; 4) prepayment of medical costs; and 5) protection against loss of wages from sickness and disability (Truman 1945, 9).

This was not the first time that a proposal for establishing a comprehensive national health program had been forwarded to Congress. Each year since 1937, Senator Wagner had introduced a bill to establish some form of national health insurance. His attempts failed repeatedly, however. This was due primarily to the organized opposition of physicians and related interests that warned of the inherent dangers of government intervention in the sphere of health insurance. With this experience in mind, Truman decided to act in a way that would not provoke unbeatable opposition and thereby deprive the American public of necessary healthcare. Instead of stressing health insurance as Wagner had done, Truman placed the emphasis on medical research, on hospital building, and on refining some aspects of the Social Security Act of 1935 (Starr 1982). Truman's success not only firmly established the federal government's role in the provision of public health services and welfare, but also did much to improve health service and the facilities in which it was provided. We should note, however, that in so doing, it ensured that the medical coalitions would continue to control clinical services and that most diagnostic and therapeutic services would be provided in institutions.

Although some major barriers that had prevented the introduction of federal housing and health policy remained in the aftermath of the war, new problems also arose. One was the location of responsibility within the federal government for the proposed new

programs. As Pierson has noted, "social policy debates in federal systems are frequently as much or more about the locus of policy control as about policy content" (1995, 455). The heated debates that took place among vocal state and societal actors who either supported or opposed government intervention (*Cong. & Nat.* 1965) in policy design, implementation, and funding in the mid-1940s confirm Pierson's point.

**Central government institutions.** Heirich observes that during the New Deal era, the federal government came to be seen as an "active problem-solver" — one that would "introduce new dynamics into the social conflicts of the time" (1998, 24). The creation of central government institutions to oversee these changes was an important part of this complex process. Heirich states that the innovations instituted by the New Deal "included the use of federal deficit spending to bolster the economy and the introduction of massive federal bureaucracies, which established a national welfare system, created public housing complexes across the nation, subsidized private home construction, and operated a set of national research bureaus" (1998, 24).

As a result, one of the major challenges that emerged during this period was how to balance government intervention with its desire to encourage partnerships with organizations in the private sector and thereby promote economic growth. Prior to 1942, the federal government had used three main approaches to encourage home-building. It offered direct loans to builders, insured mortgages, and provided subsidies. It did this through a variety of federal institutions. Among them were the Federal Housing Administration (FHA), which was created in 1934 to develop housing standards and provide loans for the building and improvement of private and rental houses;<sup>14</sup> the United States Housing Authority (USHA), which was created in 1937 to administer the United States Housing Act and oversee slum clearance and the construction of low-rent housing, the Federal National Mortgage Association (FNMA), better known as Fannie Mae, which bought and sold

FHA-insured mortgages and thus permitted liquidity in the mortgage markets; and the Public Housing Administration (PHA), which subsidized the building of public low-rent housing units (*Cong. & Nat.* 1965). In 1942, an Executive Order created the National Housing Agency (NHA). The NHA consolidated "sixteen federal housing activities under a single administrator to minimize the duplication and confusion which had characterized the defense period" (Doan 1997, 49). The NHA was also responsible for establishing federal postwar housing policy.

Several of the above mentioned agencies remained intact during the war, and, once peace was restored, continued the programs they were originally intended to implement.

The question of establishing a federal institution responsible for health had become highly contentious since the passing of the Social Security Act in 1935. To a large extent, implementation of such a plan was paralyzed by powerful intergroup arguments about the future role of the state (Steinmo and Watts 1995). For example, in 1938, the AMA supported the principle of providing additional federal aid for public health and maternal and child health initiatives. However, according to Heagerty, it insisted that any future federal intervention in health must be controlled by a Department of Health with a physician as Secretary and that the treatment of disease was to be undertaken through the existing private sector (Canada 1943). This climate of opposition forestalled direct action to establish a federal health institution in the remainder of the decade. Nevertheless, indirect action was taken by the federal government which did have an impact on health in the years to come. The following are some examples.

Under Title VI of the Social Security Act, the Office of the Surgeon General distributed funds "for the purpose of assisting states, counties and health districts and other political subdivisions of the states in the establishment and maintenance of adequate health services" (Heagerty 1943, 73). Subsequent legislation allocated more authority and control to the federal Public Health Service for research and provided additional federal funds for

specific clinical activities such as the treatment and prevention of venereal disease (1938), tuberculosis (1944), and mental illness (1946), maladies that were manifesting themselves with increasing frequency, especially in crowded urban centers (*Cong. & Nat.* 1965).

In 1939, the Federal Security Agency was formed in part to oversee Public Health Service programs (US Dept. of Health and Human Services 1998). Then, with the passage of the Public Health Act in 1944, the Public Health Agency was created. It consisted of four units: the Office of the Surgeon General, the Bureau of Medical Services, the Bureau of State Services, and the National Institutes of Health. These units were to become responsible for an extraordinarily wide range of federal government activities in the field of health. In 1945, the government spent \$65,584,313 and in 1946 allocated \$82,949,880 for these activities (*Cong. & Nat.* 1965, 1127).

Despite all of these health-oriented initiatives, no conclusive action was taken to institute a national health insurance plan during this watershed period. In good part, the fragmented nature of the federal government contributed to this failure. Steinmo and Watts (1995) contend that the incremental steps taken towards health policy development were inevitable because of the government's complex structures. Adding to this observation, Boase notes that Truman's agenda was further compromised when it "met strong congressional opposition; recalcitrant southern Democrats who were on key congressional committees opposed social policy legislative initiatives" (1996a, 299).

In short, the goal of coordinating national public housing and health policies remained elusive during the mid-1940s primarily because of blocks within the federal structures of government and opposition from powerful coalitions that resented greater government intervention in what they considered to be their particular jurisdictions. Under these conditions, the chance of actually linking housing with health at this time was even less likely.

**Inherited policy.** Few pieces of legislation related to social policy in general, and housing and health in particular, had been enacted at the federal level before Roosevelt's time. In this sense, Steinmo and Watts are correct in stating that, when Franklin Roosevelt attempted to effect this type of legislation, he was "starting from social welfare scratch" (1995, 340). Although Roosevelt had endorsed the concept of greater state involvement in helping to resolve the problems created by the Depression, he was unable to implement all of his proposed New Deal initiatives in the 1930s. Although many of the barriers were created by the structures and processes of the US federal system as well as by the tensions between government and societal coalitions, inherited policies also impeded the creation of a postwar welfare state in the US. Two pieces of legislation deserve special mention in this regard: the National Industrial Recovery Act and the United States Housing Act.

The National Industrial Recovery Act of 1933 was primarily aimed at reducing unemployment. In order to accomplish this aim, Congress created the Public Works Administration (PWA). The PWA became directly involved in the construction of public housing and this shift in federal activity caused an uproar in the private sector. Arguments between housing advocacy groups, local authorities, and builders led to a court decision involving the Constitution. The court held that the PWA "could exercise its power of eminent domain to expropriate land, but only for public purposes. The court then ruled that the construction of public housing was not a public purpose" (McGrew and Fabegras 1987, 156). This decision led to the crafting of a new national housing Act.

The United States Housing Act of 1937 was designed to counter the persistent objections of powerful lobby groups in the field of housing. According to Welfeld, the Act was, "a brilliant technical feat" with an "ingenious formula" for public housing (1988, 160). Although critics argue that the Act caused some of the fundamental problems associated with social policy that persisted, at the time of its inception it circumvented the issue of the Constitution by allowing the federal government to provide funding and local

authorities to authorize construction and administer the buildings. The matter of federal funding and state/local administration has been a major issue not only in the area of public housing, but also in health (Marmor et al. 1996).

The majority of federal health Acts that were inherited by the postwar administrations were primarily linked to public health matters and to veterans' affairs (US Statutes at Large 1945, US Public Health Service 1951). Although other Acts contained important health-related clauses, they were associated with particular occupational groups such as farmers. The Social Security Act of 1935 was the most important.

The Social Security Act was designed to provide five income replacement programs: old age insurance, unemployment insurance, old-age assistance, aid to the blind, and aid to dependent children. The Act was a mix of insurance and welfare that was funded by payroll taxes to pay for grants to the states. The goal of the legislation, enacted at the height of the Depression, was to provide welfare assistance or income insurance to American citizens in desperate economic need. According to *Congress and the Nation*, it "changed both the concept of economic security in the United States and the nature of federal state relationships in the welfare field" (1965, 1225). Amendments to the Act in 1939 expanded the programs to include payments to eligible survivors and provided limited health and welfare services to children. Nearly all subsequent federal social policy has been based upon this legislation.

**Political culture.** It was noted in Chapter 3 that the US developed its unique political culture as a result of its birth through a revolution and its strong adherence to the ideals of individualism and anti-statism. The question here is: does political culture help to explain the paths that were followed by housing and health policies? Research suggests that it does — to a considerable extent.

Lipset observes that national shifts in political culture can be identified at specific

historical junctures. According to him, the years following the Depression and war are one such period. That was the time when the nation started to emerge as a world leader (1990), expended substantial resources in overseeing reconstruction abroad, and also "took on new energy" as it reoriented its own "political-cultural identities" (Preston 1997, 129).

The American experience in social policy change during this watershed period highlights two fundamental aspects of political culture. First, that state/societal relations are highly complex and, second, that individuals and groups that wish to affect the degree of state intervention in societal matters often give rise to fierce tensions and acrimonious debate.

With respect to housing, a tremendous domestic demand for new accommodation and for jobs manifested itself in the mid-1940s, and many Americans looked to the federal government for help. Doan observes that strongly held opinions concerning state involvement in housing had been established long before the end of the war. It was no surprise, therefore, that when the National Conference on Postwar Housing met in Chicago in the spring of 1944, "differences of opinion emerged which foreshadowed the postwar struggle over housing policy, particularly involving public housing and the role of the federal government" (1997, 53).

Even after the National Housing Act of 1937 was passed and federal housing agencies were in place, the "question of whom the program was to serve was raised but not resolved by Congress" (Welfeld 1988, 162). This uncertainty continued as the nation reestablished its postwar activities. Although the federal government passed housing legislation to aid veterans, national housing legislation was not passed until 1949, and then only after intense lobbying activity from formal and informal societal groups and organizations (*Cong. & Nat.* 1965).

Similar debates were taking place in health. In 1937, 80% of Americans expressed support for greater government intervention in healthcare delivery. By 1942, a poll in

*Fortune* revealed that 74% thought that the government should act in this sphere (Steinmo and Watts 1995, 332). In spite of these results, which clearly showed an overwhelming public desire for state intervention, a health insurance package failed to be enacted. Effective lobbying by various societal groups, particularly medical and related organizations, warned of the dangers of too much government interference and promoted the concept of voluntary private insurance (Starr 1982).

The combined experience of the Depression and World War II left many American citizens with a profoundly altered view of the American Dream. The *laissez-faire* philosophy which had been pervasive in the nation before the 1930s was now balanced by an outlook that was based on new insights into the changing needs of US society as a whole (Breckenridge 1998). Summing up the postwar situation, the *Congress and the Nation* states that: "In domestic affairs, Americans in general had concluded that the social and economic reforms of the New Deal years ought to be preserved and that government had a legitimate role in protecting the individual against economic disaster" (1965, 1).

**Ideology.** Housing was a very important ideological issue in the US, and the events of the mid-1940s would have important implications for the federal government's future role in this policy field. Housing starts had declined dramatically during the Depression and in 1940, as part of his New Deal program, Roosevelt ordered that the first comprehensive Census of Housing be made. This "covered the entire nation and provided data on the physical characteristics and condition of the housing stock; on facilities and equipment; and on rent, value, and mortgage status" (Doan 1997, 46). It was clear from the census that good quality, affordable housing was needed.

With the advent of war, public funding had to be reallocated, and government-supported building was mainly dedicated to accommodation for workers involved in the war effort. However, as the war drew to a close, Roosevelt saw that the issue of

accommodation would soon become even more politically important than it had been during the Depression, and in 1944, he instructed the National Housing Agency (NHA) to initiate plans for postwar home-building. The Agency estimated that 12.6 million new homes would be needed in the following decade. Not only was a massive domestic migration underway, but it was expected that, following the physical devastation in Europe, immigrants in considerable numbers would also be seeking opportunities in the US. The NHA's estimate provided an important basis for the introduction of a housing plank in the Democratic Party's electoral platform.

In September 1945, President Truman confirmed that public housing and slum clearance would remain a core focus of his Party's philosophy. In Truman's opinion, the "largest single opportunity for the rapid postwar expansion of private investment and employment lies in the field of housing, both urban and rural" (*Cong. & Nat.* 1965, 475). State and societal actors at both extremes of the political spectrum agreed with this assessment and, thus, the issue of accommodation became a major component of the postwar economic and social recovery strategy.

In health, Roosevelt supported the concept of a national insurance plan, but in view of other fiscal demands on the federal government, he considered it too costly to introduce during the lean 1930s (Litman and Robins 1997). By the mid-1940s, however, the subject could no longer be shelved. On the one hand, state and business interests anticipated a greater need for medical services during the postwar period; on the other, suburban growth was leading to increased public demands for hospitals and medical care. Consequently, as prosperity returned, government participation in a variety of healthcare activities became more politically popular.

Between 1946 and 1948, however, implementation of this neo-interventionist ideology was frustrated because there was "no bipartisan consensus around which a compromise might have been built." Not only were the White House and Congress under

different partisan control during this period, but there was also strong opposition from southern conservative Democrats (Tuohy 1995, 8). As Weir et al. note, the southern Democrats in Congress, who were "opposed to national economic planning and a more comprehensive welfare state," effectively blocked many of the New Deal and postwar social policy initiatives (1988, 427). For the most part, they vigorously resisted any move that would interfere with the "southern way of life" and the segregation practices that had become well established. In addition, along with the Republicans, they, objected to greater concentration of power at the federal level, for this, they maintained, would promote socialism and also detrimentally affect the traditional roles inherent in US dual federalism (Private communication from Breckenridge 2000). Thus, the actions of divisive government coalitions and the strategies of private interests with agendas that conflicted with the hopes of the public prevented Truman from introducing many social reforms and new welfare initiatives.

In spite of these obstacles, the government attempted to enlarge its area of responsibility by responding to current ideology through a more acceptable strategy: expansion of the medical infrastructure consisting of community hospitals, clinics, and medical schools. This building program was channeled more towards the new, mostly middle-income areas that were arising than towards the poor urban and rural sectors of the country. As might be expected, the program was enthusiastically supported by physicians and hospital groups (Starr 1982). It should be noted, however, that although it served to establish a limited role for the government as builder of the infrastructure of health services, this program did not further the federal goal of providing a national health plan, nor did it provide viable opportunities to link housing and health services, even though these two areas were both in need of a collaborative policy approach during this time of restructuring.

**Definition of the problem.** Both the Executive Branch and Congress had

started postwar planning by the early 1940s. Special House and Senate Committees produced a number of important documents that would establish policy directions in several key areas. Housing was deemed to be a priority because of the implications for the US postwar economy and, as a result, the NHA administrator was the first to report to the Senate Committee. His 1944 recommendations for greater federal government intervention in the postwar period were endorsed by the National Resources Planning Board and the Twentieth Century Fund (Doan 1997).

The activities of the 1944 National Housing Conference led to the creation of plans for the Housing Act of 1949. Attended by representatives from state and societal agencies, this conference was the culmination of years of lobbying on the part of mayors and other advocates of greater government involvement in housing. The argument of the pro-interventionist camp hinged on the fact that the anticipated postwar housing boom, if left solely in the hands of the private sector, would not improve the lot of needy citizens living in slums nor aid families with low incomes (Flanagan 1997).

In good part, support of greater federal input was based on reports such as *A Housing Program for the United States*. This document, authored in 1935 by the National Association of Housing Officials, was the "first thorough, thought-out housing scheme ever developed in the country." It offered practical suggestions for administering a federal housing program with an emphasis on local level implementation linked with slum clearance initiatives and rent-geared-to-income payments (McGuire et al. 1987, 155). The Association contended that if certain standards for housing were to be established to ensure public welfare, then it was the responsibility of the national government to create and supervise them. Although they lauded the creation of local housing authorities, they lamented the fact that "the body of information and experience in this country is very small and is limited mainly to the largest cities," and they urged the federal government to undertake research and education activities to remedy the problem (1935, 42)

After deliberating on the need for federal government intervention in housing, the Senate Committee on Postwar Economic Policy and Planning made the following recommendations: 1) a supply of public housing of 1.2 million units for the next ten years should be provided, 2) a permanent National Housing Agency should be formed, 3) greater federal financial support for private house building initiatives should be given, 4) greater federal involvement in urban public housing for low-income people should be undertaken and, 5) federal support for local slum clearance and urban development strategies should be made available (Doan 1997, 52).

Other housing-related hearings in the House and Senate received submissions from dozens of national organizations that argued passionately both for and against assisted housing. The problem was viewed from two completely different perspectives. Favoring federal intervention, social activists claimed that many people, the sick and elderly among them, needed government assistance. Other groups, including national veterans' organizations and the American Federation of Labor, asserted that federal housing legislation would promote employment and reduce crime in urban areas (*Cong. & Nat.* 1965, 476-478). And urging greater federal government action in providing aid for American cities, the Executive Director of the US Conference of Mayors entreated Congress to support the President's call to proceed "promptly with public works, housing, and the meeting of other urgent local needs" (Betters 1945, 93-94).

A number of Congressional committees examined the economic and social implications of housing policy (Flanagan 1997) and also came out in favor of federal intervention. For example, the Senate Banking and Currency Committee and the Housing and Urban Redevelopment Subcommittee recommended that 1,250,000 homes should be constructed each year during the next decade, for they believed that this measure would provide an adequate, low-cost public housing stock (*Cong. & Nat.* 1965, 476-478).

On the other hand, builders and developers insisted that housing should be left to

the market. In addition, the national trade associations which financed, built, and sold houses strongly resented the plans for government control. These nay-sayers included the US Chamber of Commerce, the National Economic Council, and the Mortgage Bankers Association. One publisher of a building journal wrote that "the propaganda" encouraging government intervention was "luring the American people towards dependence on government and national socialism" (Dunn 1945, 11).

In 1945, as a result of conferences, reports, and submissions such as these, the bipartisan Wagner-Ellender-Taft general housing Bill was introduced. This Bill was authored primarily by Republican Senator Robert A. Taft who, though an opponent of New Deal policies, was sympathetic to the need for housing aid for Americans and supported limited federal housing initiatives because he believed that "there was no way but public housing to solve the slum problem" (McGuire et al. 1987, 159).<sup>15</sup> Proponents of the Bill faced vehement debate concerning its contents. Conservatives and liberals "agreed on the basic premise that Washington had a key role to play," but argued about "how much the government should spend and how much it should regulate lenders, landlords, and real estate agents" (Drier 1997, 6). Builders called the Bill "bait to lure the unwary to support a vast program of socialized housing" (The American Builder 1946, 90). Once substantially amended, however, the Bill formed the basis of the Housing Act of 1949 which, in the future, would strengthen and expand the federal government's role in housing policy.

In healthcare, the debates and reports that may be cited for this watershed period are too numerous and complex to cover here. Three examples, however, will provide an insight into the scope of the problem that the nation was facing.

First, the Interdepartmental Committee to Coordinate Health and Welfare Activities, which President Roosevelt had formed in 1935 to plan future federal health initiatives, completed its report in 1938. Entitled *The Need for a National Health Program*, this report made several proposals for much greater federal action in healthcare. Such action was to be

accomplished by directly funding health insurance, by increasing financial aid to the states for health services, and by expanding the provisions of the Social Security Act. As a result of the Committee's findings, a National Health Conference was held in Washington the same year to discuss the report. This public conference stimulated debate about the general condition of healthcare in the US and the reasons why government intervention was necessary. The enormity of this task was highlighted by the conferees who focused on the institutional and political complexities that would undoubtedly inhibit policy change in this sphere.

Second, Heagerty's analysis of the US health system disclosed that public intervention had been fragmented, with the "legislative attention in the states directed in the main toward encouraging local voluntary effort rather than compulsory state action." Heagerty was able to identify at least ten types of medical care plans in existence and noted that private insurance was not only well established in all parts of the US, but was becoming more and more popular as a method of paying for medical services (Canada 1942, 71). Indeed, during this period, private health insurance was to become firmly established and would have profound effects on future attempts to introduce healthcare reforms (Private communication from Boase 2000). Heagerty emphasized, however, that despite the growing popularity of private insurance, there was still a need for further government involvement because the plans that were in effect did not cover the entire population.

Third, in 1945, the principal officers at the first annual conference of State Medical Societies were told that, "[p]utting it bluntly, there are many Americans this very minute who are suffering and dying needlessly for lack of medical care." Statistics clearly showed that, despite the amount of money being spent on healthcare at that time, the quality of health in the US lagged behind that of other nations (Altmeyer 1945, 12). This problem was caused in good part by a general lack of disease prevention programs and, in certain

parts of the country, by an insufficiency of medical services.

Taken as a whole, these studies revealed the essence of the problem: healthcare in the US was fragmented, costly, reactive, and exclusive rather than consolidated, inexpensive, preventive, and universal in nature. In essence, despite the activities and recommendations of actors who supported assisted housing and health programs, the government's focus was on specific rather than on collaborative program development.

**Decision making.** The fragmented structure of the US government helps explain the ineffectiveness of decision making in the field of social policy in the mid-1940s. Institutional arrangements and intricate relationships between state and societal actors (Ashford 1986) adversely affected progress in the development of new initiatives in social housing and health.

During this watershed period, a change in the demographics of the nation ultimately influenced the decision making process (Heidenheimer et al. 1990). Since large numbers of people were migrating from the south towards urban centers in the north and west in search of new opportunities, there was a realignment of political coalitions and new policy networks were established along both racial and class lines (Breckenridge 1998). These coalitions and networks, plus interested state and societal representatives, made submissions to House and Senate Committees, where their proposals were extensively discussed. Decisions were influenced by a variety of factors. Although progressives within Congress and a considerable number of their constituents, as well as bureaucrats who worked within federal government institutions, tended to support federal intervention in social policy (Freeman and Adams 1983), deep divisions within the Democratic party affected the policy process. In this regard, Breckenridge notes that the power of liberal Democrats in Congress was undermined by "an informal conservative coalition" of Republicans and southern Democrats, who "came to wield great power in Congress as

chairs of key committees in both Houses" (1998, 349). Situations like this effectively paralyzed decisions concerning the setting of a new course in social policy.

The Wagner-Ellender-Taft Bill illustrates the problem in the area of housing. On 15 April 1946, this Bill passed the Senate virtually without controversy. However, it "died in the House Banking and Currency Committee — killed, according to National Housing Administrator Wilson W. Wyatt, by 'very potent private lobby groups' whose opposition was directed particularly at the resumption of public housing" (*Cong. & Nat.* 1965, 476). Both in terms of economic clout and national organization, the private interests overwhelmed the supporters of the Bill. The advocates consisted mainly of organizations representing consumer groups and were generally less well organized and much less well financed than the opponents. As a result, comprehensive housing legislation was forced to wait until 1949 before being enacted.

Decision making in health was no easier a matter than it was in public housing. In keeping with the general postwar shift by Western nations to greater government intervention in social matters and with increased adherence to Keynesian economic philosophy, the US embarked on a variety of initiatives to assist economic recovery and promote social well-being. As in Canada, the Beveridge Plan captured the interest of US policy makers. By 1943, members of the Social Security Board, in conjunction with key congressional leaders, supported by organized labor and bureaucrats who had been involved in previous attempts to introduce social policy, made proposals for the reform of health and social policy. One such proposal was the Wagner-Murray-Dingell Bill, which was described as "the American version of the Beveridge plan" (Maioni 1997a, 419).

Although strongly favored by the public, the Wagner-Murray-Dingell Bill was defeated in Congress.<sup>16</sup> One important reason for its failure is advanced by Freeman and Adams, who indicate that in a "highly fragmented political system either an exceptional ability to aggregate disparate interests or a significant degree of autonomy is essential for

policy success." They maintain that social security successfully consolidated and expanded its policy objectives because it had both of these features. It was generally supported by voters and by Congress and, probably more important, decision making was restricted to a relatively small subsystem comprised of state and societal actors who were able to exercise fiscal prudence (1983, 80).

Second, the Bill failed because Congress was unable to settle the dispute over who should be included in the plan and which policy instruments would be most appropriate for those people. On the one hand, Roosevelt's supporters maintained that the system should be universal and should use mechanisms similar to those which provided retirement insurance for the nation's elderly. On the other hand, "Republicans, Southern Democrats, business, 'conservatives' generally and the American Medical Association . . . believed that federal efforts should not go beyond aiding the indigent" and that payment should be made through existing federal public assistance programs (*Cong. & Nat.* 1965, 1152).

Third, unlike social security, which had become an accepted part of the federal government's responsibility, the health insurance proposals encompassed in the Wagner-Murray-Dingell Bill met with strong resistance from societal actors. Medical coalitions objected to bureaucratic intervention in medicine, insurance companies objected to *socialized medicine*, and conservatives within and outside of Congress objected to converting the nation into a *welfare state* by extending social security to include health insurance (*Cong. & Nat.* 1965).

The AMA, in particular, wielded enormous power (Starr 1982). Physicians insisted that government involvement would interfere with the doctor-patient relationship and that a national insurance program would lead to lowered standards of practice. Dr. Irvin Abell, who was President of the AMA in 1942, argued that the Association "has never opposed the principles of insurance, but it does oppose the political administration and manipulation of the insurance organization and the interposition of any outside agency in the relationship

between doctor and patient" (cited in Heagerty 1942, 73). So great was the Association's opposition that it threatened to deny membership to physicians who participated in group plans.

Even reformers who worked in the Public Health departments and advocated greater government input into disease prevention programs in areas of special need, such as poor urban centers, could not match the power of the medical interests (US Public Health Service 1951). Thus, decisions related to the reform of health policy were obstructed and/or postponed in good part because the "entrenched position and enormous political power yielded to economic interest groups and entrenched (southern) local elites" (Steinmo and Watts 1995, 340-341).

While the controversy raged among decision makers on the federal level, state governments and employers continued to establish local health insurance arrangements for their residents and workers. By the mid-1940s, the concept of private health insurance was well established in a majority of the states and, as will be discussed in more detail below, would become even more firmly embedded in the decades to come. However, during this watershed period only a minority of the public enjoyed the benefits of such plans.

**Exogenous influences.** When the US emerged from World War II, it did so as a global leader in military, economic, and political affairs. In this role, it would spearhead the creation of international agencies designed to effect economic reconstruction, political cooperation, and military security. President Truman would oversee the initial steps by promoting the establishment of organizations such as the UN and NATO, and the implementation of the Bretton Woods System and the Marshall Plan. These tasks were massive undertakings and entailed enormous financial commitments abroad (McCormick 1996).

On the domestic front, demographic shifts, housing shortages, the absence of a

universal system of healthcare, and deep divisions within the Democratic party compounded the government's already difficult task of winning the peace.

Although it was a time of plenty for most people because jobs became available as factories converted to peacetime activities, as new occupations took shape in the postwar marketplace, and as agriculture geared up to meet the needs of the masses, the nation was not devoid of problems. For example, the spread of mechanization and automation forced many Americans, mainly those in the southern states, to seek work in other parts of the country. The migration of workers, many of them people of color, was to have long-term implications for housing (Weir et al. 1988). For example, while the non-discrimination clauses in union contracts opened opportunities for racial minorities in manufacturing jobs that had previously been closed to them, "[a]ccess to housing . . . posed a more difficult problem. Excluded from the new suburban housing developments, they settled in older neighborhoods of central city areas. This segregation was encouraged by government loan regulations" (Heirich 1998, 33).

These newcomers were not the only people to experience problems with housing. Many of the people who had lived and worked in the cities up to this time found it increasingly difficult to find decent and affordable shelter. On the one hand, builders were not renovating old areas or clearing central urban slums; therefore, remaining in the old neighborhood was not a viable solution. On the other, many of these residents could not afford to leave and buy homes in the areas on which the builders now concentrated. And to complicate the situation even further, new immigrants from abroad were arriving in search of a better life in the New World after leaving the ravages of war in their own nations. As a result, many of the same societal ills that had befallen the immigrants of the late 1800s were emerging in the mid-1940s, although the specific circumstances were different.

In health, many of the federal laws that were introduced during this time of change "rested essentially on utilitarian or pragmatic grounds, that is, returning people to the

workforce and investing in the future — a reflection of America's reliance on and belief in the Protestant ethic" (Litman and Robins 1997, 23). One example is the Hospital Survey and Construction Act, commonly referred to as the Hill-Burton Act, a major thrust of which was to build hospitals. Proponents of the legislation argued that this would provide jobs, especially for people in new suburban communities. Opponents, on the other hand, claimed that legislation such as this further alienated the urban poor who remained in slum conditions and who were still denied access to basic healthcare services. According to Litman and Robins, by the time it was implemented in 1946, Hill-Burton was "a prototype to federal involvement in health care" (1997, 23). This is true in at least two regards: health was prone to be treated as an economic good and whatever efforts were made on behalf of the medically deprived tended to yield contradiction, friction, and disharmony.

### **Summation**

During the mid-1940s, powerful factions within government and society continued their efforts to steer domestic policy away from government intervention. Nevertheless, forces were at work which promoted greater federal involvement in the social policy realm. Three major currents should be cited. First were the economic and ideological pressures that had been engendered by the Depression, the war, and the international commitments made by the country in the postwar era. Second was the development of a political culture which, because of the failure of the private sector during the 1930s, became more favorably inclined to the idea of further government intervention than it had been before and, thus, helped weaken traditional US anti-statism. And third were the efforts of state and societal actors to redefine existing problems, build on inherited social policy, and move away from the dual federalism which had long restricted federal involvement in state and local jurisdictions.

Although some important housing and health initiatives took place, a linkage

between them failed to materialize. What must be emphasized is that each of the factors had a different impact: as the following paragraphs will show, some were stronger in abetting change and others in inhibiting it.

**Abetting factors.** At this time, intergovernmental relations were to undergo permanent change. In the formative years of the nation, social policy matters had mostly fallen under state and local jurisdiction. Passage of the Social Security Act of 1935, however, was an important step in effecting a shift away from dual federalism and towards greater federal government intervention in areas of state jurisdiction. This movement was facilitated by the Supreme Court, whose 1937 decision allowed the federal government to play a role in areas that had previously been in the states' domain, without such action being deemed unconstitutional. That decision by the Court made it possible for the government to surmount a major constitutional barrier to greater involvement in the fields of public housing and health.

During this period, new exogenous influences had to be dealt with. There was a general adaptation of industry, agriculture, and commerce to peacetime pursuits; a demographic shift of workers from the south to northern and western cities; and concomitant urban and suburban growth. This led to the emergence of new actors and coalitions as well as new demands for state intervention.

The mid-1940s was also a time of ideological change when the federal government, with the Democrats in power, was preparing to become the principal leader, protector, and model in the postwar world. Aware of the growing importance of Keynesianism and the emergence of the welfare state in other nations, the federal government became more interested in devising strategies to deal with issues such as housing and health on a national level.

The Social Security Act, which was inherited from the Depression era, led many

Americans, regardless of location or status, to see that federal government intervention could alleviate hardship.

Discrete definitions of the problems of housing and health were put forward by a variety of groups and individuals. For example, the National Housing Conference of 1944 emphasized that the private sector alone could not be relied upon to better housing conditions in inner city slums. Republican Senator Robert A. Taft defined the problem in a similar way and co-authored a bill that would support federal housing initiatives in urban areas. And labor, consumer, veterans', and women's groups tried to show that federal housing and health legislation would promote employment, reduce urban crime, and improve the quality of life of the people.

Thanks in good part to the acceptance of principles enunciated by Keynes and Beveridge, the dominant *laissez-faire* philosophy and anti-statist political culture that had prevailed during the first part of the century was now tempered by a growing desire to have greater government involvement in providing some form of aid to needy citizens.

Despite the fact that decision making and central government institutions appear in the ranking of determining factors mentioned above, during this watershed period they were not abetting factors but, as will be shown below, were primarily inhibiting influences in the areas of housing and health policy.

**Inhibiting factors.** Although many forces favored broader federal assisted housing and health policies in the mid-1940s, there were significantly more powerful forces that prevented them from materializing. The major inhibiting force was the structure of the federal government which, by virtue of the separation of powers, constrained the policy making process in these two fields.

The end of the war and the need to create optimal peacetime conditions caused the government largely to focus its attention on exogenous issues both at home and abroad.

Resettling the war veterans, retooling industry, rebuilding the nation's commercial infrastructure, and encouraging agricultural initiatives, plus working with international organizations, engaged the government's energies. In addition, although fear of conquest by the Axis powers had gone, it was replaced by the apprehension that Soviet military power and communist ideology would ultimately undermine the American system.

Ideologically, despite the existence of broad public support for New Deal strategies, strong conservative coalitions among the Republicans and southern Democrats objected to government intervention in societal matters. These factions in Congress worked with puissant financial, building, and medical groups to ensure that the federal government would have limited opportunities to expand national social policies in directions they considered contrary to their best interests.

These inhibitors of new policy development were bolstered by the fact that aside from the Social Security Act of 1935, there was a limited inherited legislative base upon which to build new federal social policies.

Numerous groups and individuals attempted to define the housing and health problems of the country. Many of their studies favored government intervention. However, reports submitted by powerful, well-organized, well-funded coalitions had a far greater impact. Because an increase in the pace of reconstruction and hence greater prosperity for the country were the foremost goals of the government, the main emphasis of the decision makers was on economic, rather than social matters.

Although progressives in Congress like Wagner supported greater government intervention in social policy, decisions were being made by Congressional conservatives who occupied positions of power on key committees. These legislators believed that the private sector had traditionally provided adequate housing and health services, and therefore blocked the setting of new directions in these fields. Moreover, coalitions of building, financial, physician, and insurance organizations constrained policy development

through the multiple points of access, which is a permanent feature in the American federal government system. They influenced the decision making process so that federal resources were channeled into building houses and hospitals for the Americans who were migrating to the city suburbs, not for assisting those for whom the New Deal policies had originally been designed.

As far as political culture was concerned, the pervasive anti-statist view that had existed before the Depression and war had been replaced in many quarters by a belief that the government did have a legitimate role in providing aid to its citizens. However, the most needy groups were poorly funded and organized, lacked the knowledge and resources to participate effectively in influencing the complex policy process, and thus were limited in their ability to influence policy change.

In the wake of these overriding forces, the federal institutions that provided housing and health services, continued to offer only limited programs. Therefore, housing and health in the US remained, for the most part, separate and in the private sector during this watershed period.

## CHAPTER 5

### THE LATE 1960s

This decade witnessed the creation of federal institutions in Canada and the US that were mandated to oversee public housing, health, and other social policies. The differences in the dynamics which affected these institutions and their programs will be the primary focus of the present section.

The 1960s was a time when existing social programs were expanded and new ones were established in both nations. The stimuli for their development came from a variety of political, social, and economic sources. As discussed in the previous chapter, unlike other industrialized nations, Canada and the US had introduced only limited national social policies immediately after the end of World War II. Both nations preferred to rely on market forces to develop healthy domestic and international economies, and believed that because of its inherent nature, the market would eventually solve most social problems. When this belief proved unrealistic, however, there was an increase in support for greater government intervention in a number of social policy fields, among them, housing and health.

In many important respects, housing policy followed similar paths in the two nations. Among other goals, the federal governments aimed to reduce the amount of substandard housing, with its overcrowding, unhealthy conditions, and financial burdens on the needy. A number of policy instruments were used: the direct provision of accommodation for those who met eligibility criteria, financial support for the construction of non-profit housing, income assistance, and housing allowances (Fallis 1993b).

In contrast to housing during this period, the framers of social policy in other areas began to follow different paths in Canada and the US. Because of the nature of Canadian federalism, the vigorous activities of political actors such as the CCF, the successful health

insurance venture by Saskatchewan, and the general economic well-being of the country, Canada took advantage of a window of opportunity and established a national health program and expanded other federal social programs designed to aid the needy. A window of opportunity also presented itself in the US. However, the outcome there was different. Despite wide support for Johnson's War on Poverty, powerful actors succeeded in influencing the multiple points of access within the US government system, constraining efforts to implement Great Society policies, and preventing the limited publicly funded insurance vehicles that were already in place from becoming more generalized.

The following sections will explain these policy choices in more detail.

### **Canada**

Banting has made the observation that, "when it comes to welfare, Canada manifests a decidedly schizophrenic character" (1982, 58). This view may certainly be applied to the evolution of federal social policy during the 1960s when, as Tuohy remarks, there "is a niggardly set of policies directed at income security" but, on the other hand, there is "a national health insurance that is both generous and outstandingly popular" (1993, 275).

Important social policy changes occurred during this pivotal watershed period. Rapid urban growth in the preceding years increased the visibility of a growing number of interrelated societal problems. In housing, for example, up until the late 1960s, "urban policies had been oriented to improving the urban environment, rather than improving the lot of urban residents" (Lithwick 1970, 18). Cognizant of this situation, state and third sector actors became more involved in attempts to alleviate some of the more evident hardships (Anderson 1992). As a result, the federal government substantially enlarged the scope of public housing strategies designed to aid the needy. At the same time, in health, the government introduced a national insurance program, expanded the scope of its pension

plans, and broadened its focus on welfare.

Commenting on the public housing, health, and redistributive social programs of the period, however, Muszynski notes that many of these policies constituted "a hodge-podge" and led to a "complex and often poorly integrated system of health, education, income security, and social services" (1995, 291-293).

### **The determining factors**

**Federalism.** As earlier discussion demonstrated, in the wake of World War II, the federal government successfully implemented top-down policy decisions in a number of fields, including those related to redistributive social programs. Because these moves conflicted with the constitutionally established scope of provincial jurisdiction, intergovernmental tensions increased. By the 1960s, the intrastate mechanisms which had exerted powerful integrative forces in the postwar era also began to weaken (Breckenridge 1998). The provincial governments claimed that the federal actions "eroded provincial autonomy and distorted priorities" (Taylor 1987, 355). For example, a majority of the provinces expressed serious concern about factors such as their fiscal and structural ability to execute federally imposed terms for conditional grants. Demanding greater input into the decision making process, these provinces insisted on gaining greater autonomy over policy areas, which, if dominated by the federal government, would redound to their disadvantage (Stein 1989).<sup>1</sup>

In order to address these challenges by the constituent units, several federal-provincial meetings involving elected officials and high level bureaucrats were held. These meetings discussed the matter of provincial responsibility in a number of policy fields, including those related to social policy (National Health and Welfare 1967).

This "conflict and controversy regarding the division of powers" (Stevenson 1985, 71) had several important implications for both housing and health policy. Over the

preceding years, a majority of the provincial governments had not only developed the administrative capacity to manage and implement programs which were cost-shared with the federal government, but had also established their own programs to meet local needs. These initiatives led to a marked shift in intergovernmental relations. The actions of Quebec, Saskatchewan, and Ontario may serve as illustrations.

The Quiet Revolution in Quebec during the early 1960s led to major concessions regarding federal funding and control in several policy areas and to the creation of integrated social programs in the province. For example, Quebec insisted that there should be minimal federal intervention in its own policy plans, particularly in the realm of social policy (Muszynski 1995, 294), and, instead of participating in the Canada Pension Plan (CPP), created its own pension program. This CPP opt-out by Quebec produced the first of what would become a series of policy dilemmas (Banting 1995).<sup>2</sup> The following were among them: it created institutional barriers that have to this day severely limited options for future policy change; it caused fragmentation of one of the key federal social policy strategies; and it led to tensions between the federal government and other provincial governments (Muszynski 1995). As Banting puts it, constitutional changes of this sort and the potential for vetoes by the provincial governments gave rise to "a joint-decision process of withering complexity" (1995, 278).

But Quebec was not the only province to develop its own social policy programs. Among the most important initiatives were Saskatchewan's public hospital insurance program of 1947 and health insurance program of 1961. Introduced by the provincial CCF government, these innovative strategies would be emulated by the federal government, which used them as a template for its own national hospital and health insurance program (Smith 1995).<sup>3</sup>

The third illustration of changes in intergovernmental relationships was Ontario's decision to establish its own assisted housing programs. Growing public demands in the

early 1960s for improved accommodation for people living in appalling conditions in the rapidly developing urban centers had forced the provincial government to embark on large housing projects (Sewell 1994). In 1963, the federal government agreed to review the National Housing Act. The changes it introduced in 1964 "virtually re-wrote most of the social provisions" of existing federal legislation and provided funds for a variety of cost-shared initiatives (Rose 1980, 32).

These three examples illustrate the outcomes triggered by resentment of federal control in areas that the provinces claimed were constitutionally theirs. In essence, they recognized that federal plans frequently did not blend with their own policy priorities and regional needs. In addition, several provinces had developed their own expertise in a number of shared policy areas. This was particularly the case in housing, where most provinces had established their own housing agencies (Banting 1990). Factors such as these generated intergovernmental tensions and likely inhibited linkage in assisted housing and health policy at the federal level.

**Central government institutions.** Until this time, the federal government had been organized "along 'departmentalized' lines [where] individual programme departments had considerable independence from central agencies." In addition, policy agreements were made between federal and provincial officials "without obstruction, as long as discussions did not move beyond traditional department prerogatives" (Haddow 1990, 218). Ottawa's main role was to fund, either conditionally or through cost-shared agreements, programs that were implemented by the provinces. This arrangement had led to the development of "a complex and often poorly integrated system of health, education, income security, and social services over the 1940s, 1950s and 1960s" (Muszynski 1995, 293). In this regard, it should be noted that although by this watershed period there had been a noticeable shift of authority in federal government institutions from bureaucrats to ministers and central

agencies (Streich 1985), the above mentioned institutional arrangement proved to be an ongoing barrier to policy linkage.

The CMHC and the Ministry for National Health and Welfare were the federal institutions responsible for national housing policy and health and welfare policy, respectively. The following paragraphs outline the major changes that took place in these areas during the late 1960s.

In housing, the review of CMHC's activities that was undertaken by the Hellyer Task Force was the first major evaluation of national housing since the Curtis Report of 1944. Hellyer's mandate was to "report on ways in which the federal government, in company with other levels of government and the private sector, can help meet the housing needs of all Canadians and contribute to the development of modern, vital cities" (Hellyer 1969, 1). The criticisms of CMHC's programs which appeared in the Hellyer Report were to have long-term implications for all federal housing and urban policy initiatives. Hellyer helped to highlight the problems associated with previous public housing initiatives. In the past, the welfare of tenants had often been "secondary to that of commercially motivated redevelopment" and large-scale projects had created "alienating, high-rise, ghetto-like concentration[s] of the poor" (Bacher 1993, 228).

The CMHC ultimately became part of the Ministry of State for Urban Affairs (formally established in 1971), which was charged with overseeing the implementation of the 1964 amendments to the National Housing Act. With this change, the federal government became more involved in financing the capital and operating costs of housing low- as well as middle-income Canadians. In addition, there was a greater institutional emphasis on urban renewal and on supporting the activities of non-profit and cooperative ventures financed through federal-provincial cost-shared agreements. More programs were designed to increase federal-provincial cost-sharing where the capital and operating expenses were split on a 75%-25% federal-provincial basis. The federal government paid

up to 90% of the capital costs of some public housing projects and 50% of the operating costs; and, to further facilitate building, especially rental accommodation, CMHC offered loans to private companies at below-market rates. In turn, the rents charged to the occupants of public housing were geared to 30% of their income. In 1968, the budget for federal-provincial Rental Housing Projects was \$16,318,000; loans for Public Housing Projects amounted to \$100,012,000; and loans to non-profit corporations totaled \$57,990,000 (*Canadian Housing Statistics* 1968, Table 36). Although "it is difficult to compare data from one era to another because not only have programs changed but also the way in which expenditures have been reported" (Private communication from CMHC 2000), these figures represent a substantial increase over the previous watershed period when, in 1947 for example, \$23 million was spent on publicly assisted house building (CMHC 1947, Table 8).

For its part, National Health and Welfare became responsible for a variety of federal and cost-shared programs dedicated to the health and well-being of the elderly, handicapped, and poor, as well as for medical, public health, and welfare services for all Canadians. Embedded in its mandate were provisions for financing shelter costs for those who could not pay the market rents. By 1968, the total health and welfare budget had reached \$6,553.1 million (National Health and Welfare 1969).

During this watershed period, both CMHC and NH&W became responsible for large and costly policies. In order to fulfill these responsibilities, each institution required staff with specialized knowledge to establish and administer its programs. In essence, however, there is little clear evidence that their respective experts communicated or worked together on related projects. In good part, this lack of collaboration at the federal level was due to the institutional structures themselves. For example, CMHC was created as a Crown corporation and, as such,

was freed from the close scrutiny of the Department of Finance and the

Treasury Board. The preservation of that freedom became an institutional goal and affected program development and mix. When CMHC began to deliver significant amounts of social housing in the late 1960s, tension emerged between CMHC as a financial institution and as an agent of social policy. The tension and dilemma concerning its appropriate organizational structure have persisted ever since (Fallis 1995, 8).

In addition, as a Crown corporation, CMHC did not have the same type of institutional linkage or policy integration with other federal departments as did NH&W (Thomas and Zajcew 1993). Indeed, there seems to have been greater communication between the federal and provincial institutions responsible for social housing and health than between CMHC and NH&W.

**Inherited policy.** Several important pieces of legislation introduced in the 1960s significantly influenced the course of Canada as a welfare state. It was an important time, when the focus was on expanding public housing initiatives, establishing public assistance programs, and instituting medicare as a national plan (Banting 1990).

In housing, the main policies inherited by the Pearson administration were those enunciated in the National Housing Act of 1949. Even with its 1957 amendments, this legislation proved insufficient to cope effectively with the growing level of poverty and the housing needs that it engendered. Recognition of this fact helped shift government attention from housing as primarily an economic issue to one where social needs figured more prominently.

The 1964 amendment to the NHA was the most influential piece of legislation stemming from this revised outlook. As Rose puts it, "[a]lthough it may not have been apparent in June 1964, the amendments passed that month proved to be a turning point in Canadian housing history" (1980, 40). The legislation provided a wide choice of funding mechanisms for housing developments. Different sections of the Act encouraged the provinces to make loans to non-profit and cooperative organizations, to embark on urban

renewal projects, and to build and manage public housing complexes. Taking advantage of the new funding initiatives from the federal government, most of the provinces established their own housing agencies and launched public and non-profit housing projects of their own. As a result, publicly funded housing complexes grew along with the size and capacity of the bureaucracies within the federal and provincial departments (Simeon and Robinson 1990).

In health and welfare, the relatively minimal policies inherited from earlier Administrations did not impede implementation of the government's decision to introduce health and welfare legislation. The Hospital Insurance and Diagnostic Services Act, which had been passed in 1957 in the wake of Saskatchewan's hospital insurance initiative, provided all Canadians with access to hospital care and services. The Pearson government's 1966 Medical Care Insurance Act increased federal funding to include cost-shared payments for a greater variety of medical, professional, and hospital services (National Health and Welfare 1969). During the same period, the federal government introduced the following welfare programs: the Canada Pension Plan in 1965, a federally administered initiative financed by employer and employee contributions; Guaranteed Income Supplements in 1966, financed by general revenues to augment the pensions of low income citizens; and the Canada Assistance Plan in 1966 for Canadians in proven need, which was funded federally from general revenues and cost-shared with the provinces (Tuohy 1993).

As the number, size, and variety of new programs replaced or were added to previous ones, the institutional complexity within the federal government increased. While these federal initiatives and cost-shared programs provided Canadians with support in times of need, the policies designed to help them continued to be administered in different federal institutions and, increasingly, were being implemented by agencies at different levels of government and by non-profit organizations (Bacher 1993). Even though the policies of the past and the programs of the 1960s did much to alleviate the problems of the needy, the

institutional fragmentation discouraged the possibility of policy linkage between assisted housing and health.

**Political culture.** The 1960s was a decade of policy innovation and expansion (Banting 1997) that reflected the general societal concern for the welfare of the poor and the elderly. As Maioni puts it, during the 1960s, an era when poverty once again became an important issue, there was a greater focus on the "notion of collective responsibility to ensure the well-being of the less well-off in Canadian society" (1997b, 180).

For this reason, as the decade progressed, demands for greater government activity increased and "housing policy focused primarily on social justice" (Fallis 1993b, 23). However, the arguments for state control in social matters were not limited to housing. Banting notes that there was "a broad emphasis on redistributive policies in many sectors" (1990, 124). This belief in government intervention was supported by the influential presence of the NDP at the federal level in Canada and, as will be discussed below, by the popularity of the national War on Poverty espoused by President Johnson in the US.

As a result of post-war "welfare liberalism in Canada," by the end of the 1960s incremental change had made government assistance into "a patchwork of social programs" (Maioni 1997b, 180). Although these programs provided Canadians with a growing number of social benefits, the fragmented pattern of their evolution lessened the opportunities for policy linkage between housing and health.

**Ideology.** The federal Liberals, first under Lester Pearson then under Pierre Trudeau, were in power during this watershed period. Pearson held that the federal government, through its spending power, had "the ability to influence . . . policy innovation and diffusion while at the same time imposing a degree of conformity among provincial governments" (O'Neill 1997, 171). The minority status of Pearson's govern-

ment and the prominence achieved by the New Democratic Party (NDP), successor to the CCF, were pivotal factors with respect to the character of the new social policy initiatives (Gray 1991). During this period, Pearson needed the support of the NDP in order for the Liberals to remain in power (Private communication from Boase 2000). Although the NDP held only 21 seats in Parliament, because of the fragmented nature of the right wing opposition, that Party was able to pressure the Liberals to support new housing initiatives, a national health system, and other social policy programs (Banting 1997, Maioni 1997a).

The situation changed when Trudeau won an electoral majority in 1968. He maintained that there should be greater central government control and fiscal responsibility (Smiley 1977) and that all social transfers should be integral components of national economic policy (Haddow 1990). According to Muszynski, Trudeau believed "that a strong federal role in social policy was essential for reasons of equality, opportunity, and the need to foster a sense of shared community" (1995, 294). Consequently, as the ideological focus related to social policy shifted more towards fiscal issues where "economic stabilization was directly associated with the provision of social transfers and was, therefore, an essential tool of national economic policy" (Muszynski 1995, 294), housing and especially health policies were destined to become increasingly important federal policy issues (O'Neill 1997, Banting 1990).

**Definition of the problem.** The need for an integrated social system, including subsidies for shelter, had been identified by federal and provincial officials at the Federal-Provincial Conference in 1963. It was noted at that time that "the whole field of social assistance should be jointly re-examined in the hope of developing one general assistance program based on need" (National Health and Welfare 1967, 9). As a result, the 1966 Canada Assistance Plan (CAP) consolidated a number of previously existing programs designed to assist citizens in a variety of areas, including payments to low-income families,

people with disabilities, and the elderly. It was conceived as a cost-shared program that would provide "a basis for a new and more flexible approach to public welfare in Canada" (National Health and Welfare 1967, 10).

Although the late 1960s produced many documents regarding federal involvement in social policy (Bickenbach 1993), the government's direction was particularly influenced by the Reports of the Hellyer Task Force on Housing and Urban Development and the Hall Royal Commission on Health Services. During the same period, concerns articulated by elected and appointed officials about the fragmented nature of Canada's social system spawned a series of meetings between federal and provincial representatives which led to a review of Canada's assistance programs. A significant number of the recommendations for change in federal policy became institutionalized and were thereafter embedded in the policy process.

Hellyer's Task Force on Housing and Urban Development was charged with examining what was viewed as "a serious urban problem" stemming in good part from the "quality, equity, efficiency, and effectiveness" of National Housing Act loans distributed by CMHC (1969, 1, 6). Seeing the housing problem in these terms, Hellyer, a former developer, took a mere six months to make the recommendation that "all urban residential land be developed and marketed by municipalities and that federal loans be made for that purpose; that social housing programs only for the poor be terminated; that subsidies be paid to people, rather than attached to buildings; that cooperative and non-profit housing programs be expanded" (Dennis and Fish 1972, 15)

The Report was severely criticized for being a pro-market strategy which did not meet the housing needs of low-income Canadians, and this criticism was instrumental in Hellyer's resigning his position as Transport Minister.<sup>4</sup> Although greeted by private sector developers, even representatives from the National House Builders Association had reservations about the manner in which Hellyer's broad proposals could be implemented

(Smith 1969). Nevertheless, several of the Report's key recommendations, including the establishment of a Ministry of State for Urban Affairs and a greater focus on non-profit and cooperative housing initiatives, were adopted by Trudeau's government after this watershed period (Hulchanski and Grieve 1984). Recognizing the multifaceted problems which plagued many of its public housing projects, CMHC's 1969 Annual Report noted that Hellyer had "raised many questions about the psychological and other difficulties of large public housing projects [and these led to intensified] discussions with the provinces with a view to improving the physical and social characteristics of public housing" (CMHC 1969, 12).

For its part, the Hall Commission conducted the most extensive review of Canadian health services and sought the opinions of health care providers and consumers. It noted that there was an "enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men [sic], on the other" (Canada, Royal Commission on Health Services 1964, 10). This view of the problem led to the establishment of a national health insurance plan that would cover all Canadians. The Report was both enthusiastically supported and vehemently condemned. The arguments fell into two broad areas, cost and control. As might be anticipated, the plan was welcomed by the public and opposed by the CMA and other state and societal actors who believed that greater government intervention would cause them to lose control and income. Because of the uproar, enactment of the Medical Care Act was deferred until 1966 (Taylor 1987).

The above examples of problem definition demonstrate that the federal government recognized that a growing number of Canadians required assistance in several interrelated social policy fields, and although the potential for integrating the policies that linked shelter and health care existed, what was missing was a coordinated government plan to provide for those who required both types of service. Such an undertaking would have required a

much greater commitment from the Liberal government and much more extensive collaboration between the organizationally separate social housing and health and welfare departments than existed at that time.

**Decision making.** By the mid-1960s, the federal government had adopted a more centralized decision making process and the ministers and central agency bureaucrats were now more responsible for determining federal policy direction. On the provincial level, several governments had already established their own social housing programs and had also produced a range of policy instruments for funding their own health programs. In the process, provincial bureaucrats in the two policy fields had greatly increased their expertise (Mallory 1971). As a result, a majority of the provinces could demonstrate their ability to design and implement innovative social program strategies. As Pierson puts it, this presented the federal government with the dilemma of having an "expansion of policy making circles" which included "multiple political authorities with distinctive interests and capacities" (1995, 459). In addition, there were changes in the roles and responsibilities of the actors in state and societal institutions. All of the above gave rise to new opportunities as well as constraints in policy choice. Housing and health were particularly contentious issues.

In the years leading up to this watershed period, decisions concerning housing programs had been made by bilateral agreements between elected representatives and senior bureaucrats in the federal and provincial governments. The initial First Ministers' Conference on Housing and Urban Development was chaired by Pearson in 1967. At that conference, the government unveiled its proposals for cost-shared programs and loans for urban affairs. Although these plans were largely welcomed by the provinces, disagreements emerged on other issues, and multilateral consultations were replaced by bilateral negotiations until the early 1970s (Streich 1985).

During this watershed period, Paul Hellyer, the Minister responsible for housing, resigned in the wake of the negative reception of his Task Force Report. His successor, Robert Andras, however, was "indefatigable in his public campaign" for community development and implemented many of Hellyer's recommendations (Anderson 1992, 35). In a speech to the Canadian Institute of Public Affairs, he even declared that the Hellyer Report had forced all government levels to seek "a deeper understanding" and engage in "broader thinking" about complex social problems in Canada's urban environment (Andras 1970). Capable individuals were recruited to assist Andras. Some of these recruits, such as Harvey Lithwick, an academic, stand out for expressing concern about the inability of public institutions to recognize the interdependencies of the causes and effects of urban problems. In his 1970 report on urban ills, Lithwick notes that many of the challenges that had emerged in the 1960s had been poorly understood by the policy makers, had been dealt with reactively, and had thus exacerbated the growing "urban crisis" (18).

In the Department of National Health and Welfare, similar concerns existed about government's role in the future, especially because demands on the federal government for all types of aid had increased markedly over the years. During the early 1960s, the bureaucrats enjoyed great autonomy and "also had substantial policy-making capacity, because decision-making was effectively centralized within federal and provincial welfare departments" (Haddow 1990, 219).

However, in the period under examination, it was the Ministers who were primarily responsible for overseeing the expansion of health and welfare services (NH&W 1967, 1969). For example, the Minister of Health and Welfare, Allan McEachen, and the Minister of Finance, Mitchell Sharp, were key decision makers in charting the new path for health policy. The decisions that were made during these tumultuous years of policy change would completely alter Canadian health programs. After vigorous debates among the decision makers, it was decided that the new health services would be comprehensive,

universal, publicly administered, and portable. "It was simplicity itself. Not a federal program, but ten provincial programs that together with federal sharing would aggregate to a national program of uniform minimum standards for all Canadians" (Taylor 1987, 362).

Policy communities continued to affect the nature of government programs, although the strength of their influence differed from that of the 1940s. While the powerful associations of physicians, builders, and bankers still wielded enormous political strength, especially in provinces like Ontario, consumer groups had also become a more visible, better organized, and more vocal political force (Haddow 1990). For example, participants in the 1967 conference of the Canadian Welfare Council (CWC) brought their concerns about the multifaceted problems of Canada's needy (Anderson 1992) to the attention of the decision makers.<sup>5</sup> However, even with their greater prominence and organization, the policy communities which represented the main beneficiaries of public housing and, to a large extent, health services, did not have sufficient influence on the decision making process to effect greater linkages between assisted housing and health.

**Exogenous influences.** Although deeply concerned about the possible impact of the Vietnam War, Canada did not share the profound social, economic, or political problems that confronted the US during or after this conflict. Indeed, for the most part, Canada's social policy development was not affected to any significant extent by external factors such as this.

### **Summation**

The above examination confirms that the roles and responsibilities of the various state and societal institutions and actors had changed since the previous watershed period, and that these changes had markedly affected the development of Canadian social policy. Housing and health were part of this process and federal policies were established in both

of these fields. However, despite the fact that there was support for greater federal involvement in the development of housing and health policy, and that a potential for linkage existed, integration did not occur because of the weight of the inhibiting factors.

The following is a brief examination of how the determining factors abetted and/or inhibited policy change.

**Abetting factors.** The innovations made by the provinces plus the still strong potential for top-down policy determination on the federal level led to the expansion of social housing programs and to the creation of a national health insurance plan.

Federal institutions retained spending control and allocated resources for the growing number of social policies, most of which entailed cost-shared mechanisms of payment. Thus, the federal government was able to introduce new initiatives as well as determine the criteria for the provision of health, housing, and other social programs.

In addition to the structures and processes inherent in Canadian federalism, other factors influenced the development of social housing and health policies. A number of important reports from sources inside and outside the government defined problems in several areas of societal need, called attention to the dearth of federal activity in those areas, and urged greater government intervention. By highlighting the plight of specific elements of the population, especially elderly and handicapped people who had discernible housing, health, and/or income problems, these documents provided justifications for initiating policy change.

Institutionally, both the CMHC and NH&W had undergone extensive reviews and were in the process of changing their organizational structure and mandate. As a result, there was an important window of opportunity for these institutions to develop closer and more coordinated links in the provision of assisted housing, health, and welfare assistance to groups that were in need of these types of services.

The factors abetting greater government involvement in social issues during this watershed period were further encouraged by the influence of the NDP during the Liberal government's minority status under Pearson and later by the Trudeau majority's belief that the federal government should provide leadership in the area of social policy.

During this period, the federal government was adopting an increasingly centralized decision making process, with the Cabinet and central agency bureaucrats becoming more responsible for charting the federal policy course. While some of the private sector actors that had forcefully influenced policy development during the previous watershed period became less influential, consumer groups, which demanded a greater role for government in the realms of housing and health, became more vocal.

Policies inherited from earlier years proved insufficient to cope with Canada's housing needs during this watershed period. This led both the federal and provincial governments to introduce a variety of strategies designed to promote public housing initiatives and encourage cooperative and non-profit housing ventures. In health, based on the success of Saskatchewan's health insurance initiative, the federal government saw the possibility of using its previous hospital insurance legislation as a basis for introducing a broader health insurance plan.

As far as political culture was concerned, the greater visibility of the urban poor prompted greater societal concern for the well-being of the disadvantaged and reinforced the traditional belief that the government had a role to play in meeting their needs.

Major exogenous factors such as involvement in the Vietnam War, that played a role in US policy making during this decade (see below), were not present in Canada and thus did not directly influence housing and health policy.

**Inhibiting factors.** The 1960s was the first time that the federal government had embarked on developing such an extensive series of social policies. As in the previous

watershed period, however, jurisdictional aspects of federalism presented themselves. New tensions arose between Ottawa and the provincial governments, which resented federal intrusions into provincial areas of responsibility. For example, the Quebec government had developed its own integrated social policy strategies during the Quiet Revolution and now argued that federal stipulations concerning the allocation of funding were unwarranted and undesirable. Ontario's Conservative government also believed that its own housing and health plans were more appropriate for its citizens than those proposed by the federal government. Tensions of this kind adversely affected the federal-provincial cooperative spirit and inhibited the opportunities for unified action.

Within the federal government itself, several factors combined to create a fragmented approach to social policy development. For example, the reports that guided future policy direction were as different in gathering information and making recommendations as they were in their policy proposals. The Hall Commission on health, after carrying out a long-term, formal, and inclusive study, concluded that health coverage was necessary for all Canadians and that a universal insurance plan should be a federal responsibility. In contrast, the Hellyer Report, which was the product of a rapid review of housing and urban conditions, recommended greater government action as well as linkages with the private and third sectors. Faced with such antithetical positions, the government lacked one of the main facilitators of policy change: consensus.

The nature of the government institutions themselves also precluded opportunities for coordinated policy development. CMHC, a Crown corporation, and NH&W, a federal ministry, were responsible for large new programs in assisted housing and in health. However, implementation of the new strategies was functionally and administratively isolated.

Despite ideological pressure from the NDP, to a large extent the federal Liberals still viewed housing basically as an economic issue. As a result, they did not focus on

providing housing aid exclusively to low-income people, but expanded the programs to include middle-income people as well. Similar ideological barriers did not apply to health, however.

Because decision making on major issues became more centralized in the years leading up to this watershed period, the federal bureaucrats, although continuing to participate in the policy process, were unable to play as decisive a role as they had in the past. More centralized decision making also inhibited the degree to which other state and societal actors influenced the process.

Inherited policy in itself did not inhibit the development of assisted housing and health strategies. But broadening the policies that were already in place increased institutional complexity and adversely affected opportunities for collaboration between the institutions.

During this watershed period, political culture and exogenous influences did not play a pronounced inhibiting role in the development of assisted housing and health policy.

### **The United States**

Expansive, innovative social policies emerged during the Johnson years. According to Breckenridge, it was a time of creative federalism in which there was "an explosion of new federal legislation in many more areas of state jurisdiction, such as education, welfare, urban development, and transportation" (1998, 115). At the beginning of this watershed period, many Democrats saw a window of opportunity to introduce legislation that would continue with some of the initiatives that had been introduced during the New Deal era. Enthusiasm for federal social programs were fueled, in part, by the strong public support of the late President Kennedy (as well as the emotions stirred by his assassination), the idealism of the early 1960s, and the large Democratic majority in Congress (Correspondence from Breckenridge 2000).

Housing and health were both perceived to be important areas for Johnson's War on Poverty. As a result, the Department of Housing and Urban Development (HUD), a new federal department, was created to design and implement housing programs for poor, primarily urban residents. In addition, the Democrats expanded the provisions of the Social Security Act and, through the Department of Health, Education, and Welfare (HEW), introduced limited health insurance initiatives for the elderly and poor.

However, as the Great Society progressed, the Vietnam War, racial tensions, and urban unrest increasingly absorbed the attention and resources of the Johnson administration. Furthermore, the earlier tendency towards cooperative federalism weakened and federalism took on a more coercive quality (Kincaid 1994). This fact notwithstanding, because of the scope and nature of federal intervention in housing and health policy, the late 1960s had considerable potential for linkage in these policy areas.

### **The determining factors**

**Federalism.** As Washington pursued its Great Society goals, it entered areas which had previously been in the states' jurisdiction. These intrusions were far from unanimously supported, however. In Congress, opposition arose from many southern Democrats and conservative Republicans. These interventionist moves were also condemned by many state governments. Despite the vehement protests, the federal government proceeded with its efforts to introduce top-down changes to social policy direction.

In housing, the focus of Congress during the Truman and the Eisenhower years had been on urban development and on creating a climate for greater investment in housing production for the private market. State and local governments also established strong links with the private sector (Flanagan 1997). With the start of President Johnson's War on Poverty, however, the federal government shifted its focus to the needs of citizens who had not benefited from what had been a buoyant market economy (Moynihan 1969).

A similar shift took place in the health and social policy arena. The federal government responded to more and more demands from the subgovernments to address problems associated with inequities in health and welfare provision in different parts of the nation.<sup>6</sup> While a significant number of state and local government officials supported these initiatives, others argued that federal action left little room for local innovation in providing housing and resolving the problems associated with urban decay (Bratt 1998). In addition, some administrations were "either unwilling or unable to expend funds." Thus there was "a considerable lack of uniformity both between and within states" (Bratt 1998, 24) and, despite the intentions of the federal administration to introduce national standards for basic social services, significant inequities in housing and health policy remained throughout the nation (Feldman et al. 1971).

**Central government institutions.** The number and scope of federal social policy initiatives that were taken during this period resulted in an increase in the complexity of central government institutions. The two largest institutions that provided social programs were HUD and HEW, each of which had annual budgets in the region of \$15 billion (*CQ Almanac* 1968). HUD, a Cabinet-level department, was established in 1965. Among the responsibilities assigned to the new institution was assisting low-income people to find decent accommodation. This responsibility was divided between two sections, the Housing Assistance Administration (HAA) and the Federal Housing Administration (FHA). These two sections were responsible for funding new building, rehabilitating houses in disrepair, and promoting better rental accommodation and home ownership for low-income people.<sup>7</sup>

HEW had been created in 1953. Among its primary responsibilities at that time was the coordination of federal programs for hospital construction and research. In the 1960s, it became increasingly involved with disease prevention and health promotion, it dedicated

Hills-Burton funds to building hospitals in rural areas, and it added cardiac, cancer, and mental health research to its activities. Thus, its function as coordinator of health services increased dramatically. But HEW's scope of activity was amplified even further as a result of the significant expansion of its welfare role as a result of the introduction of Medicare and Medicaid.<sup>8</sup>

Under the collective goal of a War on Poverty, the Democrats attempted to enact legislation that would link some of the broader determinants of health for the first time since the New Deal. With the "big increase of Northern liberals" in Congress, much of the federal legislation that determined the roles and responsibilities of HUD and HEW was passed, albeit with opposition from conservative groups in the House and Senate (*Cong. & Nat.* 1969, 760). The Administration's policies aimed at creating "new methods to assist cities and poor persons" (*Cong. & Nat.* 1969, 183) that needed assistance with housing and healthcare. Theoretically, they offered more of an opportunity to connect housing and health policies than had existed at any time in the past. In practice, however, HUD and HEW drew primarily on the expertise of people familiar with their own policy area and developed a separate set of programs. This fact, plus the very complexity of the new programs, inhibited any significant opportunity for linkage that might have been available.

**Inherited policy.** In housing, the most important inherited legislation to affect policy in the late 1960s was the Omnibus Housing Act. Passed in 1954 at the beginning of Eisenhower's presidency, this Act shifted the government's focus from public housing to urban renewal and represented a remarkable confluence of power between business and elected representatives on the federal, state, and local levels (Flanagan 1997). The Eisenhower administration's emphasis on urban development for the non-needy became a major factor leading to the civil unrest which erupted in the sixties.<sup>9</sup>

In order to combat the problems imposed by this inherited policy, four important

and highly controversial laws were introduced during the Great Society years and changed the path of federal action. They created the Department of Housing and Urban Development, provided rent supplements to help poor people afford decent housing, promoted collaborative urban development strategies between the federal and local governments, and established a three year program designed to build and rehabilitate 1.7 million homes for low-income people at a budgeted cost of \$5.3 billion (*Cong. & Nat.* 1965).

In health and welfare, policies inherited from the postwar period were also a source of contention. Three main issues were at the core of the disagreements: what type of programs were funded, who benefited from them, and how they were funded. When Johnson took office, "the focus of the federal role shifted from research and training to more direct efforts to provide improved health care for the general population" (*Cong. & Nat.* 1969, 665). Disagreement remained, however, about funding. Proponents of further government intervention believed in financing social programs through a payroll tax system and allocating funds to eligible groups without a means test. For their part, opponents believed that payments should be made to indigent people through existing federal-state public assistance programs which were largely funded through general tax revenues.

The outcome was a compromise. The Administration enacted Medicare, a hospital insurance program for the elderly which was funded by the federal government and included voluntary additional payments for other medical services, and Medicaid, a health program for the poor which was paid for by both federal and state governments (Kingson and Berkowitz 1993).<sup>10</sup>

Clearly, the policy path set by the Democrats in the middle and late 1960s was a significant departure from the one followed by the Republicans in the 1950s. What should be stressed, however, is that even though Johnson's original housing and health proposals were popular at the beginning of his tenure, they underwent marked change as a result of the complexity of the policy process in Congress.

**Political culture.** Deep societal concerns had emerged in the 1950s about the growing plight of the most vulnerable Americans, particularly the elderly and the handicapped. Although many people preferred to ignore this problem, there was a segment of the population which, though philosophically averse to government intervention in domestic matters, deplored the inequities that had arisen in the nation and conceded that greater government intervention was necessary to assist the social needs of the population as a whole (Lipset 1990). Associated with this viewpoint was a conviction that despite the presence of ideological opposition to government intervention, the nation had the wealth, capacity, and will to redistribute funds and provide services to those in need (Kingson and Berkowitz 1993). For this reason, substantial sympathy for Johnson's proposed War on Poverty began to manifest itself. This sympathy, which Feldman et al. see as a "mirror of American values in conflict" (1971, 14), increased support for greater state intervention in policy areas that had not received substantial government attention in the past. Among these were housing and health.

In housing, Feldman et al. note that "policy makers began to face up to the realities about the function and needs of central cities . . ." and to deal with issues that reflected the American public's changing views concerning the role of government in societal matters. One such issue was the detrimental impact that poor housing and previous urban renewal strategies had on the quality of life of ghetto residents and the civil unrest that they had spawned (1971, 14). As a result of this new sensitivity, there was a "marked change in philosophy of the federal government in its approach to urban problems" (13).

Public advocacy of greater federal intervention in health care delivery had remained consistently high. In one poll, it was estimated to be 67% in 1961 and 63% in 1965 (Steinmo and Watts 1995). Nevertheless, within these few short years the public's emphasis on the type of care that it desired had shifted to include community-based care in addition to that provided in institutions. More people were going into hospitals for

treatments which had previously been given at home. When assessing this situation, critics asserted that much of what was being done in hospitals could be done equally well if appropriate and less costly outpatient and nursing care were provided. In addition, "[c]riticism of the single minded emphasis on hospital construction took the same course as contemporary criticism of the bricks-and-mortar approach of urban renewal. . . In both cases, critics attacked established policy for its fragmented approach and lack of understanding of broader 'community needs'" (Starr 1982, 364, 365)

**Ideology.** Part of the reason the federal government was able to introduce sweeping new social measures was because of the overwhelming mandate the Democrats had been given by the electorate. The support for greater federal government intervention during this watershed period had begun with Kennedy and gained momentum during Johnson's early years as "a re-energized Democratic desire to complete the unfinished business of the New Deal . . ." (Private communication from Breckenridge 2000). In the 87th Congress, President Kennedy, who had enjoyed great personal popularity, worked with a Democratic majority (263 seats in the House and 65 in the Senate). Now, in the 89th Congress, Johnson worked with an even larger Democratic majority in the House and Senate (Breckenridge 1998, 487-488). Kennedy's popularity with the American people, followed by the civil rights crisis of the 1960s and Johnson's vision of a Great Society, provided a golden opportunity for the Democrats to act.

Adding to the shifts in support for federal government intervention were the Democratic successes in governorship and state elections. By 1965, the Democrats held 33 governorships and fully controlled both houses in 32 state legislatures. This was a bitter blow for the Republicans, who were forced to reevaluate their pro-business ideological stance. For the Democrats, however, it was an extraordinary opportunity to introduce what many of them believed were long overdue national policies designed to aid those American

citizens in greatest need. Their beliefs were confirmed by the strong endorsements they received from the liberal-labor-minority alliances. Thus, in only a decade, the ideological pendulum had swung from a philosophy of restricted federal government action to one of greater intervention (*Cong. & Nat.* 1965, 1969).

By the end of this watershed period, however, support for the expansion of social policies that had been at the heart of the Democrat's ideology since the Depression years began to be replaced by a general dissatisfaction with the programs and "a generation of New Deal liberal dominance" (Breckenridge 1998, 53). Thus, even though the Democrats embarked on an ambitious program of social policy development, approval for their ideological stance diminished considerably during Johnson's tenure.

**Definition of the problem.** The documents and reports that were published during this pivotal time not only reflected the changing nature of America's social problems, but also the extent to which the government was convinced it should become involved in attempting to resolve them. On the one hand, belief in the effectiveness of the market and of laissez-faire principles remained pervasive. But, on the other, the poor quality of life of growing numbers of Americans raised serious questions about the advisability of continuing to rely so heavily on the private sector.

In the sphere of housing, two contrasting reports serve to highlight the polarity of viewpoints that were held about government intervention. In 1967, Johnson established a National Commission on Urban Problems which was directed to make specific recommendations for a holistic solution to US housing issues — a solution based on an understanding of the broad scope of social, economic, and political determinants that contributed to urban decay and to the health and social problems that accompanied it (1968). The Commission undertook extensive hearings across the nation and produced a number of suggestions to improve "the quality and quantity" of social housing programs

(Shermer et al. 1968). Its proposals included improving living conditions for many urban dwellers and linking other services such as welfare and employment with those programs.

In contrast to support for a solution that included broader consideration of the underlying causes of the social problems, the Kaiser Committee of 1968 urged more government funded construction. This was a "massive study" which made important recommendations for future legislation (HUD 1998a). The committee, comprised primarily of developers and representatives from financial institutions, insisted that housing issues could be resolved by the construction of 26 million new homes, of which 6 million would be for low-income families. As Heidenheimer et al. note, this was "a classic example of the tendency of the American government to place a major share of policy-making responsibility in the hands of organized groups whose interests are directly engaged in the policy" (1990, 119). In sum, the process was essentially a "coalition of executive, legislative, and special interest politics" (Johnson 1991, 69). In the end, the private sector prevailed and its proposals became a large part of the new housing legislation.

Despite this victory by the above mentioned interest groups, the search for broader solutions to these multifaceted problems did not die. Towards the end of the Great Society years, a report authored by HUD Secretary Wilbur Cohen stressed the importance of coordinating health, housing, and other social and support services. In his arguments to the House Ways and Means Committee and to the Senate Committee on Finance, Cohen (1969) maintained that all levels of government should not consider housing as a separate issue, but should treat it as an integral component of welfare. Even though Cohen's proposals were based on "a detailed and systematic study of the housing status of welfare recipients, [they] were never acted upon" (Newman and Schnare 1992, 21-22).

As in the case of housing, the development of health policy was also affected by sharp contrasts in the way the problems were defined. The most vigorous debates took place in the Committees of Congress (Committee on Interstate and Foreign Commerce

1964). There, Johnson's attempts to promote legislation that would expand the nation's effort to win the War on Poverty were constantly thwarted by the effective opposition of special interests (*Cong. & Nat.* 1969). For example, by the 1960s, the "deterioration of existing hospitals in major urban areas" had become a pressing problem. In response, the 1964 Debakey Commission advocated more hospital construction for the treatment of illness. The Commission, however, made few recommendations to address the underlying causes of disease or strive for its prevention (Starr 1982). Realizing that the Democrats, who had the support of organized labor, would try to overcome this omission and even introduce health insurance and related social policy initiatives, opposition groups headed by the AMA and private insurance companies sought to counter the Democrats' policy plans through the submission of their own reports and proposed amendments. The bitter debates that surrounded the passage of Medicare and Medicaid highlight the barriers that confronted the policy process in Congress at that time. Even with public support of Medicare, this popular health initiative underwent significant change as it was "buffeted [on] the policy playing field" of Congress (Maioni 1997a, 422).

**Decision making.** The decisions made during this watershed period affected not only housing, but the whole character of US health and social policy.

In housing, the advocates and opponents of government intervention were generally the same as in years gone by. The notable exception was the US Conference of Mayors (USCM). This group, which had supported New Deal initiatives in the 1940s, defended urban renewal initiatives in the 1950s because urban renewal was more politically popular than public housing in many cities (Flanagan 1997). Now, in the 1960s, many mayors sought greater federal government aid as a means of combating the racial tensions within their jurisdictions.

The people who participated in the civil unrest were those who had been directly

affected by the social policies of the past. Although the consumers of public housing lacked a powerful voice in Congress, with support from others who were sympathetic to their reasons for protest, the violence of their message became a major stimulus to consider policy reform. Newspaper articles describing the "pillage, looting, murder, and arson" indicated the extent of the problem (Adams 1967, 1).

The builders and financiers, who were represented by groups such as the National Association of Home Builders and the Mortgage Bankers Association, remained intimately involved in policy development. After realizing large profits from building new cities and suburbs during the postwar era, in the wake of the urban riots these groups saw new funding opportunities. They therefore shifted their support to the government's program of building large numbers of public housing complexes, and thereby enhanced the possibility of policy change.

The elected and appointed officials who made decisions at this time were also crucial to future housing policy direction. HUD's first Secretary, Robert Weaver, was an economist who was also the first African-American to head a US federal government Department (Breckenridge 1998). He was particularly concerned with the issue of racial equality and justice, and worked to improve the lot of all inner city dwellers by focusing on community development (*Journal of Housing and Community Development* 1997).

Despite this more favorable climate, many of the barriers to decision making that had existed in the mid-1940s were still in evidence in the 1960s. For example, coalitions within Congress constrained most of the attempts to reform social policy. According to *Congress and the Nation*, "Congress's conservatism and its reticence to initiate new programs were based in large part on the committee seniority system and restrictive legislative rules. Committee chairmen often were Southern Democrats or Midwestern Republicans, representing the most rigidly held districts and states" (1965, 1-2). Compounding these traditional problems were the increasingly complex approval routes

that had to be taken through the various Congressional committees and subcommittees, as well as the fact that the "Congressional representatives least able to build up seniority, and thus the least likely to head committees, were those from the politically volatile suburbs and city fringe areas where the major new population movements — and many major problems — of the postwar era occurred" (1965, 1-2). Thus the policies that had been articulated as part of the War on Poverty were substantially constrained by opposition groups.

A most important example of the inability of even a large Democratic majority to facilitate dynamic policy change is illustrated by the path that Medicare followed in the mid-1960s. Starr suggests that many of the original proposals for the Great Society programs were created by "liberal academic reformers" who provided the impetus for creative alternative solutions to societal problems (1982). Although the consumers of social policy programs were less successful in influencing the policy process than they might have wished, a variety of societal groups did support the expansion of social policy, including the institution of a national health program. For example, now, with better organization and better funding, the labor unions gradually established a stronger presence in Washington and were able to exert a greater influence on the policy process (Breckenridge 1998). Leaders such as Nelson Cruikshank, head of the AFL-CIO lobby group, backed the government's plans, and concerted efforts to extend health and social benefits to all needy Americans continued to be made by HEW Secretary Cohen (Kingson and Berkowitz 1993).

Once again, however, the wishes of the advocacy groups were constrained in Congress. There, for instance, Representative Wilbur Mills, the Chairman of the Ways and Means Committee, proposed that Medicare should be divided into "a three layer cake." The first layer would consist of hospital insurance under Social Security; the second, would be a government subsidized voluntary insurance plan to cover physicians' payments; and the third, Medicaid, would assist the states to pay for medical care for the poor (Starr 1982).

This compromise was a feat of brokerage and finesse between competing actors — a compromise which allowed the Republicans to effectively block any future steps to bring a national health insurance plan into being (Steinmo and Watts 1995). It also precluded any opportunity for linking assisted housing and health, because the powerful coalitions within Congress decided that this was to be the limit of government action in this sector.

**Exogenous influences.** Combined with the impact of the civil rights movement on the American consciousness, the War in Vietnam was a major factor leading to a shift in federal policy development in the spheres of housing and health.

"By the late 1960s, the New Deal and Great Society political coalition had begun to unravel in response to urban riots, white flight, and suburbanization, and conflict over spending priorities between Vietnam and domestic matters" (Drier 1997, 10). One of the underlying causes of the civil unrest was the appalling condition in which low-income people of all races lived. Flanagan maintains that the "southern agrarian African-Americans who composed the great postwar migration to northern cities were poorer than the new suburbanites they replaced, and the white ethnic machines that held power did not know how to assimilate, and often refused to assimilate, the new migrants into politics and the local economy" (1997, 279). As in Canada, a greater focus on urban development during the 1950s exacerbated these problems by displacing a large number of urban poor from their neighborhoods (Feldman et al. 1971). Very few had affordable housing alternatives and often found themselves in even worse housing conditions than the ones they had left (Whiteis 1997). In spite of this, the amount of money that Congress was ready to approve for new housing initiatives was frequently far less than that which had been requested. Numerous arguments were put forward to justify this restraint. One was that "Members of Congress disliked taxing one person to pay another's rent"; another was that, at a time when Vietnam costs were mounting, it was indefensible to fund such a plan (*Cong. & Nat.*

1969, 183); and a third — highly significant in the ideological fabric of capitalistically oriented Americans who for decades had feared expansion of the "Red Menace" — was that it was a giveaway to socialism. This confluence of factors would greatly affect housing policy under the Johnson administration.

The situation in health was not noticeably better. In the years leading up to the outbreak of violence, provision of health services to the urban poor had declined. In good part, this was caused by the fact that previous governments had failed to introduce health insurance and because they had given ongoing support to "corporate medicine." Government support of private medical services facilitated the emergence of "unhealthy cities" because it gave little incentive for the development of local public health initiatives (Whiteis 1997, 227). Added to this, wartime spending exacerbated the situation, for it inhibited efforts to alleviate the plight of the poor, especially in decaying American city centers which suffered from a serious lack of adequate hospital facilities and related support services.

### **Summation**

Housing and health policy received considerable attention during this watershed period, and there were unprecedented opportunities for intersectoral linkage between the two areas. However, this failed to take place because of the greater negative impact of the determining factors.

The discussion above has shown that Johnson's War on Poverty was specifically designed to improve the lot of Americans who lived in substandard housing and had limited access to health care facilities, as well. Despite the earnest intentions of policy makers and their supporters to create and implement programs that would enhance the quality of life of many low-income Americans, for the most part their policy initiatives failed. What did emerge were large, complex federal institutions within which separate programs dedicated to health (nested in a broader social system) and housing developed in a fragmented and

incremental fashion. While the determining factors discussed above promoted opportunities for policy integration, they also produced constraints that obstructed the intended policy paths.

**Abetting factors.** With a large popular mandate for action, the Democrats made plans to bring their ideology into reality. Their primary focus, proclaimed under the banner of a War on Poverty, was to assist the needy in American society and to reduce existing social inequities. Part of their aim was to address the deficiencies related to the broader determinants of health, including housing.

The beginning of Johnson's tenure was an era of creative federalism during which intergovernmental cooperation promised to develop policies that would produce a better quality of life for many Americans, especially those who had been driven towards the periphery of society by the economic and political climate of the Eisenhower years.

As the Johnson years progressed, exogenous influences such as the Vietnam War, the anti-war protests, and the race riots that erupted throughout the country helped foster the opinion that, by so massively investing in overseas hostilities, the government was misdirecting its resources, thus depriving a substantial minority of citizens, mostly African-Americans who lived in blight-ridden urban centers, of sorely needed housing, health, and welfare services.

Federal institutions such as HEW and the newly created HUD had the potential to produce collaborative policies to provide aid which state and local governments could tailor to meet the needs of their citizens. Both institutions had knowledgeable bureaucracies responsible for making decisions, and these, in good measure, were supported by business and labor interests.

A number of influential reports highlighted the need for increased government intervention in social policy. Among these reports were those of the National Commission

on Urban Problems, which suggested that the quantity and quality of public housing should be linked with other services, including welfare and employment, and thus improve the quality of life of urban slum dwellers; and the report of Wilbur Cohen, which recommended to the House Ways and Means Committee that housing should be considered as an integral component of welfare.

The shift towards federal support for community development brought in a variety of state and societal actors who had largely been excluded from the decision making process before, and as a result, the scope of decision making itself was notably expanded.

The ideology and policy goals of the Democrats were sanctioned by a sufficient modification of the traditional anti-statist political culture to produce for the Party an overwhelming electoral victory in 1964. Because the policies inherited from the previous Republican government had, for the most part, neglected both social housing and health issues, the policy path open to the Johnson administration appeared to be relatively unencumbered by earlier choices which might have constrained the plans of the new government.

Although the policy path appeared to be relatively smooth, there were very different forces working within and outside of the federal system that would once again undermine the potential for the desired policy development, including linkage between housing and health. These will be examined briefly in the paragraphs below.

**Inhibiting factors.** The preferences of powerful actors reinforced many of the political rigidities that existed within the federal institutional structures. As a result, even with its large mandate from the electorate, Johnson's Democrats were able to introduce only a portion of their social policy strategies, and these remained, for the most part, fragmented. The following inhibiting factors contributed to this end.

Even though the ideology of the federal government, as revealed in the Democratic

Party's 1964 election platform, was popular among many of the voters because it was directed towards combating the manifold evils of poverty, it was not strongly supported in Congress. In addition, some state and local governments did not, or were unable to, work in concert with Johnson's aims.

With the War on Poverty, the federal government entered into realms that had previously been within the jurisdiction of the states. Although this shift was supported by some congressional factions and subgovernments, strong opposition emanated from powerful conservative Democrats and Republicans in Congress. In addition, resistance arose in state and local governments which expressed an ideological unwillingness or financial inability to participate.

Despite the racial and economic inequities that existed primarily in urban centers, the government was unable to devote enough resources to resolving America's multifaceted domestic social problems. In large part, the government was compromised by the financial drain of the Vietnam War, the most important exogenous factor of the period.

Johnson's policy goals were further undermined because the federal institutions created to alleviate the core problems failed to establish functional links among themselves. The fact that the administrative capacities of the federal bureaucrats in HUD and HEW were restricted to implementing specific department goals worked as a major inhibitor of collaboration. Circumstances such as these were instrumental in precluding policy linkage between assisted housing and health.

During this watershed period, the government received considerable input from consumer advocates that defined America's complex social problems in a manner consonant with that of the Great Society vision. However, coalitions that had influenced decision making by creating barriers to the introduction of bold policy initiatives in the mid-1940s succeeded again in the late 1960s. Powerful societal actors, such as physicians, builders, and financial organizations whose political interests and perception of the problem

were antagonistic to government intrusion in *private* matters, opposed social policy change and continued to support the interests of strategically positioned conservative members of Congress. Alliances like these succeeded in keeping both housing and health legislation to a minimum, and even the Acts that were passed did so only once the financial interests of the pro-business coalitions were protected. Thus, in housing, developers benefited by acquiring favorable government building loans, and in health, physicians gained by receiving substantial payments from the government as well as from private insurance companies.

Because of the shift in political culture outlined above and the dearth of inherited legislation from the Eisenhower years, these two factors were not significant inhibitors of policy development during the late 1960s.

When assessing the influence of the variables, we find that the preferences of powerful actors reinforced many of the political rigidities that existed within the federal system and institutional structures. These, coupled with the exigencies of the Vietnam War, had an major impact on policy development in public housing and health. As a result, even with popular support for Johnson's ideology and backing from liberal analysts of the problem, the Administration was able to introduce only a portion of its social policy strategies, and these remained, for the most part, fragmented.

## CHAPTER 6

### THE LATE 1970s

In contrast to the expansion of federal government activity that had characterized the mid-1960s, during this watershed period the provision, financing, and regulation of social policy were substantially altered in both Canada and the US because changes in the domestic and international environments provoked a marked shift to economic austerity. It was an era of uneven social policy development when the scope of some publicly funded programs was broadened and other programs were redefined and restructured. The relationships between state and societal institutions in each nation underwent considerable change as the economic upheavals of the previous years took their toll on the federal government's capacity to provide support to needy citizens.

The policy paths that were taken by each government continued to reflect the dynamic relations that had developed between the institutions and actors that sought to influence policy choice within the federal system. In housing, Canada and the US followed a similar policy path: although public housing programs were maintained, there was a shift towards greater private and third sector involvement in the provision of shelter. In health, however, they moved in divergent directions: Canada reinforced its commitment to a national healthcare system, while the US relied increasingly on the private sector for health insurance.

#### **Canada**

By the early 1970s, the federal government had already established a strong presence in a number of social policy areas that were constitutionally in the provincial domain (Tuohy 1992). It had accomplished this through intergovernmental agreements

resulting in direct payments, loans, subsidies, and cost-shared programs, as well as through the use of its spending power in areas of provincial jurisdiction (Streich 1985). Such interventions were fiscally possible because Canada, like other western industrialized nations, had enjoyed an extended period of economic growth and prosperity after World War II. Later in the 1970s, however, the economic picture changed dramatically and "the long post-war period of almost uninterrupted growth came to a halt. Wages grew faster than productivity, and other factors, such as oil price shocks and increased international competition from newly industrialized countries, helped to cause stagflation (inflation without growth)" (Muszynski 1995, 296).

Canada's federal and provincial governments responded to the economic upheaval by introducing conservative monetary strategies whose aim was to control costs, rein in public expenditures, and prevent further inflation. These efforts led to significant cuts in social programs at all levels of government and stimulated vigorous debates about the role and responsibilities of government in society. The housing and health policy fields were directly affected by these changes.

In housing, the government introduced a variety of measures designed to stem costs. Among them were rent controls, tax incentives, and subsidy programs to promote construction (Anderson 1992). The government sought effective ways of controlling spiraling expenses in health, as well. To this end, it introduced Established Programs Financing (EPF) (Smith 1995). In doing so, however, it found that its control over the way in which the provincial governments allocated these funds declined (Boase 1998).

While the late 1960s had offered a potential for linkage between assisted housing and health policy, both exogenous and endogenous pressures in the 1970s forced a dramatic shift in policy direction. This shift affected all public and private institutions in these policy spheres and had long-lasting constraining effects on the potential for future policy integration.

### **The determining factors**

**Federalism.** During this period, the federal government embarked on a series of highly complex intergovernmental negotiations dedicated to constitutional renewal. The serious differences between the two levels of government that had begun to appear in the 1960s (Rocher and Smith 1995, 9-10) now intensified. The federal government faced two distinct and simultaneous pressures: namely, "growing western alienation and increasing support for separatism in Quebec" (Stein 1989, 20). Although it is not within the scope of this paper to examine this problem in detail, Simeon and Robinson provide us with a sense of its magnitude: "The developing crisis of the role of the state in the early 1970s translated into a crisis of federalism. The growth of government had already multiplied the potential for intergovernmental contradiction, duplication, and mutual frustration" (1990, 127).

Intergovernmental tensions were exacerbated by various financial arrangements for funding assisted housing, health, and other social policies (see below). Furthermore, the efforts of the federal and provincial governments to alter their policy paths in response to the pressures placed upon them led to "blame avoidance" strategies (Pierson 1995). As Stevenson puts it, "Federalism makes it convenient and easy to blame the other level of government [as each] seeks to attribute the financial responsibility for social policy to the other level" (1985, 172).

The social policies that had been developed through intergovernmental negotiations and institutional change during the previous decades now faced a fiscal crisis. The federal and provincial governments were forced to reexamine their roles and responsibilities as well as the types and scope of their social policy interventions. The cooperative federalism of earlier decades was now fully replaced by executive federalism, which had begun in the late 1960s and which permitted senior elected officials to become more directly involved in the decision making process (Streich 1985).

As the federal government's financial capacity for social policy expansion declined,

not only did questions concerning governance focus on which level of government was now responsible for the array of Canada's social programs, but on how inflation and government spending could be contained. For example, voluntary wage and price controls were introduced, unemployment insurance payments curtailed, and plans for further income supplements canceled (Muszynski 1995). The federal government under Trudeau was also anxious to have greater control over the size of the federal transfers to the provincial governments. It achieved its goal in part by introducing Established Programs Financing, a new block funding mechanism for health and post-secondary education (Taylor 1987). EPF involved cash transfers — calculated by the growth of the GDP, the provinces' population, and by an escalator formula — and tax point components (Trudeau 1977). By introducing this complex mechanism, the federal government was able to gain greater control over its share of health and education spending and to discontinue the open-ended system which had been "determined on the basis of the provinces' own expenditures on health and education" (Boase 1998). Moves such as this help confirm the accuracy of Simeon's assertion that during this watershed period, Canada "had two levels of aggressive governments, often pursuing competing goals, and seeking greater control over the whole range of contemporary policy instruments" (Simeon 1986, 20).

**Central government institutions.** Federal policy had undergone profound changes since the previous watershed period, and these changes were reflected in the institutional structure responsible for the design and implementation of housing policy. In keeping with the main recommendations of the Hellyer Report (1969), the Ministry of State for Urban Affairs (MSUA) was inaugurated in 1971. The MSUA's mandate concerned all aspects of urban development, including tri-lateral meetings with provincial and municipal governments. However, CMHC remained as a federal Crown Corporation and, though organizationally subordinate to the MSUA, retained responsibility for social housing policy

(Federal-Provincial Relations Office 1977).

During the early part of the decade, the primary goal of social housing was to produce new homes for low-income, elderly, and/or handicapped Canadians. However, as the decade progressed:

New factors increasingly intruded, like the level of unemployment, interest rates, and the energy crisis. Housing construction was seen increasingly as an important cylinder in the national engine of growth, and perhaps less as a national human commitment. In other words, housing policy tended to develop in an economic rather than in a social context (Anderson 1992, 37).

As a result, the government's emphasis, as recommended in the Hellyer Report, shifted towards the construction of housing for middle-income earners as well as for the disadvantaged (CMHC 1977). The result was the production of a large number of high-rise complexes. These complexes, while providing subsidies and tax incentives that appealed to builders of cooperatives, to non-profit agencies, and to upper income Canadians (Hulchanski and Grieve 1984), did little to meet the functional requirements of those truly in need.

By the end of the decade, the MSUA was dismantled. In part, this was due to criticisms about the "apparently parallel work in the CMHC and in the Ministry" (Anderson 1992, 36) and to problems within the institution itself. Rose remarks that it "was not at all clear that the Ministry of State for Urban Affairs and the CMHC were at one with each other as policy agency and implementation agency respectively" (1980, 63). And, as Anderson, a former president of CMHC observed, the multifaceted pressures on the federal housing institution were affected "by subtler offensives by the Ottawa bureaucracy which would happily live without co-ordinating ministries" (1992, 3).

With the demise of the MSUA, the CMHC — now with grants and subsidies for social housing in excess of \$212 million (CMHC 1977) and called the *Canadian* Mortgage and Housing Corporation rather than the *Central* Mortgage and Housing Corporation — continued its control of federal housing policy. This time, however, CMHC, though working under the aegis of the Department of Regional and Economic Expansion, was

largely independent of central agency scrutiny (Streich 1986) and focused its funding on middle-income people as well as the disadvantaged. In addition to these organizational and funding changes, Ottawa indicated that "while the federal government may act to stimulate and supplement the market for house building, it should not assume direct responsibilities which are constitutionally allocated to other governments, or which could effectively be borne by private enterprise" (Federal-Provincial Relations Office 1981, 172-173).

During this period, several important changes also occurred to the funding arrangements for both health and social support. Since the mid-1970s, the federal government had sought ways to control the "fifty cent dollars" that the provinces had been spending on hospital and health services under previous cost-shared agreements. As a solution to this problem, in 1977 it negotiated a fiscal arrangement whereby payments for hospital and health insurance and post secondary education were merged into a block grant which was calculated on a per capita basis and linked to the GDP. As indicated above, Established Programs Financing contained a cash component and a tax credit component (National Health and Welfare 1978). Hobson notes that the "genius" of EPF was that it created a decentralizing thrust, provided the provinces with cash and tax credits, and rectified some of the disparities between the provinces by placing them on an "equal footing with Quebec (which had secured additional tax room for itself under earlier opting-out provisions)," and ensured a greater degree of federal control over costs (1995, 185).

Changes to CAP were an important part of the reorientation in funding. CAP now assumed responsibility for "extended health care services," which were now broadened to include nursing homes and other special residences for adults who were unable to care for themselves in their own homes. In the 1978-79 fiscal year, these additional payments were estimated to be \$520 million (National Health and Welfare 1979). During the 1979-80 fiscal year, the combined cash payments and the value of the tax points of the Hospital Insurance Program and the Medical Care Program amounted to over \$5,888 million

(Federal-Provincial Relations Office 1981).

With these changes, CMHC and NH&W continued to offer separate and sometimes overlapping programs, instead of linking their activities and providing coordinated services. This institutional separation did not reflect the coordinated approach to the health of Canadians proposed in the Lalonde Report. Lalonde's intention was that the Government of Canada "give human biology, the environment and lifestyle as much attention as it has to the financing of the health care organization" (1974, 6). Thus with organizational changes in housing and significant shifts in the programs under the purview of both institutions, the potential for greater linkage became more limited.

**Inherited policy.** By this watershed period, the national economic picture had changed markedly and, in many instances, the policies of the past did not meet the needs of the time (Hulchanski and Grieve 1984). As both the federal and provincial governments increasingly turned their attention to solving Canada's fiscal problems, they began to reexamine their housing and health programs in earnest.

As we have seen, in the late 1960s the federal government embarked on a number of assisted housing and urban renewal initiatives in concert with the private and third sectors. These initiatives were in keeping with recommendations made principally by Hellyer. The amendments to the National Housing Act in 1973 reflected this change in policy direction by providing funding for rent supplements and neighborhood improvement as well as tax incentives for non-profit and cooperative housing ventures. Rent supplements allowed people to find accommodation in the private sector, with the government paying the difference between the market rent and a percentage of the renter's income. Funds for urban improvement through housing rehabilitation encouraged the continued use of existing dwellings. And legislation concerning non-profit and cooperative housing insured that low-income people would be lodged in the same neighborhoods as

middle-income earners. This policy shift hastened the move away from construction of large public housing complexes (CMHC 1990) and encouraged non-profit and cooperative housing (Rose 1980). These changes in policy, however, did not impede CMHC's ability to avoid close scrutiny from central government agencies (Streich 1985).

In health, the focus of the Department of National Health and Welfare remained on implementing the programs which had been introduced in the 1960s (Federal-Provincial Relations Office 1977). However, during this watershed period, primarily for economic reasons, the federal government decided to change the funding mechanisms for the Hospital Insurance Program and the Medical Care Program (Federal-Provincial Relations Office 1981) by introducing Established Programs Financing. This new funding formula, "represented an end of the commitment to an expanding welfare state" (Simeon and Robinson 1990, 288) and highlighted the growing role of the Department of Finance in controlling future healthcare costs (O'Neill 1997, 174).

These broad changes to the policy path were triggered primarily by factors other than the impact of already existing policies. Therefore, inherited policy played a relatively minor role in the policy choices that were made during this watershed period.

**Political culture.** Mishra maintains that adherence to the Keynes and Beveridge philosophies during the postwar era rested on the assumption that the state and the market would both contribute to the overall well-being of society. This view was supported by a majority of Canadians, who believed that the "welfare state was to be an integrative measure that would make liberal capitalism more productive economically and more just socially." The stagflation of the 1970s, however, undermined such assumptions (1990, 84).

Although the postwar political culture that supported social benefits for the poor, elderly, and handicapped continued into the 1970s, the unfavorable economic climate

caused Canadians to question the desirability of large scale state funding of aid programs. The tensions that emerged as a result of this shift in attitude forced all levels to reevaluate their social policy goals, procedures, and instruments although, as Lipset maintains, polls taken in 1978 continued to show that Canadians still had a "greater propensity to favor a strong role for government" (1990, 142).

**Ideology.** In 1968, Trudeau had led the Liberal party to a parliamentary majority. In 1972, however, he managed to win only a minority victory. Trudeau, with his belief in a centralized decision making process within the federal government, aimed at overcoming some of the nation's financial problems by reviewing the manner in which federal funds were being spent by Ottawa and the provinces. Because it made social programming "increasingly subservient to fiscal planning" (O'Neill 1997, 174), this affected all aspects of social policy.

As far as the Liberal's approach to housing policy was concerned, the "increased pressures for restraint emanating from Finance and the business community" (Haddow 1990, 225), made housing an important part of Canada's economy, and every effort was made to promote building and home ownership. Mishra contends, however, that as the government increasingly provided tax incentives and subsidies for housing construction and purchase instead of allocating funds for social housing programs, it was halting "the country's progress towards a comprehensive housing policy" (1990, 107).

In contrast, national health insurance was recognized as a popular and important program, but one whose costs needed to be controlled through alternative financial mechanisms. But, as Boase (1998) has noted, even with this emphasis on cost control, the EPF arrangements provided the provinces with greater options for allocation of the federal funds. In essence, this strategy recognized Trudeau's desire for centralized decision making; at the same time, it acknowledged areas of provincial jurisdiction (Private

communication from Boase 2000).

Whether the Liberals held a majority of seats in Parliament, as they did during the first Trudeau administration, or a minority, as they did during the second, they still had to overcome strong opposition to their policy paths. Not only did the NDP in Parliament put pressure on them, but the provincial governments were particularly vociferous in their objections to federal retrenchment, because it would mean that they would have to absorb more of the costs of the programs (Haddow 1990). That combined opposition, however, was not strong enough to deter the Liberals from following the cost-cutting policy direction that they had chosen.

**Definition of the problem.** The primary concern of social policy in the late 1960s and early 1970s had been the well-being of the poor, and a considerable part of federal action which developed during those decades had been geared towards meeting the needs of that population. By the late 1970s, however, the groups which had previously fitted this description had enlarged considerably. Numerous documents and reports dealt with the social policy problems caused by this change and prescribed solutions for them.

In housing, two reports which were published in the early seventies deserve mention: the Lithwick Report (1970) and the Dennis and Fish Report (1972). These were presented by individuals who had worked with the federal government during the days of housing policy change inspired by the Hellyer Report, and reemphasized the need for a radical review of federal housing policy. Lithwick declared that the neglect of public housing within the broader picture of urban development had exacerbated the social ills that existed in many urban centers. For its part, the Dennis and Fish Report urged greater federal linkages with the private and third sectors, as well as an increased use of shelter subsidies as a policy instrument to ameliorate the situation. However, as the seventies progressed, the government began to direct more attention to economic issues and less to

social ones. This shift in direction is reflected, for example, in the federal budget of 1975, where the government announced plans to increase CMHC loans to assist private and non-profit organizations (Budget Speech 1975). As explained in CMHC's 1977 Annual Report, these "policy changes have shifted the emphasis away from the public housing programs ... and have strengthened those programs such as non-profit and cooperative housing which are privately financed and which help people to help themselves" (1977, 12).

In health, the most important document of the 1970s was Lalonde's *A New Perspective on the Health of Canadians* (1974). As stated in Chapter 1, what must be emphasized is that the main short-term impact of the Lalonde Report did not stem from its advice about disease prevention and health promotion, but from its recommendation that there be "a reorganization of the health-care delivery system and a shift in funding priorities from hospital and medical services to primary and ambulatory services" (Gray 1991, 109). Despite the importance of this and other reports, changes came slowly to the health system. In good part, this was due to the resistance of established groups who were extremely reluctant to accept changes in the status quo.

**Decision making.** Although the period of cooperative federalism that had existed during the previous decade ended in the mid-1970s (Boase 1998), elected and bureaucratic representatives from federal and provincial governments continued to meet on a regular basis. Nevertheless, changes to budget arrangements for housing, health, and other social policies were made primarily at the federal level. However, even when confined to this level significant changes took place. Housing and health offer good examples. In housing, during the early years of CMHC, bureaucrats such as Carver and Clark had been prominent in directing the course of policy development. In the 1970s, on the other hand, largely because of Trudeau's insistence on greater centralized control, the high-profile role in decision making was played by the Ministers responsible for housing (Robert Andras, Ron

Basford, and André Ouellet). In the Department of Health and Welfare, two Ministers in particular, Marc Lalonde and Monique Bégin, stand out for undertaking bold policy initiatives.

In response to these moves towards executive federalism, leaders of the provincial governments complained about Ottawa's "illegitimate 'intrusions'" into provincial areas of jurisdiction (Simeon and Robinson 1990, 286). Provincial reports such as *The Western Premiers' Task Force on Constitutional Trends of 1977* are illustrative of these complaints against the federal government for using its spending power to encroach on constitutionally defined provincial policy domains. What the provinces called for was greater collaborative decision making, especially in matters related to taxation and the allocation of the revenues derived from them.

Economic stress and intergovernmental tension also led to changes in the access which societal actors had to the decision making process (Haddow 1990). The realities of the 1970s constrained the opportunities that many influential actors had traditionally enjoyed and gave new opportunities to others. In housing, for example, in order to stimulate the building industry that was being hard hit by economic conditions and to encourage greater participation by third sector groups willing to embark on community initiatives, the federal government "expansively subsidized nonprofit societies and tenant co-operatives." The intent was to create a "large, publicly subsidized rental housing stock that would assure high-quality, low-rent accommodation to all modest-income Canadians" (Fallis et al. 1995, x-xi) and to involve the housing consumers in the process. At the same time, the provinces had established their own housing agencies which enabled private and third sector groups to launch local housing initiatives.

In health, changes to the funding formulas caused problems for both state and societal actors. Since the provinces now became more responsible for the allocation of funds, they began to use the poor economic conditions as "either a reason or an excuse for

parsimonious approaches to health, education, and social services," and the doctors either tended to "withdraw from the program or to collect extra fees from their patients on top of what they received in payments from the provincial government" (Stevenson 1985, 169).

In short, with the decision making process limited primarily to the top elected officials in the federal government and with funding reallocated, the dynamics of decision making essentially changed during this watershed period, as did the relationships between the levels of government and the societal actors. These new circumstances ensured that housing and health would remain on separate and diverging policy paths.

**Exogenous influences.** The global economic turbulence of the 1970s affected all aspects of Canadian life. In addition to obliging the federal government to impose spending cutbacks, wage and price controls, and other anti-inflation strategies, it triggered the start of a radical restructuring of Canada's welfare system and promoted a redefinition of the role of the state in the provision of social policy. Mishra holds that the "Keynes-Beveridge package of welfare implied that state policies would sustain both economic well-being (full employment and economic growth) and social welfare. As the economic side of the equation lost its credibility, the social side of the equation became increasingly vulnerable" (1990, 87).

Despite the fact that both federal and provincial levels of government had played an increasing part in the design and delivery of social programs since the end of World War II, it was within the federal government's realm of responsibility to take steps to stabilize the national economy (Campbell 1995). These actions constrained social policy development and substantially altered the power relationships that had been established between state and societal actors in the preceding years.

In conclusion it should be noted that even in the face of the exogenous influences described above, actual implementation of plans for dramatic policy change did not occur

quickly. In good measure, this was because of the inherent institutional inertia and political rigidities that exist in federal systems (Pierson 1995). As Maioni puts it, "just as the development of the welfare state in Canada had been incremental, so too were attempts at retrenching social programs [because] welfare state retrenchment is shaped by institutional factors . . . that brake efforts at radical change" (1997b, 181).

### **Summation**

The above discussion demonstrates that the emphasis on social policy development that had dominated the previous watershed period had all but disappeared by the end of the 1970s. There was a notable shift of policy focus away from state responsibility for the provision of public housing and towards greater federal control over health and social spending. The period signaled a clearly divergent trend between housing and health, and also a greater separation between health and other social policy programs. Thus, during this watershed period, the potential for linkage between the two policy fields declined.

An examination of the determining factors within the context of the neo-institutional framework confirms that during this era, the state institutions responsible for social policy underwent structural and procedural changes in response to dynamic pressures created by both endogenous and exogenous factors. These included pressures from the socioeconomic and political environments, the influences that shaped the preferences, goals, and strategies of state and societal actors, the salience and power of those actors, as well as the altered relationships that developed among them. When these variables are analyzed within the neo-institutional framework, they reveal that policies produced by state institutions are not always path dependent, but that when different environmental conditions come into play, seemingly predictable policy direction can be changed and unanticipated outcomes can emerge.

**Abetting factors.** Because it had the administrative capacity and, in some measure, the fiscal resources, the federal government was able to maintain an active role in social policy development. Nevertheless, pressure from the provincial governments forced it to reexamine the manner in which its programs, especially in housing and health, were being funded and delivered.

Central government institutions such as CMHC and NH&W had undergone structural and program changes since the late 1960s and became firmly embedded as integral components of the state. CMHC had remained a Crown corporation after the demise of MSUA, and preserved its responsibility for designing social housing programs. For its part, NH&W continued to oversee national health standards, but after the introduction of EPF, with a greater emphasis on fiscal control.

Exogenous influences such as problems with the economy at home and abroad constrained existing programs in both housing and health, and forced the federal government to change its policy path. In housing, it now considered the needs of middle-income earners as well as those of the disadvantaged who had been the primary beneficiaries in the past. In health, after consultation with the provinces, it introduced EPF. This lessened the fiscal strain on the government and gave the provinces more leeway to allocate available funds.

Despite the emphasis on cost control, Trudeau's government maintained a focus on social policy as a result of pressure from the NDP. In housing, while not entirely turning away from existing programs, the federal government provided tax subsidies for private and non-profit building. And by centralizing decision making, it increased the potential for integrating the development of social policy on the federal level.

Reports on housing that had been published prior to and during this period affirmed that urban problems were multifaceted and that, to solve them, it was necessary for government to focus more broadly on the causes of urban ills. In health, a broader

approach was also advocated. Lalonde, for example, specifically recommended that disease prevention and health promotion should become an integral component of public policy.

Because of the centralized decision making process favored by Trudeau, there was greater opportunity for collaboration among Cabinet members on social policy issues. There was also an increased number of policy communities many of which had not sought government aid in the past. These suggested additional policy options such as the subsidization of cooperatives and non-profit ventures in housing which would serve people such as the elderly and handicapped who needed both shelter and healthcare.

Even with the mounting pressures on the federal government to redirect many of its social policies, there was an ongoing belief that government had an important role to play in dealing with societal problems. Other less dominant factors also supported the continuance of government involvement in the provision of social programs. Among these were the numbers of previously latent and new societal groups that expressed a commitment to social equity.

The inability of some policies that had been inherited from the previous administrations to meet the challenges of this watershed period triggered the establishment of new policy paths. Innovative strategies in housing and health had to be created to respond to current needs. Not only did they produce substantive changes in addressing the housing requirements of a broader spectrum of the population, but also fiscal changes in funding health programs that were already in existence.

**Inhibiting factors.** During the 1970s, social policy had become both a fiscal and a constitutional issue, and even the most powerful actors that had influenced policy development in the past were restrained by the economic and political realities that demanded major alterations. Although compelling forces supported increased government intervention in social policy and promoted the concept of greater intersectoral linkages in

fields such as housing and health, the combined impact of other factors inhibited marked expansions of federal activity in this area.

In spite of the fact that the provinces, especially Quebec, demanded greater autonomy over their constitutionally allocated areas of responsibility, Ottawa continued to hold the dominant role in social policy development. However the cuts in spending provoked by the economic conditions of the time increased intergovernmental tensions as each level of government blamed the other for withdrawal from social programming.

As institutions, both CMHC and NH&W followed similar paths. In housing, CMHC developed programs that treated shelter mainly as an economic issue and thus inhibited expansion of its social programs. In health, NH&W introduced a funding system designed to contain costs. In the process, however, the government lost some of its control over the way in which federal health monies were allocated. Furthermore, these changes did not lessen the functional independence of the institutions responsible for assisted housing and health.

The economic imperatives caused by global events and the inflation that accompanied them had forced the federal and provincial governments to embark on a series of austerity measures designed to drastically reduce their expenditures.

Under Trudeau, social programming became subservient to fiscal planning. This affected all aspects of social policy. In housing, the Liberals inhibited development of a comprehensive housing policy by promoting strategies that encouraged building and home ownership. In health, by changing the funding mechanism, they limited the extent to which the provinces could spend federal money.

During this watershed period, enhancement of the direction of social policy was not significantly inhibited by the way Canada's problems were defined. What compromised proposals to expand social policy initiatives and link policy fields were the economic constraints on government action.

As a result of the centralized decision making process and the government's focus on the economics of social policy, tensions increased among the political actors, including the bureaucrats at both the federal and provincial levels. In addition, the consumers and providers of the various public housing and health programs remained relatively ineffective in their capacity to effect policy change.

The late 1970s also underscored a less prominent element in Canada's political culture. Even though many people supported the idea that government had an important part to play in helping the needy, there was a change in the concept of who was needy as the challenges that faced the poor spread upward to middle-income groups. This inhibited an expansion of aid to the lowest levels of society.

During this watershed period, the policies inherited from previous administrations were substantially altered as the government's focus on social development was replaced by an emphasis on fiscal restraint. As a consequence, the federal government undertook several top-down initiatives primarily designed to cut costs.

### **The United States**

During this watershed period, the multifaceted economic effects of inflation increased demands from societal groups for US government assistance. However, the growing societal tendency to reject massive government intervention in favor of more conservative policy initiatives obstructed the potential for success of any federal effort to solve the problems of housing, health, and social welfare in a concerted manner.

Despite the fact that New Deal and Great Society ideas had remained popular for many in the US, there had been limited political support in Congress to continue with these policies. As a result, many of Johnson's attempts to expand welfare failed. Indeed, Weir et al. claim that by the 1970s, "many social policy reforms of the 1960s soon backfired to disturb rather than reinforce Democratic coalitions. National politics underwent a sea

change" (1988, 26).

Resurgence of the conservative approach to government was given a boost during the early 1970s when increased business regulations and economic problems led growing numbers of people to believe that New Deal liberalism had not succeeded. Breckenridge states that the "reaction was fueled by the economic difficulties of the 1970s and the consequent loss of confidence in Keynesian techniques for managing the economy. Political conservatives turned to the alternative theories of Austrian economist Friedrich von Hayek and of University of Chicago economist Milton Friedman, both strong advocates of a return to *laissez-faire*" (1998, 53).

Although the Democrats had won a significant electoral victory, the complexity of existing institutional arrangements, the self-protectiveness of bureaucratic agencies and departments, and the preference of congressional decision makers to reform policy incrementally ensured that any window of opportunity for linkage between housing and health policy that might present itself during this watershed period would not be opened. Indeed, as will be discussed below, President Carter's attempts to reform many of the existing social programs met with failure.

### **The determining factors**

**Federalism.** Kincaid contends that the cooperative federalism that had been in evidence until the late 1960s had gradually evolved into one of "coercive federalism" during the 1970s when the federal government held "unilateral authority over more facets of state and local authority than ever" (1994, 25). The federal government's power, which had grown substantially during the War on Poverty, was challenged by Johnson's successor, Republican President Nixon, who was elected in 1968. Nixon believed that central government dominance in policy making should be reexamined and that strategies should be developed for promoting greater government efficiency and accountability. This belief

led to a "commitment to limiting the scope of government, while reducing the amount of money allocated by the federal government" (Rich and White 1996, 14). Among the strategies that were proposed was the creation of new block funding and revenue sharing mechanisms for most of the existing social programs. Although these fiscal instruments permitted greater state control over the expenditure of funds, they also led to a greater reliance of the states on the federal government for aid. As Elazar puts it, "Nixon's implicit theory was that the White House should decide what the federal government would do and what would be left to the states and localities based on what was politically helpful or potentially harmful to the president" (1994,139).

During Carter's tenure, new economic pressures were placed on all levels of government. Weir et al. note, however, that "the configuration of social and economic policies that grew out of the New Deal and the Great Society proved ill-suited to cope with the human problems of an American economy troubled by recession, inflation, and industrial dislocations." Many people believed that federal government dominance was the cause of "America's malaise" (1988, 434). Despite this perception, the federal government continued to exert control over the other levels of government and, with ever greater deficits, federalism was still seen to be coercive (Kincaid 1994).

**Central government institutions.** In the aftermath of the Watergate scandals and revelations about government waste and incompetence,<sup>1</sup> public faith in the federal government was severely undermined and a concerted effort was made to prevent similar problems from occurring in the future. Congressional reforms not only changed the power structures within the institutions of Congress, but made the passage of laws even more complicated during Carter's presidency. As Boase notes, for example, the Ways and Means Committee was expanded, thus making it harder to achieve consensus; assignment of health policy reform was divided among four congressional subcommittees, thereby

giving a larger number of legislators an opportunity for input; and "[t]he further fragmented institutional structure encouraged more fragmented input from societal interests, as every major medical lobby group resisted Carter's plan, and individual legislators were pressured by the many more stakeholders in the system" (1996a, 300).

Because the complexity of the legislative process increased to the point where reaching agreement became even more difficult than before (Steinmo and Watts 1995), the fragmented nature of the presidential-congressional system seriously obstructed Carter's plans to introduce social policy reform. This was especially true in the House of Representatives where many of "the long-serving committee 'barons'" were forced to relinquish their hold on the policy process and where the new rules generally offered greater opportunities for "a much more individualistic, entrepreneurial spirit among members" (Breckenridge 1998, 143). These organizational and procedural changes further fragmented the policy process and also affected the manner in which central government institutions directed the policy path. This was particularly the case in housing and health, which, by the watershed period of the late 1970s, were undergoing considerable stress.

From an organizational perspective, HUD's roles and responsibilities did not undergo major structural changes in the 1970s. However, fiscal pressure on it increased markedly throughout the decade, and by 1977, HUD's budget for public housing and associated grants and subsidies rose to \$38 billion (*CQ Almanac* 1977). This dramatic escalation from the previous watershed period occurred because the economic downturn of the early seventies had forced growing numbers of people to lose their homes and then look to government for assistance with accommodation.

In order to rein in unnecessary costs and thus reduce the stress on HUD's already strained budget, the Carter administration made a series of proposals designed to change public housing programs. For example, in 1977, the Office of Management and Budget suggested that it would be more cost-effective to end housing subsidies for the poor and to

provide housing support in the form of additional welfare payments. It was anticipated that the savings would amount to over \$500 million. However, the outcry from public housing providers and consumers alike was so great — the argument being that "housing subsidies play an important role in revitalizing urban areas and that more poor persons would live in substandard housing if they did not exist" (*CQ Almanac* 1977, 477) — that the plan was deferred.

The Carter administration also placed great emphasis on social policy. Its aim was to streamline a number of areas, including services in institutions and the community for elderly and handicapped persons. For the most part it failed to reach its goal, however (*CQ Almanac* 1977). The efforts it made in HEW illustrate this point.

As health and welfare costs soared, with medical expenditures growing at twice the rate of inflation, organizational and policy changes were made in an attempt to control finances. For example, in 1977, the Health Care Financing Administration (HCFA) was established to oversee Medicare and Medicaid (HHS 1998), and responsibility for other assistance programs was assigned to the Social Security Administration (*CQ Almanac* 1977, 1978). HEW's budget for 1978 was set at \$42,886,472,000 (*CQ Almanac* 1977). Two years later, with the establishment of a separate Department of Education, HEW became the Department of Health and Human Services (US. Government Manual 1986).

Institutional changes such as these were part of a strategy to introduce a national health plan, reduce fraud in the system, and reign in excessive and unnecessary health costs in both the public and private sectors. However, many of the administration's efforts were thwarted as a result of a national shift to a more conservative economic philosophy, of widespread demands for budgetary austerity, and of the massive institutional complexity within HUD and HEW, which by this time had developed into enormously powerful institutions in which an elaborate series of expensive programs had evolved and become embedded.

**Inherited policy.** President Nixon had inherited policies from the Great Society years, but worked to alter the social policy path that had been set by the Johnson administration (Breckenridge 1998). Nixon's attempts to decentralize social policy at the beginning of the 1970s affected the process and the funding mechanisms of housing and health policy design and implementation. Even though there has been debate about the success of these efforts, with some claiming that there was a "myth of decentralization" (Reagan and Salzone 1981), legislation inherited from the Nixon and Ford administrations severely curtailed Carter's ability to introduce any significant reforms to housing and health.

Two housing initiatives inherited by Carter are especially noteworthy: the 1972 Community Development Block Grants (CDBG) and Section 8 of the 1974 Housing and Community Development Act (HCDA). Nixon introduced CDBGs as mechanisms to control federal housing costs. Peterson et al. state that these "consolidated many of the specifically urban programs of the federal government, had strong support among mayors, who wanted control over the many new programs, and new community organizations that the Great Society initiatives had spawned" (1986, 4). Two years later, the block grants were made part of the Housing and Community Development Act. Originally, the belief was that "fragmented welfare programs were not only inefficient but far more difficult to control budgetarily" and that this was a way of establishing a ceiling for federal expenditures on social programs (Peterson et al. 1986). Once the grants were in place, however, the way in which the CDBG funds were being allocated came under severe criticism. One report indicated that "cities did not concentrate their funding and that they spread their assistance throughout their communities, reducing the possibility for any significant long-term effect." In 1978, during the Carter presidency, the reality of these charges led HUD to refine the system and gain greater control over allocations by directing cities to target their resources in "strategy areas in which programs could be administered in a concentrated and

coordinated manner" (Hershey 1983, 144).

The Carter administration also inherited the HCDA's Section 8 certificate program. This initiative, a "deep subsidy, private supply-side initiative" (Keyes 1990, 175), was introduced in 1973 and incorporated into the Housing and Community Development Act in 1974. Low-income people could rent accommodation in the "existing private rental market. The government would then provide certificates to pay the difference between 30 per cent of a household's income and the market rate" (Linneman and Megbolugbe 1994, 644). However, charges of "outright fraud" during the Nixon years in public housing programs prompted warnings about the future costs of federal housing initiatives. In view of this, a moratorium on the production of new public housing units was called in 1973 (Doan 1997, 96), and Washington sought alternative strategies to provide assistance to people who qualified for government-funded assistance.

Carter expanded a rent subsidy program which was "a modified form of housing allowance" for consumers (Heidenheimer et al. 1990, 125) and which avoided the certificate problems of Section 8 by giving vouchers for accommodation directly to the consumer. With housing vouchers, recipients had greater choices in selecting accommodation and could spend "as much as they want for housing by supplementing the voucher with their own funds" (Linneman and Megbolugbe 1994, 645). According to Keyes, this was "the first federal demand-side subsidy to low-income tenants in private housing" and came in response to contentions by researchers "that the 'housing problem' was an affordability issue and as such could be better handled by demand-side efforts than by supply-side subsidies to private housing developers" (1990, 175).

Another important aspect of the voucher system was related to HUD's stipulations concerning the quality of the accommodation that could be offered to tenants. Although building codes were already in effect under local and state jurisdictions, the private sector landlords were now required to adhere to a specific set of housing quality standards (HUD

1998b). This shift from public funding for construction to private provision with public funding substantially reoriented the housing program and promoted greater linkages with the private sector (Linneman and Megbolugbe 1994).

Since the CDBGs had been very expensive, had been ineffectively spent, and had been associated with fraud (Doan 1997), and the Section 8 system was also deemed to be too expensive and inefficient in its direction, Carter attempted to deal with some of these problems of inherited policy by including housing assistance in his proposed welfare reforms (*CQ Almanac* 1977, 1978). This was one of the few efforts since the Great Society to effect linkage between housing assistance and another essential federal social policy area. But, with growing public demands for tax cuts and an emerging neo-conservative opposition to government intervention during Carter's tenure, his proposals failed (*CQ Almanac* 1978). Thus housing, health, and welfare still remained separate policy issues (Newman and Schnare 1992).

Two pieces of inherited health legislation that were passed during the early 1970s had particularly important implications for policy at both the federal and state levels during Carter's tenure: the first was the Health Maintenance Organization (HMO) Act of 1973; the second was the Employee Retirement Income Security Act (ERISA) of 1974.

The intention of the HMO Act was to create healthcare institutions that would offer a wide range of prepaid services to communities throughout the nation. Although supported by influential actors such as Senator Ted Kennedy, broad implementation of the Act was strongly opposed by the American Medical Association and insurance companies. Their involvement forced it to remain an experimental program (Starr 1982). Dissatisfied with this situation and in keeping with his election promise, Carter sought to incrementally introduce a national health insurance plan. However, because of resistance from the same coalitions that had challenged Nixon's plan, as well as from Democrats such as Kennedy, who favored a labor-drafted blueprint which was non-incremental and all-inclusive,

Carter's proposal did not pass in Congress. After this failure, Carter chose to expand the existing HMO strategy for providing health insurance (*CQ Almanac* 1979).

The Employee Retirement Income Security Act (ERISA) was primarily an effort to protect employee retirement plans "against loss of benefits due to bankruptcies, mergers, or unscrupulous employers." As part of its mandate, this Act regulated health plans operated by private companies for their workers. (*CQ Outlook* 1998, 13). ERISA, however, "included a clause preempting self-insured health benefit plans from state insurance regulation" (Rich and White 1996, 21) and according to Davidson, this provision of the Act was a federally legislated constraint that limited the opportunity for state action and innovation (1997). Although ERISA itself may not have been a barrier to health reform (Grogan 1995), during the Carter years it did strengthen the resolve of large employers to avoid supporting federal and, in particular, state health and pension reform plans (Sparer and Brown 1996).

**Political culture.** From the period of the Great Society to the late 1970s, a variety of neo-liberal and neo-conservative pressures affected the federal government's role in social policy development. Weir et al. state that: "[w]hatever the social policy gains . . . a bitter legacy of the War on Poverty and the reforms of the Great Society and its aftermath was a deepening of the rifts within the ranks of U.S. public social provision" (1988, 430). The preference of a return to laissez-faire became even more pervasive at the end of the 1970s after the voters, in support of tax-cutting and anti-spending measures, symbolized by California's Proposition 13,<sup>2</sup> made it plain that social programs "are often associated in the public mind with the worst of government waste and inefficiency" (*CQ Almanac* 1978, 555). Indeed, the persistence of poverty and inequality well into the 1970s convinced many Americans that the failure of the War on Poverty clearly demonstrated the futility of following the path of liberal reform. In particular, as Zarefsky indicates, "conservatives

concluded that the liberals' record showed the dangers of government regulation of private enterprise, denied that a strong president was an appropriate instrument for social reform, and established that government was the enemy rather than the friend of the people" (1986, 205-206). Despite the "intellectual backlash against 'liberal extremism'" (Breckenridge 1998, 355), the polls showed that, in 1976, 66.7% of Americans urged that some form of state action be taken with respect to the provision of national health insurance (Steinmo and Watts 1995, 332), while at the same time objecting to state intervention in other realms such as housing.<sup>3</sup> For these reasons, the Carter years may be described as a period of divergent and clashing perspectives.

**Ideology.** In 1976, the Democrats captured the White House and dominated Congress with 292 seats in the House and 61 in the Senate. After the subsequent congressional election in 1978, they retained 276 seats in the House and 58 in the Senate. A majority of the states were now also controlled by Democratic administrations (Breckenridge 1998). In his campaign, Carter had pledged "to end the 'imperial presidency' which had led to Watergate" (Zarefsky 1986, 207) and also promised to overhaul social policies and programs. In particular, the Democrats claimed that "the skyrocketing cost of hospital care and the sprawling labyrinth of programs known as the welfare system" needed attention (*CQ Almanac* 1977, 447).

Despite the fact that the Democrats had a strong mandate, the Carter administration was stymied where federal social policies were concerned. Ideological reasons were partly responsible. For example, it was noted that, in Congress, liberals and conservatives alike believed that the welfare system had to be revamped. Nevertheless, consensus could not be reached on how this was to be accomplished, because some elected and appointed officials thought Carter's proposals were overly generous while others thought they were niggardly. These conflicting views were to have extremely important implications.

Although one of Carter's primary goals was to reform the leviathan of welfare, there were significant ideological differences even within the Democratic Party as to the best course of action to take. This split reflected the desire of the liberal Democrats, including Senator Ted Kennedy, to expand many of the Great Society strategies. Other Democrats believed, as did Carter, that other reform strategies were necessary. They recognized that many of the Great Society policies had not worked and that a "new Democrat approach was required to welfare reform as well as a need to cut government expenditures" (Correspondence from Breckenridge 2000).

Carter's plan was to "develop 'a comprehensive plan that was pro-work and pro-family' . . . [and which provided] some relief for states and localities" (Califano 1981, 325). His plan included changes to nine of HEW's income assistance programs: General Assistance, Veteran's Pensions, Aid to Families with Dependent Children, Housing Assistance, Food Stamps, Medicaid, Basic Education Opportunity Grants, Supplemental Security Income, and Earned Tax Credit (*CQ Almanac* 1977, 473). The reforms had two tiers — one for those who were not expected to work, such as the elderly, severely handicapped, and single parents with young children. The other tier was for those who could, or who were expected to work, and the payments reflected the recipients' eligibility for payments. Carter's plan was also to introduce a national health program which would cover Americans receiving Medicaid. However, in part because of fundamental ideological differences within the Democratic Party itself, as well as the major institutional barriers identified above, these sweeping plans were not realized. The *CQ Almanac* notes that "legislation that would have led to basic changes in the society — national health insurance, welfare reform, fundamental tax revision, and a new urban strategy, to name a few — never got off the ground" (1978, 9).

As a result, in housing, Congress never acted on the major parts of Carter's plans to redirect greater amounts of urban funding towards housing assistance (*CQ Almanac*

1978). Similarly, in health, even though there apparently was ideological consensus about reform in Carter's presidential campaign, "none of the competing Democratic proposals dominated; all were caught up in intra-party rivalries" (Tuohy 1995, 13). Consequently, health reform was never seriously considered by full committees in the Senate or House. Thus, even though the Democrats had taken approximately the same number of seats as Johnson had won a decade earlier, they were unable to muster enough support in Congress, even within the Democratic Party itself, to introduce the reforms that were central to their ideological focus.

**Definition of the problem.** The domestic and international problems that beset the Carter administration during this watershed period were highly complex. On the domestic front, government aid for social programs was costly and, in many instances, was not being provided to those who had the greatest need. Problems with fraud and mismanagement both inside and outside the government cast a negative pall over all social programs and triggered a public backlash against further government intervention.

Reports and proposals from politicians of all persuasions, as well as actors in the public and private sectors, were based on conflicting definitions of the problem and generated a series of contrasting proposals. Many of the plans came from elected Democrats who, even with the same ideology as Carter, offered alternative definitions of the problem and alternative solutions for future government intervention in social policy. Some of the formulas were sweeping in their scope, whereas others suggested that incremental measures be taken. In welfare, for example, although Carter proposed to abolish existing programs and replace them with a single cash payment, Ways and Means Chairman Al Ullman thought that Carter's plan was doomed to failure and submitted a totally different and much more complicated welfare proposal. Ullman recommended that there should be nationwide eligibility standards for welfare recipients, that minimum benefit

levels be set, that intact families be made eligible for benefits, that private sector jobs be made more attractive than public sector ones, that administration be simplified, that fraud and abuse be cut, and that states be given some fiscal relief (*CQ Almanac* 1978, 601).

In housing, the Carter administration received reports from housing officials, providers, and consumers. These reports highlighted the difficulties consumers were facing in coping with neighborhood decline and other problems stemming from the quantity and quality of public housing and related services (HUD 1998a). One report, *To Save a City* by Democrat Henry Ruess, was particularly provocative: not only did it examine the problems of housing, but it also linked those problems with welfare, employment, and urban revitalization (HUD 1998a). Unfortunately, the Carter administration's effort to solve the problems of housing by introducing "local control of federally funded programs" (Johnson 1991) was not adequately supported by the coalitions that had energized reforms during the Great Society.

Health policy also received attention from a wide variety of actors who had vested interests in this field. The primary concerns of the policy makers were the rapidly increasing cost of health care and the growing numbers of people who had no health insurance. In 1975, an HEW study estimated that "twenty-four million Americans had no basic health coverage and another nineteen million had inadequate coverage" (Steinmo and Watts 1995, 357). Once again, a series of documents emerged which produced a mass of proposals, some designed to contain costs in the existing system and others to reorganize the fragmented care offered by public, private, and non-profit hospitals. For example, advocates of HMOs appeared at the 1978 hearings of the Senate Committee on Human Resources to support plans for greater federal funding, and a coalition comprised of HMO trade and health insurance associations joined with the AFL-CIO and other lobbyists to support legislation that would challenge the dominance of traditional fee-for service hospitals (*CQ Almanac* 1978). As expected, the AMA opposed the initiatives. One com-

mentary in the *New England Journal of Medicine* summed up the widespread belief among physicians that health care was being "destabilized" by government intervention. Ginzberg wrote that "[d]uring the 1970s, the emergence and substantial growth of for-profit hospital chains weakened the hegemony of the community hospital in many parts of the country, and the emergence of potential surpluses of both physicians and hospitals resulted in corresponding threats to the continued dominance of these two key power centres" (1986, 758). As a result of the broad spectrum of views, Congress failed to produce any concrete national health plan or initiative that would integrate assisted housing and health policy.

**Decision making.** As far as decision making in Congress was concerned, the processes that had been used previously were changed in the wake of Watergate. One of the most significant changes had to do with membership on key decision making committees: as already noted, power that had traditionally resided in the hands of a few senior senators and representatives had been substantially diffused. As a result, not only had the hegemony of a few congressional coalitions been disrupted, but the decision making process itself became much more open to influence from societal actors who now had many more points of access for lobbying. As Pierson (1995) indicates, although this type of situation provided more opportunities for interested parties to influence policy decisions, it also led to institutional fragmentation and a dispersal of power.

According to Tuohy, the incremental approach to policy making that typified the Carter years promoted "categorical programs and regulatory constraints" which in turn created highly complex interorganizational relationships between institutions in the public, private, and non-profit sectors (1995, 13). This was particularly true in the case of housing, where President Carter had appointed Patricia Harris to be Secretary of HUD. Harris's goal was to improve housing and urban conditions in "distressed communities," and her chosen path for reaching that goal was to extend the CDBG programs and to

expand the Section 8 voucher system (HUD 1998b).<sup>4</sup> Although HUD continued to finance public housing construction, it did so at a considerably reduced rate. In part, this was because of the skyrocketing construction costs and the emphasis that was being placed on urban rehabilitation and private market rental. However, during this period of "turmoil" (Doan 1997, 101), the situation became even more complicated by the fact that there was a change in the circumstances of many of the actors that had participated in the decision making process in the past. For example, economic difficulties forced many builders to withdraw from public housing construction. Keyes believes that the Nixon administration's efforts to put a halt to large housing projects was responsible for the fact that the "national housing coalition, with members ranging from public housing and non-profit advocates to developers and bankers, never regrouped after the 1973 moratorium" (1990, 175). Because of this shift in the power of the coalitions, by the end of the 1970s "what emerged was a complex series of programs, each created for their own unique purposes, attempting to satisfy or respond to some specific needs, but in no way resembling a coherent nonprofit housing system" (Bratt 1998, 148).

A similar situation existed in health. Despite energetic efforts, HEW Secretary Califano's decisions on how to introduce "major changes in health insurance and welfare systems were frustrated by the new conservative spirit. Congress was clearly reluctant to approve new programs with the potential to add billions of dollars to federal spending" (*CQ Almanac* 1978, 555). Change was also obstructed by the bureaucrats on all governmental levels who were charged with implementing health programs and, in the process, with eliminating mismanagement and duplication. For example, according to Califano, in 1977, when ideas were explored that might integrate jobs with cash assistance and to link pensions and rent supplements, the "turf-dominated discussions" effectively sent the various "bureaucratic constituencies to war" (1981, 330) as each department attempted to protect its own policy area.

Meanwhile, the physicians and private insurance companies, jealous of their position as primary influences on the policy process and well organized, continued to effectively lobby decision makers for legislation that would preserve their importance and autonomy in the decision making process. In addition, for-profit hospital organizations (particularly large HMO chains) continued their efforts to ensure that their facilities would remain the principal source of health care delivery. Thanks to lobbying by the health industry, a Bill to limit increases in hospital rates, seen as a necessary prelude to national health insurance, fell victim (*CQ Almanac* 1978, 4) and the focus in the US continued to be on institution-based curative services, rather than community-based preventive health care.

Finally, prospects for change were blocked by the beneficiaries of existing health programs, who feared that they would lose if the system were altered. Not only were societal actors such as these unwilling to support change in the healthcare system, but, like the politicians and bureaucrats who supposedly represented their interests, they found that influencing the decision making process had become extremely complicated, fragmented, and contentious during this watershed period. On the one hand, "many forces old and new produced effects on the health care system that, in combination, led to its destabilization" (Ginzberg 1986, 758-759); on the other, "the dispersion of institutional power — both political and bureaucratic — [constrained] policy decisions and [had] a formative effect on the structure of societal interests" (Boase 1996b, 302).

**Exogenous influences.** The primary concerns of the Carter administration were related to the combined problems associated with the national economy and the energy crisis (Breckenridge 1998). With the global economic upheavals of the first part of the decade still reverberating through the nation, the cost of living continued to increase and household incomes either plateaued or declined (Doan 1997). As a result, many Americans faced serious financial challenges such as loss of their home, their job, and/or their health

insurance.

In addition, the postwar baby boom affected the demographics of the nation and had a significant impact on the demand for both housing and health services. According to Doan, citizens aged between 20 and 34 made up nearly a quarter of the population and were now attempting to establish their own homes and start families. Most of these households were formed in urban centers as rural populations continued to decline. Thus, during this period of profound economic difficulties, urban households grew in number. Weir et al. observe that under these new circumstances, the policies that had been well suited to the situations that existed during the New Deal and Great Society eras "proved ill-suited to cope with the human problems of an American economy troubled by recession, inflation, and industrial dislocations" (1988, 434).

### **Summation**

The policy path that had been charted by Johnson during the late 1960s had taken an abrupt turn by this watershed period. The Democrats had been elected to office in the aftermath of what was arguably the lowest point in recent US history. As the above discussion has confirmed, they faced massive challenges related to both international and domestic issues. Compounding the difficulties were the differences of opinion within the Democratic Party itself on how to resolve these issues and, increasingly, the opposition of the American public to ongoing government intervention in welfare policy. These inhibitors of expansion and reform of social policy in the US also prevented any potential for linkage between housing and health from taking place.

**Abetting factors.** Congress had undergone significant institutional reforms since the last watershed period. As a consequence, the powerful coalitions that had previously blocked social policy initiatives no longer dominated key committees. Thus, when calls for

change in social policy came forth, Carter considered proposals to make organizational modifications in HUD and HEW which would improve the types of programs that those institutions offered and the manner in which they were implemented.

This was still a time of coercive federalism when the government, through its funding mechanisms, was able to induce state and local governments to implement its proposed social policies. This fact encouraged those who supported Carter's plans to undertake reforms of social welfare programs.

Exogenous factors, such as the economic stresses of the period and the changing demographic picture in the United States, animated reformers who sought to assist the elderly and disabled population as well as workers who had difficulty keeping their jobs, homes, and health insurance.

Carter retained many of the housing policies that the Republicans had introduced, especially the Community Development Block Grants which were designed to promote initiatives to address local needs. However, where policies provided insufficient choice for aid recipients, he instituted modifications such as housing vouchers — a demand-side mechanism — that extended the scope of rental possibilities. In health, Carter was obliged to continue with the HMO insurance strategy that had he had inherited from the previous administration.

As far as American political culture was concerned, during this period the public still largely supported the notion that government assistance to the disadvantaged should be continued. What it objected to was the fraud, waste, and mismanagement that had been revealed in the provision of government aid. Therefore, it backed calls for extensive reviews of existing social policies.

The proposals put forth by the policy makers were based on a multitude of studies which confirmed that many of the problems of low-income Americans were caused by programs that were inequitable, ineffective, and poorly coordinated. Powerful reports that

were published in the 1970s endorsed efforts that would arrest urban decline, promote the well-being of residents of badly affected areas, and find a solution to the lack of health insurance options available to seniors, the unemployed, and low-income earners — a lack due in good part to the dominance of the private sector.

Key decision makers within government and society agreed that reforms such as these were desirable. Their position was supported by an increased number of consumer groups that had been affected by contemporary circumstances and program deficiencies.

Finally, in this discussion of the factors that abetted the potential for policy change, it is necessary to mention the victory given to the Democrats in the election. This seemed to provide the Carter administration with enough support to begin formulating plans for an extensive reform of social policy.

However, even with these factors favoring policy change, very few substantive alterations occurred. The reasons for this failure are reviewed below.

**Inhibiting factors.** The window of opportunity that had promoted greater federal intervention in social policy during the Johnson era failed to open during the Carter administration. Carter's goals of reforming the leviathan of welfare and introducing a national health plan were overwhelmed by the combined effects of a devastated economy and a neo-conservative backlash which increasingly called for reduced government activity in a number of policy fields.

The barriers to policy redirection that stemmed from the institutional complexity of Congress were compounded by the organizational reforms made to HUD and particularly to HEW. Together these institutional realities presented serious obstacles to policy change and the potential for linkage between housing and health. Ultimately, they not only proved costly, but also had little positive effect on the scope and efficiency of program delivery. In good measure because of the above reforms, the policy process in the federal institutions

became very complex, fragmented, and incremental.

During this watershed period, the coercive federalism that had been fostered by Nixon underwent little change. Therefore, the states and localities still relied heavily on the federal government for social policy direction and funding.

The economic problems that had started during the early part of the decade led to rising costs both for the population as a whole and for the government. Adding to these problems was the increase in the number of young people who needed homes and health insurance. Among other factors, these pressures strained the government's ability to provide services to all of those in need.

In housing, Carter inherited Community Development Block Grants from the previous administration. However, questions arose about the manner in which the grants were being targeted and whether the projects for which they were intended were actually receiving them. The perception of mismanagement made further government action in the realm of housing assistance more difficult. In health, inheritance of the Employee Retirement Income Security Act reinforced the reluctance of large private employers to sanction federal as well as state health and pension reform plans. A still more important inhibiting factor was the inheritance and expansion of the Health Maintenance Organization Act. This guaranteed that private insurance companies and hospital chains would continue to be a barrier to the introduction of a national health insurance plan.

With respect to political culture, even though there had been broad support for the Democratic Party's social policy goals at the beginning of Carter's term, there was still a pervasive distrust of government in the aftermath of Watergate. This distrust, plus the sense that New Deal and Great Society initiatives had not fundamentally improved the lot of the disadvantaged, led to the development of a resistance to government expansion and to a belief that market forces should prevail in housing and in health.

By the late 1970s, reports from a wide variety of substantially different sources

offered such conflicting ideas about how American social problems should be examined and resolved that consensus among the decision makers could not be reached. In this environment of conceptual discord, interdepartmental conflict emerged among bureaucrats and other government officials as they attempted to protect their particular policy domains.

It should be noted, however, that even if consensus could have been reached among members of the Administration, the decision making process in Congress had become so fragmented that if it did not entirely block policy change, it forced it to operate only on an incremental basis.

Although the Democrats had won the White House and Congress, there were deep ideological divisions within the Party itself. The Party's lack of agreement on the best policy course to follow and its inability to overcome the growing conservatism in Congress and the nation ensured that Carter's social policy reforms would founder.

## CHAPTER 7

### THE MID-1980s

Liberal welfare states that had endured the economic challenges of the 1970s entered the 1980s with even more intense debates than before about the role of government in social policy issues. As these nations grappled with massive deficits and budget crises, economic and social policy goals came into conflict. This became a major source of concern because such a great percentage of their GDP was being allocated to social programs. For example, by the early 1980s the OECD average for this type of expenditure was 25.6% (OECD 1985b).

As a result of these economic pressures, the neo-conservative ideology that had started its ascendancy in the 1970s became firmly embedded by the 1980s. In nations such as Canada and the US, this change in thinking led to an espousal of targeted cuts in social spending and, despite protests from state and societal interests that stood to lose from this change in policy direction, both assisted housing and health policies were directly affected. The federal governments in Canada and the US became less involved in public housing programs. In health, the divergent policy paths that manifested themselves in the previous watershed period became even more pronounced: while Canada adhered to legislation which firmly entrenched healthcare in the public sector, the US moved more resolutely towards private sector involvement.

#### **Canada**

During the late 1970s, the postwar consensus regarding the role of the welfare state had been seriously eroded. What remained of the Keynesian and Beveridgian philosophies was further reduced by the mid-1980s, when the Conservatives under Brian Mulroney

came to power. The reasons for the weakening of state involvement in the provision of social policy during this period differed in many important respects from those of previous phases. One of the main causes of this change was that the structures and responsibilities of federal institutions were influenced by new state and societal actors that had adopted a variety of strategies to promote their interests and policy preferences.

The altered power relationships that resulted changed the social policy path significantly. Neo-conservative governments had been elected in several western nations, and even though Canada followed a different route from its counterparts in Britain and the US, the Conservative government's direction with respect to social policy devolution was similar in several important respects. Not only did it seek strategies to control the massive deficit, but also sought ways to reduce its responsibility for the provision, financing, and administration of a number of programs. Although major federal social programs remained in place, the mechanisms for delivery and the level of government responsible for their implementation changed. Both housing and health programs were included in the restructuring. In housing, the Conservatives devolved administrative responsibility for existing cost-shared programs from CMHC to the provincial governments; in health, they ensured that the provincial governments adhered to the five principles of medicare enunciated in the Canada Health Act (CHA). The CHA, which had been inherited from the previous Liberal government, consolidated the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966 and "defined more precisely the conditions upon which federal payments would continue" (Taylor 1987, 441). These changes produced conflicting pressures on each of the policy areas and made the potential for linkage between them even more remote than it had been previously.

### **The determining factors**

**Federalism.** Simeon and Robinson (1990) hold that, during this period,

federalism presented a joint-decision trap of the most challenging type. The Conservatives started to change the federal government's role in certain areas that were constitutionally assigned to the provinces.<sup>1</sup> Their aim was to find "the means whereby cooperation, coordination and consultation rendered imperative by the shared occupancy of the policy space [could] be reconciled with the virtues of competition, variety and government autonomy in charting policy and responding to citizen preferences" (1990, 335). Housing and health were among the policy fields that offered these challenges to both the federal and provincial governments. However, the situation that resulted confirms the accuracy of Scharpf's observation about the flaw in joint programs: namely, they "were increasingly seen as either inefficient, or inflexible, or unnecessary" (1988, 247),

The central government's efforts to reorganize the structures and processes related to social policy worked both to inhibit and to abet policy development. It inhibited development by reducing funding and by introducing restrictive stipulations concerning the manner in which the provincial governments could allocate federal monies for specific programs. And by forcing the provinces to pay for the programs that now had limited funding, it abetted social policy development, albeit on the provincial level where policy innovation would now take place.

This change in intergovernmental relations affected social housing and health policies in significantly different ways. In housing, the federal government continued to fund existing cost-shared programs with the provinces but, to all intents and purposes, withdrew from the planning and administration of assisted housing. In health and other social policy areas, the federal government provided new mechanisms for payment and at the same time giving the provinces more leeway in the allocation of the funds. In particular, the CHA led to increased intergovernmental tensions as the federal government continued with its strategy to control costs and reinforce national standards in a policy area that remained in the provinces' constitutional domain.

**Central government institutions.** In 1980, the Trudeau Liberals attempted to integrate social policy programs by forming the Ministry of State for Social Development (MSSD). The MSSD was an effort to coordinate the activities of over 50 agencies, committees, and departments responsible for social policy. Although it was designed to centralize decision making and control department budgets by advising the Cabinet Committee on Social Development, the MSSD did not directly affect the programs that were part of the CMHC or NH&W mandate. Disagreeing with Trudeau's rationale for this institution, John Turner dismantled the MSSD in 1984. After becoming Prime Minister later that year, Brian Mulroney returned the responsibility for policy development to the individual departments and gave the task of overseeing the federal budget to the Department of Finance (Doern et al. 1988, Tuohy 1992)

After MSSD was dismantled, CMHC and NH&W remained responsible for the design and implementation of federal policy for housing, health, and related policy fields, but both departments — CMHC to a much greater degree than NH&W — underwent a range of organizational and funding transformations which affected the scope and types of activities that each had to offer.

From an organizational perspective, CMHC was preserved as a Crown corporation with responsibility for a variety of housing and residential development programs. However, during this watershed period, the government signaled its intent to withdraw from all new public housing programs and to devolve administrative responsibility for social housing to the provinces. In an effort to implement this decision, in 1985 the federal government embarked on a series of federal-provincial consultations that would not only effect fiscal retrenchment by the central government, but would also encourage the provinces to provide "affordable, adequate and suitable housing to households in core housing need, in a way that reflects regional concerns" (CMHC 1986). The intention was to leave better-off Canadians to find homes in the private sector, with aid, if necessary,

from the provinces or from non-profit and cooperative groups. In 1985, the federal government allocated a total of \$1.183.3 billion to cover all aspects of social housing programs (Private communication from CMHC 2000). In addition, it established allocation rules which were designed to ensure that there was a balance in the provision of shelter for the poor, the elderly, and citizens with special health needs (Banting 1990, 137). These plans for administrative devolution continued the "trend of withdrawing from new production and slowly allowing existing commitments to lapse . . . which was supposed to establish a new, and stronger, provincial role in the area of social housing" (Klodawsky and Spector 1997, 263).

The Department of National Health and Welfare remained responsible for funding and overseeing a wide variety of programs in "cooperation with provincial authorities in efforts directed toward the preservation and improvement of public health and toward the provision of social security and welfare for all Canadians" (Federal-Provincial Relations Office 1987, 167). Despite the apparent continuity in these broad goals from the previous watershed period, NH&W had undergone significant institutional changes with the introduction of the Canada Health Act (CHA) of 1984. This Act ensured that the federal government, through NH&W, would remain in control of national health standards and would "preserve a popular national program without having to take responsibility for its implementation [because] it was up to the provinces to find any additional money needed to reach settlements with provincial branches of the medical profession" (Gray 1991, 129).

The EPF formula, which had been introduced in 1977, continued to fund health services including long-term residential care; however, special care accommodation for the elderly and hostels for children and battered women was provided through the Canada Assistance Plan (Doern et al. 1988). During the 1986-87 fiscal year, the federal government's cash and tax transfers and equalization payments for EPF exceeded \$16,725 million (Federal-Provincial Relations Office 1987).

As this review of CMHC and NH&W shows, the Conservatives believed that the provinces should assume greater administrative and financial responsibility for public housing, but that the federal government should retain control over national health and welfare programs and ensure that the criteria for the universal health plan were maintained. In attempting to realize these goals, they substantially reorganized CMHC and NH&W. In essence, these measures reinforced the tendency towards policy divergence that had manifested itself in the 1970s.

**Inherited policy.** When the Conservatives took office in 1984, they continued to use many of the policy instruments that had been inherited from the past in social housing. Among these were federal-provincial cost-shared subsidies (usually on a 75-25% basis) for publicly managed dwellings and rent supplements for dwellings in the private sector. Except in the case of persons receiving welfare, the rents paid by the occupants of assisted housing funded through cost-shared agreements continued to be calculated on a rent-g geared-to-income basis. After 1986, when the Conservatives made their unilateral decision to retrench, however, all new initiatives became the sole responsibility of the provincial housing agencies, and these could determine their own terms for tenancy.

The federal government continued to pay for accommodation for those Canadians who required supervised care in facilities such as "homes for the aged, nursing homes, child care facilities, and hostels for battered women and children" (NH&W 1987, 1). Funding was provided by NH&W's Canada Assistance Plan and eligibility was conditioned by income.

In health and social services, the Conservatives continued to use Liberal government funding mechanisms such as EPF and legislation such as the Canada Health Act, whose stated goal was to "protect, promote and restore the physical and mental well-being of residents of Canada." It should be noted that, in order to accomplish this goal while at

the same time circumventing constitutionally defined areas of provincial jurisdiction, the CHA obliged the provincial governments to pass their own legislation that would meet federal criteria for healthcare funding (Boase 1998). In this way, despite vehement protest by the physicians, the federal government showed its determination to maintain a national health plan that observed the principles of universality, portability, public administration, comprehensiveness, and accessibility (NH&W 1987), and to prevent extra-billing by physicians and the imposition of user fees on patients (Bégin 1983, Heiber and Deber 1987, Taylor 1987).

**Political culture.** Important trends in Canadian political culture emerged during the mid-1980s that reflected tensions between the ideology of the Mulroney government and the views of the Canadian public. In keeping with the Conservative ideology, the federal government's strategy for social policy included "a preference for expenditure restraint and targeting resources to those most in need" (Doern et al. 1988, 156).<sup>2</sup> However, many Canadians, notably senior citizens who were faced with the specter of substantial cutbacks to their government pensions, argued against this approach (Gray 1990). They claimed that, in comparison to other OECD nations, Canada spent less on social programs and, as a result, the ones that already existed should remain intact (OECD 1994).<sup>3</sup>

Goar reports that a Maclean's/Decima poll conducted early in 1985 indicated that 86% of the respondents favored cutting the federal deficit, while 67% insisted that social programs, especially medicare, should be maintained (1985, 18). Goar adds that more than merely being a roadblock to Mulroney's plans to cut the deficit, the expectation that the government would "provide safety nets for the poor, sick, elderly and unemployed" demonstrated a conflict of demands on a range of important issues (1985, 16, 18).

**Ideology.** Under Brian Mulroney's leadership, the Conservatives were elected

with a majority in 1984. With 50% of the popular vote and 211 of the 285 seats in Parliament, the Tories "pledged a return to cooperative federalism, reforging the linguistic, regional and intergovernmental accommodations" (Simeon and Robinson 1990, 301). In practice, however, ideology triumphed over electioneering: despite its promise to maintain Canada's universal medicare program policy as a "sacred trust," the government attempted to redirect the social policy path by introducing significant changes in the design and implementation of several social programs that had become well established over the years. In good part, this occurred because one of Mulroney's principal goals was to substantially decrease the federal government's budget deficit which had risen to an alarming degree since the 1970s. In keeping with its ideological support of the market, the government also included plans to further devolve social programs to the provinces. However, as stated above, a massive protest by seniors who vehemently opposed the plan to de-index their old age pensions forced the government to retreat from its new strategy, which was described by one policy analyst as "social policy by stealth" (Gray 1990, 17).

Because of the outcry against this strategy, the Conservative government adopted a more incremental approach to social policy change (O'Neill 1996) in which "the Tories put in place an effective system of automatic social program reductions and tax hikes." This program, which was less visible and affected broader segments of the population, was implemented over a longer period of time (Gray 1990, 29). Thus, the neo-conservative philosophy ultimately prevailed. As Boase points out, "the manifestation of this ideology is evident in widespread questioning of the universality of social programs" as well as in government support of a market approach to societal issues (1998, 6).

**Definition of the problem.** The government's direction was set early in its first term with the issuance of *A New Direction for Canada* (1984). This publication by Michael Wilson, the Minister of Finance, voiced the Conservatives' intention to undertake a detailed

review of all government expenditures, including those related to housing and health. The tone of the message was that the best way to help Canadians in need was through fiscal restraint and economic recovery (O'Neill 1996).

Several influential reports written during the early days of the Mulroney government were to have long-term implications for the evolution of assisted housing and health policy. Some, such as the Macdonald Report (Canada 1984), dealt with these policy fields in a tangential way. Others, such as the Neilsen Report of 1985, were far more direct in their focus.

The Macdonald Commission, which examined issues such as income supplements for those who required government assistance, noted that although the postwar consensus for state intervention in social policy had diminished, there was still an important role for the government to play in providing support for citizens in need.

The Neilsen Task Force, which reviewed federal programs, including the manner in which public housing subsidies were being allocated, demonstrated that although the costs associated with housing subsidies were rising, less than a quarter of social housing was being allocated to low-income people. This report, in concert with a series of studies undertaken by CMHC, led to high level negotiations between federal and provincial officials in which new social housing agreements were established. These agreements stipulated that the federal government would relinquish many of its administrative responsibilities, but, in return for ongoing funding, would require the provinces to adhere to specific requirements regarding the allocation of social housing.

Much to the chagrin of retrenchment advocates, this shift in policy direction increased rather than decreased the strain on the budget. Because more emphasis in assisted housing programs was placed on accommodating low-income groups rather than middle-income ones, government expenditures rose, since the subsidies required by low-income housing consumers were necessarily greater than those needed by consumers whose

incomes were higher. Succinctly put, "the gap between operating costs and rents" widened considerably as more poor and welfare recipients occupied social housing (Fallis 1995, 19).

The Neilsen Task Force identified other important factors that affected social housing for the needy during this period. A growing number of Canadians, including the elderly and physically and/or mentally handicapped, required assistance with shelter because of their special needs. By 1984, approximately 15,000 special purpose housing units existed in Canada, comprising 12 per cent of all social housing (Banting 1990). Because of changes to provincial healthcare delivery systems, a significant portion of individuals with multifaceted problems were being moved from healthcare facilities into community-based centers. In many instances, costs were thus transferred from health and welfare to social housing budgets. In view of this, the Neilsen Report suggested that changes be made to existing health, CAP, and housing budgets to ensure that subsidies were fairly and appropriately allocated. Banting summarizes the situation as follows:

The federal government was not slow to point out that social-service budgets are cost-shared under the Canada Assistance Plan on a 50:50 basis, while housing budgets are most often shared on a 75:25 basis. Moreover, the federal contribution to health care is locked in under the EPF formula and does not decline if health costs shift to the housing budget. Not surprisingly, the Neilsen Task Force recommended federal/provincial negotiations "to shift responsibility for subsidizing special purpose housing to health and social service budgets" (1990, 157).

The reports related to health led to dramatic changes in federal spending during the Conservatives' nine year tenure. Some of the reports were written during Trudeau's stewardship; others, during Mulroney's. Liberal Health Minister Monique Bégin's paper, *Preserving Universal Medicare* (1983), provided the infrastructure for the Canada Health Act of 1984, which was subsequently adopted by the Conservatives. This report focused on physicians who extra-billed the government and charged patients user fees for health-related services, and confirmed the government's desire to eliminate the additional costs to

patients and to enforce the five principles of Medicare.

Even though the Conservatives stressed the need to reduce the costs of social policy, they also took steps to reorient the social policy framework towards disease prevention and health promotion. Drawing directly from Liberal Health Minister Lalonde's *A New Perspective on the Health of Canadians* (1974), the Conservative government introduced Jake Epp's *Achieving Health for All* (1986). One of the major conclusions reached in this report was that the government should coordinate public policy between related policy sectors and should also strengthen community health services. In the past, few other documents had called for direct policy linkage between agencies dealing with the different determinants of health (Pederson et al. 1988). But even with this long overdue shift in emphasis, those who were responsible for resolving Canada's financial and social problems saw cost-cutting in terms of devolution rather than institutional integration. Pederson et al. hold that although *Achieving Health for All* implicitly emphasized the importance of intersectoral collaboration for future social policy development, it did not articulate how the multifaceted barriers to integration could be overcome (1988). This lack of policy linkage was highlighted in the influential Obstacles report, which noted that a significant number of barriers had been created for handicapped and elderly people when "planning Canada's protection of human and civil rights, health care services, employment opportunities, and the various facilities and systems of housing and shopping, education, recreation, communication, and transportation" (1981, 1).

On the whole, these reports confirmed that while the federal government had a role to play in the provision of housing and health programs, the institutional reality was that these policy areas would remain separate.

**Decision making.** Two important issues related to decision making stand out during this watershed period. The first concerns the government's ideological desire to

focus on fiscal issues and, to this end, initiate a period of disentanglement from housing obligations (Carroll and Jones 1999). The second pertains to the change in input by actors that had a stake in the process.

The Conservatives based their course of action on their pro-market ideology and on several major reports, some of which had been commissioned by the previous Liberal administration (see above). The policy decisions that they made reflected their perceived need for retrenchment at the federal level. This was in keeping with moves taken by other major industrialized nations (Jacobs 1993). The key decision makers in the federal government were the Minister of Finance, Michael Wilson; the Minister Responsible for CMHC, Stewart McInnes; the Minister of Health and Welfare, Jake Epp; and the Prime Minister, Brian Mulroney. In order to establish a more cooperative climate for decision making than had existed during the previous watershed period, the Conservatives included federal bureaucrats and their provincial counterparts in the discussions.

Most of the policy decisions, however, were made without significant input from societal groups which, though greater in numbers, now had less influence with parliamentarians and bureaucrats than in earlier times (Haddow 1990). For example, because of their unpopular extra-billing practices, the physicians and medical groups lost much of their ability to sway the federal policy process to their own benefit. Despite doctor-inspired pressure strategies such as the organization of highly publicized demonstrations (McMonagle 1986), the government opted to ignore the doctors' demands (Heiber and Deber 1987). Consumers, on the other hand, were much more visible and, as shown by the seniors' protests against Mulroney in Ottawa, were able to exert some influence on policy direction during this period. For instance, the government's plan to economize in the area of seniors' benefits became so unpopular that, as Gray points out, "even prominent business lobbies such as the Business Council on National Issues, the Canadian Chamber of Commerce and the Canadian Organization of Small Business acknowledged that the

cost-cutting measure would unfairly hurt the elderly poor" (1990, 17). In spite of this, when all was said and done, the policy communities that lobbied on behalf of the poor had little long-term impact on the government's decision making processes. As Gray explains, the reason for this outcome was that "[s]ocial policy groups lack political clout with a government which considers them fiscal naifs and does not believe they carry much popular support" (1990, 29).

**Exogenous influences.** During this watershed period, Canada, along with other industrialized nations, was facing challenges created by the deficit and the increasing effects of globalization. As Simeon and Robinson put it, this was a period when federal and intergovernmental matters were "made more complex and multi-dimensional by changes both within Canadian society and in the global environment" (1990, 336). The following paragraphs illustrate the impact of another important influence on housing and health: namely, changes in the demographic makeup of the nation.

Demography became more salient than it had been in the past. A few figures will show why. In 1985, 13.1% of Canadian men and 16.5% of women were over the age of 60 (United Nations 1992). The Health and Activation Limitation Survey conducted by Statistics Canada during the 1986 Census found that 45.5% of adults over the age of 65 reported some form of disability and that 15.7% of adults between the ages of 35 and 65 also had functional problems (1988, 30). Other demographic trends, such as single-parent families, smaller family size, and growing numbers of elderly single people affected the "volume, type, and intensity of demands on health-care services" (Coburn et al. 1987, 654) as well as other forms of government aid. These demographic changes also had an impact on the number of homes that were able to accommodate the functional and financial requirements of the needy (CMHC 1994).

This type of information made it plain that demographic changes would have

marked effects on all health and social services (Roos et al. 1987). As a result, researchers could no longer limit themselves mainly to studying reactive and curative strategies, as they had in the past, but with cost-saving as well as public health questions in mind, must seriously probe into the underlying causes of health problems and the possibilities of disease prevention. Many of these researchers claimed that expenditures on costly high-tech interventions, although beneficial, were not the first-line answer in cases where appropriate community services could have prevented the problems in the first place. This was a very persuasive argument, since procedures such as diagnostic imaging and bypass surgery were becoming, "in terms of social priorities, competitors with increased pensions, subsidized housing and various forms of social support" (Evans 1987, 622). Although these demographic realities and the fiscal consequences they occasioned should have become prime ingredients in the government's decision making process, as well as a justification for the policy choices it made, the Conservatives tended to give them less weight than the researchers might have desired.

### **Summation**

During the mid-1980s, the federal government's approach to cost cutting included an extensive review of all aspects of Canada's social system. Decisions by the Conservatives led to significant changes in Canadian social policy, affecting both program providers and recipients. A major feature of these changes was that the provinces were forced to adhere to greater restrictive stipulations and, at the same time, assume even more fiscal and administrative responsibility for cost-shared programs. This caused the inter-governmental strains that were already evident during the previous watershed period to become even more pronounced. Assisted housing and health were unable to escape involvement in these tensions and the potential for linkage between the two fields became even more unlikely.

**Abetting factors.** Neo-conservative ideology predominated during Mulroney's tenure in office. One of his major efforts was to reorient social policy in areas that were constitutionally within the jurisdiction of the provinces, but increasingly under the fiscal aegis of Ottawa.

Unlike the 1970s during which executive federalism prevailed in social policy fields through centralized decision making and fiscal control, the 1980s was a period that aimed to achieve a greater degree of cooperative federalism. To this end, extensive intergovernmental negotiations were held in order to encourage the provinces to design their own innovative housing strategies, and in health, to adhere to the principles set out in the Canada Health Act, and thus reduce the strain on the federal budget.

During these negotiations, the central government signaled its intent to retain institutional control over specific programs. In public housing, CMHC remained responsible for funding existing cost-shared programs. In health, NH&W maintained responsibility for overseeing the provincial governments' adherence to health and welfare legislation.

In the mid-1980s, although societal groups attempted to influence the policy paths in both housing and health, these paths were determined largely by elected officials and senior bureaucrats on the federal and provincial levels. The decisions that were made reflected Mulroney's neo-conservative ideology and the federal government's desire to maintain control over the national health plan, while limiting involvement in social housing policy. In essence, these decisions conformed with the political culture of the time which still supported government intervention in social matters, especially health.

During this watershed period, studies and reports on housing and health advocated intersectoral cooperation and greater integration of policy planning, with a particular focus on the broader determinants of health.

In housing, the Conservatives continued to fund the assisted housing programs that they had inherited from the Liberals, but transferred responsibility for their administration

to the provinces. In health, they implemented the Canada Health Act which had been passed by Turner's Liberal government just before the 1984 election.

The massive deficit and growth in the size of the elderly and handicapped populations abetted the federal government's desire to examine the manner in which funds for social programs were being allocated.

**Inhibiting factors.** The ideology embraced by the Mulroney administration ensured that expansion of social programs and the expenditures that went with them would be curtailed. In housing, this ideological position was implemented by restricting funding to programs already in effect and by devolving responsibility for all new programs to the provinces. In health, the government prevented further expansion by establishing restrictive stipulations for healthcare funding.

By informing the provinces that it planned to limit its involvement in assisted housing and to control escalating costs in healthcare, the federal government in effect continued to put a brake on social policy development at the national level. In the process of carrying out housing devolution, it also reduced the possibility of policy linkage between housing and health.

CMHC and NH&W remained in functional isolation from each other. In public housing, CMHC bore significantly diminished responsibilities for policy development. In health, the federal government focused on provincial disbursement of federal funds and, instead of designing new programs, emphasized greater adherence to national standards.

In decision making, the Cabinet Ministers responsible for the various federal institutions had collectively set government cost-cutting as a priority. Under Mulroney, the decision making influence of the bureaucrats became more diffused between the federal and provincial governments. This helped to reduce the impact of once influential groups such as builders and physicians. Under the new circumstances, these lobbyists could no longer

concentrate on federal decision makers, but had to disperse their efforts among each of the provincial governments and their respective institutions. Even social policy consumers failed to wield long-term influence. Despite the fact that they had become more organized and successful in raising public awareness about their circumstances, they remained poorly financed and still operated on the periphery of the decision making process.

Despite the fact that many Canadians still believed in the need for government involvement in social policy issues, they acknowledged that, given the nation's economic circumstances, the government was obliged to reevaluate its role in the provision of social programs. Just such a recommendation was made by Michael Wilson, the incoming Minister of Finance. Subsequently, all federal government programs were reviewed and steps were taken to meet the government's overall goal of retrenchment.

Although the Mulroney government continued to implement the housing and health policies that it had inherited from the past, in its desire to cut costs it shifted emphasis from social aspects of policy towards fiscal aspects. This move was caused in good part by the economic upheavals of the 1970s which produced a massive deficit while at the same time increasing the numbers of people who sought government aid. The competing demands for funding made it increasingly difficult for the government to provide the same scope of services as it had in the past.

### **The United States**

As in Canada, this watershed period was notable for the transformation of the structures and processes of the institutions responsible for social policy, for changes in the location of decision making, for dramatic shifts in the relationships between the actors, and for the ability of the actors to achieve their policy goals.

Disenchantment with many federal policies during the 1960s and 1970s prompted numerous Americans, including those who had previously supported Great Society pro-

grams, to question the extent to which government should be involved in social matters. As citizens reacted to the economic and social challenges that affected all aspects of American society, Ronald Reagan's neo-conservative approach to the problem of big government received a boost. Indeed, the Republican ideology had the greatest impact on policy development during this watershed period. According to Starr, this "newly revived conservatism sought to throw back the boundaries of the political, to return tax money and government functions to the private sector — in short, to reprivatize much of the public household" (1982, 417). By the mid-1980s, Reagan's presidency was well established, and so were the pro-market policies that his administration embraced as the optimal federal policy path.

As part of his neo-conservatism, Reagan supported tax cuts and increased military spending. In addition, he introduced legislation designed to substantially reorient the role of government in social welfare. In social housing, Keyes notes that Reagan's impact on housing and community development was profound. "Armed with the arguments of thoughtful critics of the federal housing system as it existed in 1980, a political mandate, a weakened housing coalition, and a compliant HUD secretary, the Reagan administration worked hard to remove the federal government from a central role in housing policy and expenditures." The Administration was very successful in achieving this goal (1990, 170).

In health, the Republicans were not able to implement their policies to the same extent as in housing, although the manner in which healthcare services were provided and funded underwent significant change. Marmor observes that:

The Reagan administration came into office in a time of great economic unrest. It ushered in an era of celebrating "competition" in medicine, getting government off the industry's back, and letting the fresh air of deregulation solve the problems of access, cost, and quality. This picture captured the ideological direction that debates over American medicine took during most of the 1980s — the pushing off the political agenda of universal health insurance, and the dismantling of some of the regulatory programs assembled in the 1970s (1998, 556-557).

But Marmor also indicates that Reagan was unable to completely withdraw from the popular Medicare and Medicaid programs which had become firmly embedded since the Great Society years. Even though there had been calls by neo-conservatives to return to the pre-New Deal laissez-faire arrangements, Weir et al. note that there was "little prospect that wholesale dismantling of social programs could possibly occur, given the common stake of citizens, provider groups, and congressional representatives in sustaining many existing policies" (1988, 435). What did transpire during Reagan's administration were cuts to welfare programs intended for the poor. These were targeted to a far greater extent than the popular social security programs which were supported by the majority of Americans. Included in this sweep of retrenchment was a disproportionate reduction in benefits for low-income people living in urban centers (Banting 1997). All aspects of public housing and health provision were affected. Changes to both policy fields ensured that any potential for linkage between the two areas would be vastly reduced.

### **The determining factors**

**Federalism.** The coercive federalism that had emerged at the end of the 1970s was strongly in force by this watershed period. Kincaid states that "President Reagan opposed federal aid to local governments. Viewing federalism as a federal-state relationship, Reagan refused to accept local governments as the third partner" (1994, 40). Reagan's idea of "New Federalism" was to shift "governance toward the state as a means of realizing a vision of downsizing government overall and of curtailing regulation" (Rich and White 1996, 15). As a result, several key social programs which involved the provision of federal funds to the states were reduced and others destined to local governments underwent severe cuts. Urban Development Action Grants and Medicaid were among the HUD and health and welfare programs that were affected.

The intergovernmental changes embodied in the devolution of responsibility for

program funding, administration, and implementation to the states provoked considerable debate as all levels of government responded to the new arrangements. According to Reagan, by devolving responsibility for a variety of previously held central government responsibilities, the "mass of federal regulations and federal paperwork" would no longer hamper state and local government initiatives (cited in Peterson et al. 1986, 5).

Left with drastically reduced federal funding for a number of expensive health and welfare projects, state and local governments were obliged to seek alternative strategies to meet the social demands of the citizens who had been the beneficiaries of these federally-funded programs. This presented particular challenges for states which had constitutional limits on their revenue-raising capacity (Banting et al. 1997) and which also had citizens that opposed further government intervention in societal matters. Peterson et al. contend that several states did discontinue many projects, but that others "moved to replace the federal presence, albeit selectively and according to their own priorities" (1986, 28). In addition, with less federal and state support, more and more municipal governments established new partnerships with reformers and non-profit organizations as they "stepped into the vacuum" in order to meet local needs (Dreier 1997).

**Central government institutions.** The Department of Housing and Urban Development and the Department of Health and Human Services remained responsible for the design and implementation of federal policies related to public housing and health and social welfare. What differed during this watershed period, however, was the extent to which the Office of Management and Budget (OMB) intervened in housing and health. In keeping with the Reagan government's central tenet of New Federalism, the OMB became primarily responsible for maintaining tight budgetary controls over all federal departments. In this way, grants for specific programs could be targeted and cut. This created significant problems for HUD, whose budget had been reduced from \$33 billion in 1979 to \$13

billion by 1985 (*CQ Almanac* 1979 and 1986).

HUD remained the "the principal Federal agency responsible for programs concerned with housing needs, fair housing opportunities, and improving and developing the Nation's communities" (US Government Manual 1986). It also continued to be responsible for a variety of mortgage insurance and loan programs contained in the amended National Housing Act and, in addition, provided five major public housing programs where tenants paid 30% of their income, 10% of their gross income, or the amount of their welfare check that was dedicated to shelter. The programs included assisted housing initiatives that were operated by state or local agencies as well as vouchers and certificates that allowed recipients to live in accommodation in the private sector. However, because the government began reducing its budget, HUD was obliged to modify several of the programs it offered and also the mechanisms by which they were supplied. The primary mechanism by which these changes to assisted housing were achieved was through the block grant system which, during Reagan's time, "systematically reassigned program and funding control to the states," thereby targeting specific programs and eliminating aid to local governments (Peterson et al. 1986, 5).

These tactics caused Mary K. Nenno, the Associate Director for the National Association of Housing and Redevelopment Officials, to express profound concern about HUD's role in the years to come. Declaring that the Reagan government was planning a major reversal of commitments for the provision of accommodation to those most in need, she believed that: "the future mission of the department as a major actor in housing and community development is cast into doubt. The Reagan blueprint appears to be for a greatly diminished federal role in housing and community development, if one at all" (Nenno 1983, 43).

The Department of Health, Education, and Welfare had been reorganized in 1979 and renamed the Department of Health and Human Services (HHS). This massive institu-

tion now encompassed health and welfare and their related agencies (Office of the Federal Register 1987). Despite the fact that the Republicans had attempted to reduce the HHS budget, for the most part, their attempts failed and the HHS budget — and with it the national deficit — to grow. By 1986, the final health and welfare budget was over \$76 billion (*CQ Almanac* 1986).

**Inherited policy.** Reagan faced problems with spending on social programs that he had inherited from the Nixon, Ford, and Carter administrations. In housing, for example, budgetary strains were created by the Section 8 voucher system, CDBGs, and Urban Development Block Grants. Reagan had these reduced, and in addition, reallocated to state control for urban and community development much of the funding which had previously been targeted to low-income housing (Hershey 1983, 143).

As far as health and social policy were concerned, David Stockman notes that even with the strong ideological intent espoused by Reagan, the "legacy of the New Deal's social democratic impulse" was so forceful that the Republicans found it necessary to modify their policy direction and maintain the popular universal benefits. Because these were backed by a large percentage of the electorate and their congressional representatives, who would "not take on the 36 million who get the social insurance checks" (Stockman 1986, 402), the Republicans did not make significant reductions in the Medicare and Social Security budgets. However, they did reduce non-universal programs such as Medicaid and Aid to Families with Dependent Children

**Political culture.** The strong support by state and societal coalitions for the New Deal and Great Society programs had been eroding for over a decade (Banting 1996), and by the late 1970s, there was a return to "advocacy of a weaker government, one less involved in welfare programs and more supportive of the free market" (Lipset 1990, 219).

By the time Reagan assumed office, the political climate of uncertainty about the need for government involvement in social matters that had characterized the previous watershed period had largely been replaced by a belief in less intervention by the government.

Compounding the nation's reluctance to sanction further government intrusion into societal issues was the desire to dismantle some of the complex regulations that had constrained private enterprise in the past (Marmor 1998). This was not only the case in housing, but also in health policy, where federal control had, in many instances, restricted the opportunities for state and local government policy innovation (Sparer and Brown 1996).

Yet there was a limit to which Americans were willing to sacrifice federal control. This was especially true in policy areas that affected Social Security payment systems.<sup>4</sup> Indeed, "even in the most influential early years of the Reagan administration, the vast majority of Americans favored increasing government regulation of both the prices and the regulation of health services," and support for medical care was considered "virtually on par with Social Security as an entitlement" (Schlesinger and Lee 1993, 555). Confirming this attitude were a series of polls conducted by the *Atlantic Monthly*. These clearly demonstrated that as the rollbacks in regulation and the cutbacks in domestic spending became evident, the public increased its endorsement of regulatory and support programs (Ferguson and Rogers 1986, 45). Thus, although there was backing for the initial rounds of budget cuts in health during the early 1980s, public opinion later shifted to the point where universal benefits were deemed to be an important federal responsibility (Kingson and Berkowitz 1993).

**Ideology.** As we have seen, the initial appeal of Reagan's ideology to the public was his goal to limit the size and the influence of the federal government, to curtail central government costs, especially those related to social programs, and to restrict government

intervention "in the private market at any level" (Rich and White 1996, 15). This was mainly because there was a sense among Americans that previous social policies had been "wasteful and unsuccessful" (Elazar 1994, 153) and that state and local governments should be responsible for providing necessary services.

In order to enhance the appeal of his ideological position, Reagan described his Program for Economic Recovery as a way to lessen the burden of scattered federal regulations and to reduce the amount of paperwork on other levels of government (Peterson et al. 1986). Even though the Democrats had a majority in the House, the Republicans managed to put important aspects of Reagan's ideology into effect. For example, the block grants which had been employed as the primary funding vehicles for state and local governments were reorganized, consolidated, and substantially cut. Simeon and Willis supply the following information: "federal transfers to the states and localities declined quite sharply, falling 33 per cent in real terms and dropping from 26.5 per cent of state-local revenues in 1978 to 18.2 per cent in 1987, thereby reversing a long period of steady growth" (1997, 180). And Kincaid notes that instead of allocating funds to local authorities for the construction and maintenance of public housing, the Republicans preferred to provide vouchers and tax credits directly to the recipient so that low-income persons would find housing on their own. In other words, some Reaganites wanted to "simply mail checks to poor people so as to cut costs, eliminate the 'undeserving' poor and middle-class claimants, and decimate the federal-state-local 'welfare bureaucracy' which, in their view, is populated with liberal Democrats" (1994, 41). These ideological positions adversely affected the nature and scope of social policy in general and public housing policy in particular.

In health, the Republicans actively supported a reduction in federal government funding of healthcare services as well as an expansion of private hospital facilities and insurance mechanisms.

**Definition of the problem.** With Reagan in the White House, policy makers began to examine alternative neo-conservative policy proposals, many of which had been forwarded by the think tanks that had proliferated since the 1960s and 1970s. These organizations produced reports which espoused "new right" changes to the ideological and political climate (Dreier 1998, 126). Social policy, in particular, had become a high profile issue with the American public and redistributive policies came under close scrutiny by the new administration. Conservatives had advanced the argument that social programs were wasteful and undermined opportunities for self-reliance (Private communication from Breckenridge 2000). And critics of the Great Society and of Carter promised to end the problems of a "runaway federal budget" and, thus, the era of "Big Government" (Stockman 1986, 408).

As a result of the Reagan administration's efforts to overhaul social policy, people who had previously been recipients of aid found themselves with reduced support from the federal government and, in certain instances, from state or local administrations, as well. In response to this situation, there was a "public outcry over the 'purge' of people on the rolls" (Kingson and Berkowitz 1993, 140), and in order not to alienate the electorate, the Reagan administration became more selective with the programs it targeted and modified the speed with which it retrenched.

Many of the problems that stemmed from the speed of the federal devolution process were brought to light by reports from a variety of sources. The following three will illustrate the concerns regarding housing and health.

First, the House Select Committee on Aging's Subcommittee on Housing and Consumer Interests reported that, in 1984, out-of-pocket medical expenses had grown to such an extent that many seniors had less money to pay for necessities, including accommodation. According to Subcommittee Chairman Don Bonker, this was "a national crisis and a moral disgrace" (1986, 2) This report, in particular, drew attention to an

important aspect of the relationship between housing and health.

The issue of affordable accommodation was also emphasized during the hearings of the Subcommittee of the Committee on Government Operations chaired by Rep. Barney Frank (United States 1986). Since the cost of renting shelter had grown substantially during the 1980s, and, concomitantly, shelter allowances (whether through rent subsidies or welfare) had declined, Frank attempted to determine whether HUD's public housing rents fairly reflected the prevailing level of rent being charged in the private sector. His subcommittee concluded that they did not.

Finally, Arnold Relman, a physician, published findings in the *New England Journal of Medicine* which indicated that the "competitive health care markets . . . have no interest in the poor and uninsured. In the absence of a substantial increase in the expenditure of public funds, little or nothing will be done about the estimated 30 or 40 million citizens lacking adequate medical care" (1986, 1609). Statistics such as these were not new to the government,<sup>5</sup> but their publication at this time prepared the way for introduction of the Urgent Relief for the Homeless Act in 1987, which provided only limited relief for families which, in the prevailing economic climate, were in need of both health and housing services.

**Decision making.** The primary decision making body charged with determining policy direction during this watershed period was the Office of Management and Budget, which was headed by David Stockman. A strong supporter of laissez-faire ideology, Stockman was an economic conservative who believed in self-reliance, minimal government intervention in society, and the desirability of respecting market forces. According to Johnson, "armed with the tools of fiscal restraint, Stockman recognized his power over public policy [believing that] policy and budget were inextricable" (1991, 76).

In order to implement their substantial policy changes, the Republicans passed the

Omnibus Budget Reconciliation Act in 1981. This legislation bundled "a number of controversial policy changes in with the budget for one 'yes or no' vote" (Private communication from Breckenridge 2000).<sup>6</sup> This Act permitted HUD Secretary Samuel Pierce to implement extensive reforms and dramatically reduce federal funding for public housing.

In addition, decisions to reorganize HUD's bureaucracy were made because of widespread perceptions of "mismanagement and corruption" by bureaucrats and influential developers (Dreier 1997, 10). Pierce protected the decision making process from what some would consider outside interference and kept it in the hands of relatively few people. Johnson asserts that there was a "vacuum in terms of a normal housing policy process," and adds that if Congressional hearings were called at all, testimony was sparse (1991, 81). Frequently, the only actors to appear before committee hearings were Secretary Pierce, senior HUD officials, and representatives from major business interests such as the Mortgage Bankers Association and the American Builders' Association. Under Reagan, the primary focus of the federal government was on the financial and business aspects of housing (Johnson 1991).

Many state and societal actors, including housing providers, housing consumers, and representatives from other government levels who had participated to varying degrees in the policy process during previous administrations now became conspicuous by their absence at the federal level. The builders and developers who had benefited from government grants in the past were no longer interested in public housing. As Dreier puts it, "[w]ithout subsidies, it simply isn't profitable to build housing for the poor. When HUD'S production subsidies dried up in the 1980s, private developers walked away from the inner cities" (1997, 11-12). And consumers now became active at the local level, as they and housing reformers established partnerships with community-based businesses and municipal governments to create local housing projects.

In health, as in housing, policy decisions were also mainly left to senior officials,

who had moved immediately after the 1980 elections to limit and "consolidate federal health programs in block grants and to cap federal support for Medicaid" (Starr 1982, 419). Indeed, by the mid-1980s, HHS, headed by Dr. Otis Bowen, had terminated most of the regulated health delivery programs inherited from previous administrations. This opened a path for increased representation by private organizations that offered health delivery (Litman and Robins 1997). Soon, HMOs, which provided a range of prepaid health services, became the predominant model, with citizen enrollment growing from 5.7 million in 1975 to over 19 million in 1985 (Heidenheimer et al. 1990).

Although senior officials held great power during Reagan's administration, and the decision making process in the social policy field was substantially altered, proposed changes to the status quo tended to be constrained by protests from state and societal actors who would stand to lose from those changes. Reagan may have strongly wished to make further modifications in the health and welfare system, but the politicians were faced with enormous pressure from middle class Americans who did not wish to have their entitlements reduced (Stockman 1986).

**Exogenous influences.** As the century progressed, the US, like Canada, experienced an increase in its elderly population — by 1985, 14.3% of men and 18.7% of women were over the age of 60 (United Nations 1992, 81) — and these citizens were requiring ever greater amounts of healthcare. The costs of this type of service grew constantly after World War II, and when federal health and housing assistance was cut back in the wake of the economic upheavals of the 1970s, the people who suffered most were the elderly, especially those within the low-income ranks of American society. As conditions worsened and unemployment spread, people of all ages were affected. Whiteis tells us, for example, that between 1985 and 1991, approximately 1.2 million employed Americans lost work-related health insurance and were unable to pay for the services to

which they previously had access (1997). The rapid rise in for-profit healthcare facilities also had a significant impact on the availability of health services in poor urban centers during this time. Whiteis describes the situation in the following terms: "As conditions in core urban communities have worsened and their pathogenic effects have become more severe, the need for available and accessible medical care has become more pressing." Whiteis adds, that during Reagan's tenure the closure of hospitals in these inner city areas was often portrayed in "business-oriented health services research literature as little more than the results of an industry shake-out where inefficient competitors are squeezed out by rational market forces" (1997, 234-235).

Furthermore, the combination of "the weakening of the redistributive impulse in both transfers and taxes" (Banting 1997, 302) and the growing inequality in income for elderly, handicapped, and minorities in the US compounded the problems associated with poor housing conditions (Newman and Schnare 1992).

Despite these policy outcomes, the federal government's intervention in assisted housing and health services continued to decline, and, as stated above, much of the responsibility for these services now fell to other levels of governments and, more importantly, to the private and non-profit sectors.

### **Summation**

The Reagan years left HUD with a diminished budget for public housing and HHS providing fewer benefits for those on welfare. This was the result of a broader political agenda designed to reduce taxes, increase military spending, and decrease expenditures on domestic programs. There was a massive transfer of social costs to state governments and a return to the private market. In this climate of federal retrenchment in policy areas dedicated to low-income Americans, much more attention was paid to fiscal issues than to functional ones. As a result, any remaining potential for linkage between housing and health policy

became even more remote.

**Abetting factors.** Ideologically, the Republicans stood for a reduction in wasteful spending and believed that, in public housing and health, federal funds should be targeted only to those who were most in need of assistance.

With Reagan in the White House, the Republicans had an opportunity not only to review the structures, policies, and processes of HUD and HHS, but to reduce waste and improve program targeting. HUD, in particular, was seen to be wasteful and inefficient.

In order to achieve their goals, the Republicans continued with the coercive federalism of previous administrations. Although this type of federalism resulted in central government retrenchment in some areas of the social policy field, by facilitating the transfer of costs and responsibilities to the states it enabled some subgovernments to embark on innovative strategies for the provision of assisted housing and healthcare.

In political culture, even though the laissez-faire philosophy enjoyed support in many quarters, a significant number of Americans still believed that the federal government should establish and maintain a clear presence in the social policy field. This sentiment grew as the Republican cuts began to detrimentally affect more and more people, and ultimately ensured that Medicare and Social Security payments were preserved to a far greater extent than the Republicans had originally intended.

With federal retrenchment, decision making in public housing and health matters fell more and more within the purview of the states. In order to formulate their plans, state governments relied on their bureaucracies, the private sector, and societal coalitions. In housing, there was a resurgence of community-based groups and organizations that were able to link with local governments and businesses to create vibrant neighborhoods in what had previously been slums. In health, the private sector offered a variety of insurance strategies.

Studies and reports from Congress and societal coalitions defined the multifaceted problems that faced the nation, demonstrated the detrimental impact of aspects of the Republicans' social policy strategy, and suggested ways to assist the growing number of individuals who were in need of help with accommodation and healthcare services.

A reduction in taxes, a rise in military spending, a growth in the deficit, an increase in the number of elderly and unemployed, and a worsening of conditions in urban centers were key factors that helped determine the policy path chosen by the Republicans. These exogenous influences intensified the need for better social program targeting and fiscal management.

Although wherever they could, the Republicans largely de-emphasized inherited policies that dealt with low-income Americans, they maintained the integrity of Medicare and Social Security, two universal programs that remained highly popular with the American public.

**Inhibiting factors.** Housing and health were two of the many policy areas that were included in Reagan's ideologically driven move to decrease federal involvement in social matters and to encourage private and third sector participation in program delivery. His retrenchment strategies inhibited attempts to expand involvement in these areas on the federal level.

As fiscal matters commanded ever greater attention, the OMB played a particularly important role in furthering Reagan's policies. As a result, both HUD and HHS underwent significant institutional changes. These changes, plus the cuts to HUD's programs, produced a diminished federal role in all aspects of assisted housing, and, as far as the Administration was able, HHS also relinquished responsibility for a number of programs that were targeted to the poor.

The coercive federalism that prevailed during this watershed period made it easier

for the federal government to implement these retrenchment strategies. Even though many states found it difficult to absorb the fiscal and administrative responsibilities for housing and health, the federal government stood firm in its position on social policy.

Support for the Republican's neo-conservative agenda had grown steadily since the 1970s. Americans perceived the federal government to be a leviathan in which expensive, poorly managed programs wasted the taxpayers' money. This resurgence of the political culture that preferred to direct responsibility for the poor to the private sector and to non-government agencies had a negative impact on federal housing and health initiatives.

To a greater extent than in previous watershed periods, policy decisions were made by elected and appointed officials who worked in concert with OMB staff whose primary goal was to cut costs in federal social programs. On the state level, administrators, now faced with a deluge of claims for assistance but with a limited capacity to provide aid, were obliged to deal with the consequences of the federal government's withdrawal. The stand taken by the Republicans also changed the degree to which input was provided by societal actors. For example, in the increasingly laissez-faire climate of the time, builders made their own decisions and constructed new homes for profit, not to help the urban poor. Large, health insurance organizations developed private healthcare plans and built new for-profit hospitals. In addition, previously influential groups such as the medical associations and coalitions of workers lost much of the decision making clout they had had during the previous watershed period. Meanwhile, consumers were even further marginalized from the decision making process than they had been in the past.

Despite the fact that the Administration was determined to continue on the policy path that it had set, a plethora of studies and reports called attention to the detrimental impact that the government was having on the needy and on the potential for coordination between housing and health policy. Coupled with the impact of the political culture, this worked to discourage the government from making the deep cuts that it had planned for

### Medicare and Social Security.

The Republicans' interest in reducing taxes and increasing expenditures for the military outweighed concern for the needs of the elderly, handicapped, and unemployed. With this policy focus, the deficit grew to such an extent that housing programs had to undergo further devolution, while in health, government involvement was largely restricted to the core policies of Social Security that it had inherited from its predecessors.

## CHAPTER 8

### CONCLUSION

The neo-institutional framework has provided valuable guidance in exploring the manner in which Canadian and US assisted housing and health policies were created and changed at four specific times since the end of World War II. This framework was chosen because it helps the researcher to analyze specific institutions, their history and structures, the dynamic processes that take place within and between them, the state and societal actors that influence them and are in turn affected by them, and the environments in which they interact over time. Much of the efficacy of neo-institutionalism lies in the fact that it obliges the investigator to limit the parameters of study and maintain a clear focus in a multifaceted research area. And of equal importance, it facilitates the organization of the complex information that results from the research effort.

Use of the neo-institutional framework in the present study has confirmed Inglehart's assertion that an analysis of the factors which produce political, social, and economic change in an advanced industrial society reveals that "each factor is part of an interdependent system of causes" (1990, 14). In addition, it has substantiated Krasner's claim that examination of the historical developments of state structures allows us to appreciate the "different environmental pressures that are placed on them" (1988, 67) and Boase's observation that it helps "to explain how particular state-societal institutional junctures unfold, become interdependent, and effect quite different policy strategies" (1996a, 288).

The study has drawn our attention to some of the differences that exist between nations that are considered to be alike in many important respects. It has shown us that even though Canada and the US have been described as "liberal welfare states" by Esping-Andersen (1990), each government has taken a unique approach to the development of

assisted housing and health policies. And it has helped confirm Banting's view of the root of the differences in Canadian and US social policy choices in the postwar years:

[P]olitical institutions of the United States represent the classic example of fragmented power, combining congressional government, federalism, and decentralized political parties. As a result, policy innovation requires the construction of often fragile and temporary coalitions, a painful process that increases the likelihood that any proposal will be delayed, diluted, or defeated. In contrast, power is more concentrated in Canada by the combination of parliamentary government and cohesive political parties at the national level. Although Canada's federal nature ensures that power is more dispersed than in a unitary state such as Great Britain, its decision making is more concentrated than in the United States, a difference that facilitated the development of social programs (1997, 281).

Although housing has generally been viewed as an economic issue in both countries, at certain times it has also been seen as a necessary part of the nation's social fabric for those in need of shelter. Healthcare, on the other hand, has been perceived in markedly different ways in each country at different times during the postwar era. The discussion above has provided us with a way to account for the manner in which Canada and the US have established their housing and health policy paths. It has shown that both Canada and the US followed similar policy paths in housing. However, the choices they made in health were different. One of the results was that although there was a potential for linkage between the policy fields in the mid-1940s and late 1960s, this potential became remote in the late 1970s and mid-1980s. The following paragraphs summarize the findings and provide a brief comparison of the main similarities, differences, and impacts of the variables.

### **The mid-1940s**

Canada and the US both seemed to have opportunities to introduce significant housing and health policies at this time. Neither country did, however, because of constraints placed upon those opportunities by the determining factors discussed above.

In the aftermath of the Depression and war, the provinces and states did not possess

the fiscal or institutional capacity to implement wide-reaching and effective social programs for those in need. In good part, this gave rise to public support for greater federal government intervention in social policy. Therefore, each nation undertook extensive surveys to determine whether viable national strategies could be crafted.

Canada's government, with its unique parliamentary structure embedded within a federal system, had specific, constitutionally assigned areas of authority, including that of taxation. Under the stresses of economic calamity and war, the central government used its taxation powers in conjunction with intergovernmental agreements to exert more control over national policy than it had done before. In the US, the 1937 Supreme Court decision ruled it constitutionally permissible for the central government to formulate and implement national policies. Thus the Supreme Court decision weakened the notion of dual federalism and broadened the federal government's sphere of legislative authority. However, the institutional complexity associated with the constitutional separation of power made the US policy process more difficult and social policies developed in an incremental manner.

During these times of change, Canada and the US also received reports recommending federal government intervention in areas of social policy such as housing and health. Although neither Canada nor the US had the necessary institutions in place to design and implement policies for all social needs, both governments had the fiscal capacity to create the required structures, including the expertise of highly knowledgeable bureaucrats.

In spite of the fact that there was a potential in both countries to move toward the establishment of national social policies, as was shown above stronger elements discouraged the formation of such policies in housing and health. For example, powerful private sector coalitions such as builders, physicians, and insurance companies, which had well established linkages with the government, worked successfully to ensure that their own interests would be protected in a free market environment; while for their part, social reformers and consumer groups were weak and fragmented and had little access to or

influence on the decision making process.

In addition, and much more significantly, constitutional barriers continued to be a factor in Canada. Despite the fact that the provinces had not challenged the fiscal power of the federal government in court, in its interpretations of the British North America Act, the Judicial Committee of the Privy Council had consistently restricted the federal government's legislative powers, thus promoting a much more pervasive concept of dual federalism. Because of this constitutional apportionment of responsibility, Canada's provinces were able to exert greater pressure on the federal government than was possible for the states in the US.

If in the wake of the Depression, the US federal government experienced strong centralizing pressures as it assumed greater responsibilities for establishing policies that constitutionally lay in the purview of the states, by the end of the Second World War, that government had the constitutional authority to increase its legislative scope. In contrast, Canada's central government was obliged to enter into federal-provincial agreements, including the 1940 amendments to the Constitution to introduce unemployment insurance. Thus, in both nations, although the pressures on the central government were similar, the institutional and societal mechanisms were significantly different. In this regard, the characteristics of the federal systems in each of the countries were and remain crucial elements in the evolution of social policy, in general, and housing and health policy, in particular.

The interplay of other important factors also affected the social policy paths chosen by each country in the mid-1940s. Among those factors were political culture and partisan politics. With respect to political culture, both Canada and the US recognized value in the Keynesian and Beveridgian philosophies. Without a strong anti-statist attitude, Canadians were generally amenable to government assistance in the field of social policy. But in the postwar period, even the Americans, despite their traditional aversion to state intervention and their growing fears of socialism, in increasing numbers came to appreciate the need for

a measure of government assistance to solve pervasive social problems.

As far as partisan politics was concerned, Canada was more influenced by the ideological left than was the US, its policy goals being greatly affected by the presence of a third party representing the views of a significant portion of the population. Prior to the Depression, these views, which expressed the preferences of workers and farmers located primarily in the western provinces, had limited impact at the national level. With a federal election on the horizon in the mid-1940s, however, and despite the reluctance of the Liberal party in power, the government was forced to broaden the scope of its social policy proposals to satisfy public demand.

The US did not experience similar ideological influences. Even though the leaders of the Democratic Party wished to implement greater interventionist policies and did succeed in introducing important social policy initiatives such as the Social Security Act of 1935, many of their policy plans failed due to the opposition of powerful coalitions within Congress, the strategies of business and professional associations, and the lack of concerted action by consumer groups.

Thus, although a variety of pressures from state and societal sources in both countries favored the development of assisted housing and health policies, and even provided an opportunity to link the two policy fields during this period of massive domestic change, the barriers that already existed and the tensions that arose prevented the necessary institutions from being created at the federal level. The notable exception was the Canadian (Central) Mortgage and Housing Corporation, which, however, focused mainly on the economic aspects of housing rather than on the amelioration of social problems.

This, then, was the state of assisted housing and health policy development in the mid-1940s. The events during this formative time tend to confirm the theoretical assumptions outlined at the beginning of this study. The overall structure of the state, determined primarily by each nation's constitutional and institutional frameworks, set the

stage for the manner in which postwar social policies would evolve. The complex and dynamic relationships between preferences and power affected the strategies of state and societal actors within each nation, and these relationships both facilitated and constrained policy opportunities and policy choices.

### **The late 1960s**

This was a time of greater cooperation and creativity between the federal and provincial/state governments. Both countries witnessed economic growth, social policy development, and opportunities for linkage between assisted housing and health policy. The governments of both nations were elected in part because of their ideological support for state intervention to aid less advantaged citizens. Studies and reports redefined the causes of societal problems which emanated from poor housing and health services and urged greater government action. In response, Canada and the United States created institutions dedicated to the design and implementation of national housing, health, and welfare programs. There was an increase in the scope of the initiatives taken by policy makers, the number of bureaucrats to carry out those initiatives, the complexity of the programs, and the linkages with specialists at other levels of government and in the private sector. In the process of social policy expansion, both countries introduced public housing plans that utilized similar policy instruments to aid individuals and families that required government-funded accommodation. In addition, the state and societal actors who provided input to the system retained their relative positions of power and influence and acted to defend their interests as they had during the previous watershed period.

Despite these similarities, marked differences manifested themselves in the paths taken by each country. In Canada, intense intergovernmental pressures developed as the provinces demanded less federal encroachment into their constitutionally defined areas of authority. These pressures notwithstanding, Ottawa expanded the existing institution

responsible for housing (CMHC) and instituted an innovative universal healthcare plan similar to the one designed by Saskatchewan, which at the time was headed by the NDP.

In the US, even though the concept of dual federalism still had support in some quarters, opposition to federal government intervention diminished because of the desire of many Americans, including President Johnson, to continue the social policy agenda begun during the New Deal era. The race riots and protests against the war in Vietnam placed new pressures on the federal government. The cooperative federalism that marked the beginning of this watershed period facilitated the War on Poverty, but anti-statist sentiment lessened the ability of the federal government to focus its full attention and resources on the goals of the Great Society. In that tumultuous era, the Johnson administration managed to introduce public housing and community development programs through HUD and limited health initiatives (Medicare and Medicaid) through HEW — but only after vigorous debates and hard-won compromises between Congress, the Executive branch, and the lobbyists.

### **The late 1970s**

In contrast to the 1960s, when the Canadian and US federal governments both embarked on expansionary social policies, the 1970s were marked by reactive cost-cutting moves. Economic pressures caused by international events produced uncertainty and austerity, and both nations undertook extensive reviews of the policies that provided aid to the needy. Social problems were redefined and existing institutions responsible for assisted housing and health were modified in order to cope with the political and economic realities. The steps to reduce government intervention, however, were made more difficult because of the expansionary policies that had been inherited from the previous period. The relative influence of state and societal actors had also changed. For example, physicians and builders, although still prominent influences, were less able to sway the decision making process and, even though the numbers of consumers in need of government assistance had

increased, these groups became even more fragmented and less able to influence the decision making process than they had been in the 1960s.

In Canada, concerted efforts to reduce costs meant that the private sector coalitions lost the degree of influence that they had previously had in determining the government's policy direction. Relying on new definitions of the problems that faced the nation, Ottawa, with its centralized decision making system, was able to substantially change the institutions responsible for housing and health, as well as the mechanisms by which those programs were funded. In the United States, on the other hand, the institutional reforms in the federal government caused the policy making process to become more fragmented. This fact, along with the policies inherited from the Nixon-Ford era and disagreements within the Democratic Party about policy direction, prevented the administration from introducing a national health insurance program and from undertaking welfare reforms, including those related to public housing. These difficulties were compounded by a neo-conservative influence and a growing lack of faith by the public in the integrity of government.

### **The mid-1980s**

During this watershed period, there was an erosion of consensus about the desirability of large-scale government intervention in the provision of social policy. The neo-conservative ideology that had gained support in both Canada and the US by this watershed period led to determined efforts to reduce government presence in a number of social policy areas, particularly in housing. Decisions made with less input from other state or societal actors resulted in government retrenchment and devolution of responsibility to the provinces and states, as well as to private and, increasingly, third sector providers.

As federal housing institutions underwent structural and funding changes, lower levels of government and non-government providers initiated their own strategies to deal with regional and local problems. Builders tended to focus even more intensely on

construction for middle- and upper-income consumers, and concurrently, there was an increase in the number of low-income persons who sought some form of government assistance for shelter.

In health, the physicians, who had been so influential in the past, were largely excluded from the federal policy making process and were obliged to defend their interests through points of access at the provincial and state levels. Here, their position was often challenged by previously weak or latent actors, among them nurses and other healthcare professionals who were becoming increasingly vocal, and patient advocacy groups that sought alternatives to institution-based healthcare. As noted above, however, the neo-conservative governments of both countries were unable to withdraw completely from the social policy field.

Although Canada and the US continued along essentially the same housing policy paths that they had followed in the late 1970s, their health policy strategies diverged even further than they had during that watershed period. In Canada, the Mulroney administration tried to contain health costs by taking legislative steps that had been proposed by the previous Liberal government. In combination with maintenance of inherited financial controls and a reinforcement of the nation's five principles of medicare, the Canada Health Act, under threat of fiscal sanctions, pressured the provincial governments to introduce legislation that restricted the fees that physicians could claim for their services and, hence, the amount of money that the federal government would have to expend in this field. In contrast, the Reagan administration embraced expansion of the private sector, including greater participation by private insurance companies and HMOs.

As the previous discussion has shown, the development of housing and health policy created institutions and areas of responsibility filled by actors who developed parochial interests and defended those interests by availing themselves of the policy making

processes inherent in the federal system of their country (Pierson 1995). Often vigorously protected by the decision makers, bureaucrats, stakeholders, and clients, programs tended to become embedded with the passage of time and the incremental nature of policy making. Although subject to preservation "by their number and the crowded agenda of cabinets and legislatures that can only focus their attention on the minuscule proportion of ongoing state activity" (Cairns 1986, 57), those programs were not completely rigid and path dependent, but gave prominence to different agents of change and were open to manipulation as circumstances varied.

### **Recent trends in Canada and the US**

In Canada and the US, the role of the federal government in the provision of social policy has undergone profound change since the last watershed period in this study, and the potential for linkage between public housing and health has become even more remote than before. A brief synopsis of these trends follows.

In assisted housing, the federal governments of Canada and the US have followed a similar policy path and have largely relinquished their leadership roles. They have relied more and more on other levels of government as well as on private and third sector agencies to supply accommodation to those in need. In health, completely divergent policy directions have been chosen. Canada, for the most part, has maintained federal control over national health policy and has substantially altered the funding mechanisms for other welfare programs. The US, in contrast, has increasingly relied on the private sector for health services and has severely curtailed federal funding for selected welfare programs.

In Canada, the federal government, with its parliamentary system, executive-centered cabinet, and stress on adherence to party discipline, has ensured that the state-directed path of social policy reform established in the 1980s would be continued. Not only have the central institutions been reorganized, but the roles and relationships between state

and societal actors have also been transformed because all levels of government have been "[c]onfronted with the need to address deficits and reduce and redirect spending" (Boismenu and Jensen 1998, 58).

In housing, the federal Liberal government has continued the Conservative ideological stance of the mid-1980s and has fostered a program of steady devolution of housing-related responsibilities to the provinces, with the federal government continuing to fund previous cost-shared programs. Indeed, although the question of homelessness has taken on growing importance (Golden 1999), the issue of funding for public housing has only recently re-entered national social policy discourse. According to Klodawsky and Spector, this "policy of inaction and divestment in the absence of concerted provincial and territorial efforts is slowly leading to the emergence of a patchwork, both of programs and of levels of social housing availability" (1997, 263). This deliberate strategy of disengagement has forced the provinces to embark on their own housing programs in concert with private and third sector partners (Carroll and Jones 1999).

In health, in addition to restructuring health and welfare by creating a Ministry of Health and a separate Human Resources Department for other social programs, the government has made changes to the mechanisms by which healthcare funding is allocated. Although there have been radical alterations in funding mechanisms such as the 1996 Canada Health and Social Transfer (CHST) which combined EPF with CAP, the provinces gained "enhanced flexibility to design and administer social programs and to allocate funds among social programs according to their specific priorities" (Department of Finance 1999, 11). However, these steps have not diminished the federal government's control of the purse and the amounts allocated to the provincial governments declined during the 1990s.

The features of the American federal system, coupled with the complex evolution of social policy within its institutions and the fragmentation of state and societal interests, have ensured that comprehensive links between the paths of public housing and health policy

would remain elusive.

Both the housing and health policy communities have become increasingly congested (Journal of Housing and Community Development 1996; Boase 1996a). In addition, elected officials and bureaucrats are being pressured by growing numbers of professional lobbyists who have much to gain by federal involvement in both public housing and health. Complex, fragmented decision making processes within and outside of Congress<sup>1</sup> together with competing reports from representative groups have compounded the institutional barriers to reform to a far greater extent than before.<sup>2</sup>

In housing, HUD underwent a major reorganization in 1997 (HUD 1998c). This promoted further division of federal social policy, in large part because of Washington's offloading of responsibilities to state and local governments (Anton 1997) and increasingly to third sector groups (Koebel 1998). In welfare, substantial reforms radically changed the manner in which a number of social programs provided assistance to those in need. By reducing housing allowances, these changes had a direct impact on people who had previously received assistance with shelter (Castro 1997). In health, despite President Clinton's efforts to introduce national health insurance in 1993-4, the initiative failed. In good part, this was due to a combination of institutional complexity and the manner in which powerful groups (most notably the insurance companies) made use of the multiple points of access in Congress (Private communication from Boase 2000). And during these years, most Americans continued to believe that "all able-bodied adults can and should support themselves by working and that the market should provide most services" (Robinson 1997, 260). With aggressive action from the private sector and the growth of Managed Care Organizations (Jost 1998),<sup>3</sup> the private sector's hold on the health industry is now primarily in the hands of insurance companies and their shareholders (Anders 1996) and the federal government's role has diminished to that of payer for services for the elderly, the very poor, and the handicapped.

As the US federal government continues reducing its role in the provision of social programs, state and local governments have embarked on their own strategies which, in turn, have led to "multiple models of reform" in both health (Marmor et al. 1996, 277) and housing (Dreier 1998). In the process, many state governments have "recaptured a reputation for effective government and policy innovation" (Breckenridge 1998, 121).

### **Some final comments**

Both Canada and the United States have increasingly moved away from the Keynesian and Beveridgian philosophies of the 1940s-1960s. However, given the public's desire to have federal government intervention in certain social policy fields, further retrenchment characteristic of the mid-1980s and early 1990s is rather unlikely. As Mishra reminds us, industrialized nations seem to be experiencing an ideological shift towards a mixed economy of welfare. This ideology is "largely pragmatic and accommodative" in that it accepts that the state has responsibilities to ensure that services are available, adequate, and consonant with set standards, but that other levels of government as well as private and non-profit groups also have a role to play (1990, 92-93).

If this is so, a window of opportunity exists for both governments to provide leadership and promote policy change that includes intersectoral linkages and interjurisdictional cooperation among assisted housing, health, and other social policy areas. To achieve this, it is necessary for policy makers to appreciate that their decisions will depend, to a large extent, on the structures and processes of the federal government system in which they operate, the state and societal institutions that come into play, the preferences and strategies of the actors who try to influence the policy path, and the realities of the past that still influence the present. Taken together, these elements determine the possibilities that exist today and the obstacles that currently constrain such action. And in their endeavor to plan for the future, the policy makers must expend special efforts to foresee the potential

long-term as well as short-term consequences of their decisions, not only on the general population but also on individuals who, because of age, disability, and the like, are especially vulnerable. Finally, they should adopt a holistic approach which, wherever possible, factors in the quality and suitability of accommodation as well as accessibility to a continuum of healthcare services. The importance of accessibility was underscored in a study that suggested that universal healthcare insurance and availability of healthcare services in Canada may have contributed to lower mortality rates among homeless men when compared to a similar population in the US (Hwang 2000).

Because critics have claimed that public housing programs have tended to be "unfair, ineffective, and inefficient" (Newman and Schnare 1992, 7), this thesis recommends that both countries establish national principles concerning the types and quality of accommodation for populations deemed to be in need; that they forge intergovernmental agreements which would create "supportive, empowering environments" (Klodawsky and Spector 1997, 274) that strengthen the communities which provide housing and health services for vulnerable citizens; that they link the institutions, policies, and programs which provide health and social services by recruiting knowledgeable officials to proactively design programs that provide for those who require housing and health aid; and that they promote greater ties with the private and third sectors to facilitate the achievement of the chosen policy goals.

If this is the path that Canada and the US would follow in housing, it is requisite for policy makers to understand that policies are most effective when they provide maximum flexibility for a population that is increasingly diverse in age, in functional capacity, and in need; to acknowledge that location, design, construction, and maintenance of shelter all contribute to the physical, psychological, and social well-being of the individual (Stirling 1997); and to recognize that persons with compromised physical or cognitive function do not necessarily require institutionalization if appropriate accommo-

dation and support are available.

In health policy, Canada and the US occupy different positions. With this in mind, the present study recommends two distinct paths of action that would reflect current social, economic, and political realities.

As far as Canada is concerned, the most desirable course would be for the nation to begin by maintaining its current adherence to its five principles of medicare and then to integrate health, public housing, and social policy institutions and programs to a far greater extent than at present. The recent Canadian federal government interest in home care may ultimately lead in this direction. The federal government has proposed a national plan which would be cost-shared with the provinces. This plan calls for an expansion of health services which would not only permit greater public access to primary healthcare in the community, but would also include home care that would allow people to receive medical and other support services outside of the hospital or institution. By linking health services with the existing hospital system, the plan would provide an easily accessible continuum of care. An important aspect of the plan is that the federal government would also develop national standards for the delivery of the community-based health services.

Implementation of the above proposal would lessen the pressure on emergency departments and the demand for hospital beds, and home care would make relevant services available to those in need in their own community. Nestman, an academic who specializes in healthcare issues, notes that this "sound proposal recognizes the priority areas for development in our own provincial health-care systems" (2000, A17).

With the greater shift to community-based care, there may be an opportunity to link housing and health. As Smith and Mallinson indicate, "There are . . . two senses in which housing provision might be expected to work in alliance with the provision of community care: by inter-agency collaboration to ensure that dwellings are appropriately designed, adapted, managed and serviced for occupants with health, care and mobility needs; and by

mechanisms which ensure that people can attain and sustain homes in places where they have adequate access to the care and support they need" (1997, 193).

This will not come about easily or quickly, because there are still many competing interests that stand to gain or lose with policy change (Weller and Manga 1996). However, research done for this thesis supports the view of McGuckin and Smith that now more than ever, "there is an urgent need to reappraise the steady divorce of housing provision from the aims of social policy, and to reconsider the extent to which housing policy, in addition to its role in environmental and economic management might also be viewed more explicitly as an instrument of health care" (1991, 13).

With respect to the US, it would be beneficial to set national criteria for healthcare and strive to reach a "consensus of goals . . . while permitting different approaches to achieving those goals" (Marmor et al. 1996, 280). This would facilitate the creation of national legislation and at the same time would allow the states to choose the types of programs that would best meet the needs of their citizens. By enlarging the scope of discretion and options available to those subgovernments, such a plan would create a "political cornerstone of national health reform" (Marmor et al. 1996, 281).

This type of model has been described as "cooperative." Based on a federally-defined framework with minimum national standards, it would benefit the states in a number of ways. For example, the states would receive federal funding for adherence to those standards and would have broad latitude to innovate and experiment with their own healthcare policies (Rich and White 1996, 299). Establishment of a consensus on healthcare would be a model for a similar consensus in housing and welfare, and would provide an opportunity for HUD and HHS to review their respective programs in order to resolve the "battles . . . over who should pay housing costs of welfare recipients" (Castro 1997, 47).

In order to make this a reality, it is incumbent on policy makers to distinguish

between *health* as defined by the medical professions and *well-being* as understood by the individual; to understand how housing, as one of the broader determinants of health, affects well-being; to realize that, in the long run, the costs of preventing illness are generally less than those of managing health problems reactively; and to be aware of the fact that well-funded and well-administered community programs — programs consisting of primary health and homecare services which complement an accessible hospital system (Nestman 2000) and other social programs — help foster disease prevention and health promotion as well as rehabilitation after curative interventions have been used. In this way, the balance suggested by Renaud (1994) would be established: Hygeia, the Greek goddess of health promotion, and her sister Panakeia, the goddess of healing, together would guide us in the future.

In conclusion, it is hoped that use of the neo-institutional approach in the present thesis has advanced the study of social policy by highlighting the complexity of the policy process; tracing the dynamic interrelationships primarily among institutions and ideas; and demonstrating how the influence of key variables changed over time in Canada and the United States. It is anticipated that if the neo-institutional approach is employed in a balanced way with the most influential determinants of the policy process, it will provide a robust and valuable tool for the study of divergent as well as similar policies in analogous nations, and that the findings of those who use it will help decision makers involved in shaping the future to become better attuned to the opportunities and constraints that must be dealt with if their populations are to be served effectively.

## NOTES

### Chapter 1

<sup>1</sup> *Public housing* is sometimes understood to be shelter that is government or government-agency owned, with the amount of rent paid by the tenant dependent on income (Sewell 1994). *Assisted* and *social housing* are sometimes described as having the following characteristics: the numbers and types of accommodation are influenced by social demand; housing is allocated on established principles of need; and rent is not determined by a consideration of profit (Doling 1997). In this thesis, however, the expression *public housing* is used interchangeably with the terms *assisted housing* and *social housing*.

As will be discussed in more detail later, the policy instruments used by governments generally fall into three categories: non-profit accommodation, housing allowances, and income assistance (Fallis 1993a, 1993b). In both Canada and the US, housing policies have been implemented in a variety of ways: for example, through the provision of dwellings to families or individuals, rent supplements or vouchers for the landlord, subsidies for third sector groups, or cash transfers to the renter. Other strategies have encompassed supply side as well as demand side support (Heidenheimer et al. 1990).

The federal institutions in both countries that are responsible for housing and health have tended to offer programs directed to specific populations such as the physically and mentally handicapped and the aged. The types of programs and the amounts allocated to them have varied considerably over time (Fallis 1993b, Newman and Schnare 1992, Drier 1998). While it is not in the scope of this study to analyze these programs in detail, it is important to recognize that, for the most part, although the federal government institutions have provided housing and health programs for vulnerable populations, they do not appear to have coordinated or integrated policy development in these fields. This study will examine why this has been so.

<sup>2</sup> Pederson et al. believe that "healthy public policy is distinguished from traditional medical care policy by being ecological in perspective, multisectoral in scope, and participatory in strategy" (1988, 9).

<sup>3</sup> E.g., Hertzman et al. (1994) provide us with a tool for analyzing factors that have an impact on the health status of different populations across socioeconomic classes over time.

<sup>4</sup> To a large extent, this supports Ashford's (1991) assertion that a number of determining factors must be included in any examination of social policy. As will be discussed in greater detail later, this assertion also guides the present study of Canadian and US public policy and is relevant because it helps to explain why Canada and the US have been described as "laggards" in social welfare development.

<sup>5</sup> In his analysis of welfare state regimes, Esping-Andersen suggests that there are three types of welfare systems: corporatist, social democratic, and liberal. In corporatist regimes, the state is able to "displace the market as a provider of welfare," if necessary, and rights are attached to class and status. In social democratic regimes, social rights, equality, and universality are extended to all citizens. In liberal welfare states, such as

Canada and the US, there is a predominance of "means-tested assistance, modest universal transfers, or modest social-insurance plans . . . Benefits cater mainly to a clientele of low-income, usually working class, state dependents. . . Entitlement rules are therefore strict and often associated with stigma; benefits are typically modest. In turn, the state encourages the market, either passively — by guaranteeing only a minimum — or actively — by subsidizing welfare schemes" (1990, 26-27).

<sup>6</sup> The Elizabethan Poor Laws were adopted by both Canada and the US. They had a far greater impact on early social policy development in the US than they did in Canada, however (Boychuk 1997, Katz 1986, Skocpol 1992).

<sup>7</sup> In his quest for an institutional explanation of the similarities between the decision making processes in the German federal government system and those in the European Community, Scharpf holds that sub-optimal policy outcomes will be generated "unless a 'problem solving' (as opposed to a 'bargaining') style has prevailed in both cases" (1988, 239). This is an especially important concept when applied to social policy development in multi-tiered systems of government, because it adds another dimension to the decision making process. Pierson notes that:

Federal systems that develop shared responsibility for individual social policies are likely to generate complex policy designs to incorporate the needs and interests of each tier, and complex decision-rules for policy reform to insure that these needs and interests continue to be addressed. . . [S]hared policymaking is prone to 'joint-decision traps' in which efficiency and flexibility are subordinated to political accommodation and procedural guarantees (1995, 459).

<sup>8</sup> Both approaches are important and will be incorporated into the study as part of the neo-institutional framework in Part II.

<sup>9</sup> In their discussion of the complex relationships between the state, society, and public policy development, Coleman and Skogstad explore *policy communities* and *policy networks* and their roles in the policy process. A policy community includes "all actors or potential actors with a direct or indirect interest in a policy area or function who share a common 'policy focus,' and who, with varying degrees of influence shape policy outcomes over the long run" (1990, 25). A policy network shows "the relationships among the particular set of actors that forms around an issue of importance to the policy community" (1990, 26).

<sup>10</sup> Haas defines an *epistemic community* as a "network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (1992, 3).

<sup>11</sup> Kingson and Berkowitz indicate that it was the rapid onset of industrialization in Germany at the end of the nineteenth century which provoked state intervention into social policy matters. They assert that in order to "cushion the impact of industrialism, to subvert the union movement, and to tie the interest of the laboring class to that of the nation-state...Otto von Bismarck proposed state intervention on behalf of the wage earner through social insurance" (1993, 28). In Britain, Beveridge's approach to establishing the welfare state was "more along the lines of British Fabianism — based on a belief in welfare for the sake of social justice and equality" (Private communication from Boase 1999).

<sup>12</sup> In contrast to the various European approaches to healthcare, the Canadian and US systems developed in markedly different ways. Heidenheimer et al. claim that "American decisions to delay intervention produced a *segmented* system, under which several public subsystems — for the poor, the elderly, and military veterans — coexist with a myriad of other privately financed activities" (1990, 58). In Canada, the federal government introduced a national health insurance program in the mid-1960s (Taylor 1987), long after health programs were well established in Europe. This delay has prompted Leman (1977) to describe Canada and the US as "laggards" in introducing health care initiatives. Thus the American system relied heavily on private sector initiatives, whereas the Canadian approach to healthcare was under government control. This issue will be discussed in more detail in later chapters.

<sup>13</sup> Bennett has explored the issue of policy change by examining the concept of *policy convergence* among advanced industrialized nations. It is "the tendency of societies to grow more alike, to develop similarities in structures, processes, and performances" (1991, 215). In his framework, Bennett discusses four strategies that promote convergence. These are 1) emulation, in which all or part of a policy is adopted; 2) elite networking, in which expert opinion (often in the form of epistemic communities [Haas 1992]) promotes policy change; 3) harmonization, in which a high level of collaboration among policy makers leads to policy change, and 4) penetration where states are "forced to conform" to policy decisions taken elsewhere (1991, 227).

<sup>14</sup> Deacon et al. have examined in some detail the activities of international organizations and the future of global social policy. They assert that "national social policy is increasingly determined by global economic competition and by the social policy of international organizations such as the World Bank, and secondly that the substance of social policy is increasingly transnational" (1997, ix). Others, such as Simeon et al. (1997) have also discussed the effect of globalization on the evolution of social policy.

<sup>15</sup> Adding to the number of studies in this area, in their comparative analysis of the development of the social rental sector in Western Europe, Boelhouwer et al. observe that as "an alternative to demolition (chiefly in England) most countries advocate an integrated approach in which the dwelling, the dwelling's environment, the level of amenities, education, and social problems are tackled" (1998, 173).

<sup>16</sup> *Gentrification* is the relatively recent term which describes the process of clearing dilapidated or slum areas for the express purpose of creating new urban centers or residences. In the process of urban renewal, residents of the slums are frequently dispossessed.

## Chapter 2

<sup>1</sup> Breckenridge notes that *interstate* refers to negotiations between the federal and provincial/state levels of government, and *intrastate* refers to the manner in which "differences between the center and the regions are accommodated within national institutions." He indicates that, in Canada, intrastate mechanisms have increasingly been replaced by interstate negotiations (1998, 109-110).

<sup>2</sup> While the legislation has been praised for its attempts to alleviate unemployment,

especially in urban centers, it has been condemned for assisting the wealthy to buy homes and provide more business to financial institutions, instead of helping the needy procure appropriate accommodation. According to Belec: "It is difficult to imagine an outcome at greater odds with what was being demanded by the expanding body of social reformers in the depths of the depression, as was the DHA. Throughout the period, municipal surveys in some of Canada's largest cities documented the extent of housing decay. A variety of reform groups presented proposals for massive federal building programs. What they wanted was social housing: what they got in the DHA was the promotion of home ownership and the associated values of individualized consumption" (1997, 54).

<sup>3</sup> The researchers determined that "the slum population of the four cities was about 14 percent of the total; almost entirely white; disproportionately foreign-born (56 percent); had families about average size for their cities (about five persons); almost entirely without private baths or private indoor flush toilets; heavily dependent on shared foul privies; living under crowded conditions with substantial proportions falling below the minimum average of 400 cubic feet of air in sleeping rooms, but apparently in a reasonably good state of health; and paying one-third or more of income for rent except in Baltimore (Doan 1997, 20).

<sup>4</sup> Limited dividend tenement houses were apartment houses which offered smaller investment returns than were generally available on the market.

<sup>5</sup> Physicians were establishing more and more hospitals, and, when government funding was sought, it was the municipal governments that were requested to provide assistance. For example, in 1909, a local tax was introduced by the Saskatchewan government to finance new health facilities, including hospitals and, by the end of the First World War, the concept of municipal contracts with physicians had spread in popularity, especially throughout the western provinces (Gray 1991).

<sup>6</sup> Torrance summarizes the situation as follows: "Much of the western farm population and many industrial workers in the large cities across the country were on relief. . . . The Canadian health-care system came under a serious strain as the Depression wore on. . . . Medical relief plans were introduced to pay a portion of the medical bills and provide doctors with some income. Poverty, poor nutrition, and inability to afford healthcare exacerbated the health problems of the population. Communicable diseases like pneumonia, influenza and tuberculosis, the spread of which is fostered by poor living conditions, flourished" (1987, 21).

### Chapter 3

<sup>1</sup> These are the mythic institution, the efficient institution, the stable institution, the manipulated institution, the disaggregated institution, and the appropriate institution (Lowndes 1996).

<sup>2</sup> Perrow notes that in Cohen et al.'s "garbage can" model of organizational theory, problems are convenient receptacles for people to toss in solutions that happen to interest them, or for interests that are not being met at the time. The can, with its problems becomes an opportunity or resource. Depending on the number of cans around, the mixes of problems in them, and the amount of time people

have, they stay with the particular can or leave it for another. The problem, then, gets detached from the those that originally posed it, may develop a life of its own, or get transformed into quite another problem. Solutions no one originally intended or even expected may be generated, or no solutions at all. Some problems simply waste away (1986, 135).

<sup>3</sup> This list is not exhaustive. It is the product of consultation with and recommendations by my Committee members, to whom I am indebted. It is acknowledged that had there been a desire to give greater prominence to other aspects of the institutions, ideas, and interests that led to policy change, different variables might have been chosen. For example, the role of women or the role of marginalized groups such as the elderly and handicapped. These were not chosen, however, because societal interests such as these did not have sufficient voice to influence the policy process in any significant way.

<sup>4</sup> Simeon and Robinson provide us with an important observation related to Scharpf's (1988) concept of joint-decision traps. They note that:

Instead of the creativity and flexibility offered by multiple levels of government . . . the result of shared decision-making is often "either inefficient, or inflexible, or unnecessary and, in any case quite undemocratic" (Scharpf 1988, 247). The bureaucratic self-interests of governments are likely to predominate. Policy is difficult to change because non-agreement assures the continuation of the status quo, and at least one government is likely to prefer that to any alternatives on the table. Unanimity in joint decision-making can only work if the participants share common interests or a common sense of the costs of the failure to agree (1990, 335).

<sup>5</sup> Stevenson indicates that a conditional grant or grant-in-aid tends to be "earmarked for a particular program or activity, and is offered insofar as the recipient government agrees to undertake the program or activity in a way that falls within the guidelines set by the donor government" (1985, 151).

<sup>6</sup> Although voting patterns and elections are recognized as important issues, they have not been included as one of the determining factors, and are therefore beyond the scope of the study.

<sup>7</sup> Policies change with the passage of time, but in order for this to take place, the idea promoting change must be introduced onto the government's policy agenda. Kingdon has explored the manner in which this occurs. Maintaining that policy change rarely occurs in isolation, he believes that a "window of opportunity" opens when there is a convergence between three "streams," namely, the problem that facilitates the need for change, the policy itself, and the prevailing politics (1984). Once the window is open, then a policy change can take place, but when the window shuts, the opportunity is lost.

<sup>8</sup> Stein notes that Quebec's Quiet Revolution during the 1960s and its "demands that the government of the province assume the leadership of the Quebecois' struggle for national survival and expansion (épanouissement) led inevitably to a proposal that its constitutional powers be expanded" (1989, 14). During this period, Quebec "wrested from the government new revenue and authority" (Leman 1977, 278) which, as will be discussed briefly in the study, influenced policy changes in Canada's welfare system

(Banting 1997, 279).

<sup>9</sup> Although the present study will focus on the effects that shifts in intergovernmental relations have had on the opportunity for linkage since the end of the Second World War, it is not within its scope to examine in detail the debates concerning the Constitution or intergovernmental structures and relations.

<sup>10</sup> Skocpol notes that Hecló's (1974) study of social policy development in Sweden and Britain highlights the importance of bureaucratic influence on decision making. She maintains that studies such as this confirm "that collectivities of administrative officials can have pervasive direct and indirect effects on the content and development of major government policies" (1985, 12).

<sup>11</sup> Although this thesis discusses the evolution of assisted housing and health policy, it will not concentrate on specific groups such as Native peoples, war veterans, or people with mental illness.

<sup>12</sup> Carroll (1989) developed her concept of the phases in Canadian housing policy prior to writing the 1999 article with Jones. It should be noted that different sets of housing policy phases have been specified by others, including Banting (1997) and Richards (1995). Banting states that there have been "four broad periods: the post-war era of federal dominance in the 1940s and 1950s; the growth of the provincial role after the mid-1960s; the era of competitive unilateralism of the 1970s; and the era of accommodation from 1978 to the present" (1997, 122). Richards notes that there have been three phases since World War II. Phase 1, extended to the 1960s and was "dominated by the construction of publicly managed public housing projects targeted towards poor tenants." Phase 2 was from 1970 to 1985, when the federal housing policy "expansively subsidized nonprofit societies and tenant cooperatives to build a stock of publicly funded housing." Finally, Phase 3 extends to the mid-1990s and reflects elimination of subsidies to "mixed-income third sector projects" and a curtailment of CMHC expenditures on social housing (1995, x-xii).

<sup>13</sup> Some of Boase' work has been built on the exploration of health policy phases by Weller and Manga in 1983.

<sup>14</sup> Doan provides several examples of fraud associated with HUD's assisted housing programs. For instance, he notes that in the early 1970s, "program operations were plagued by abuses, including erroneous inspections and outright fraud, mainly under Section 235 and Section 221(d)(2)" (1997, 96). Later, other problems surfaced when the Bush Administration was "confronted with an unfolding series of major scandals in HUD ... [which] raised serious questions about the integrity of HUD operations and officials" (1997, 124-125). In 1989, under the new Secretary, Jack F. Kemp, the Department of Housing and Urban Development Reform Act was passed. This legislation was designed to improve HUD's tarnished reputation and to prevent fraud in the future. Johnson (1991) and Welfeld (1992) discuss these issues in greater detail.

<sup>15</sup> Stagflation "occurs when there is high inflation, but a low level of economic activity and high unemployment. It is likely to occur when cost pressures and inflationary expectations force prices up, but the level of aggregate demand is low" (*The Fontana Dictionary of Modern Thought*, 2nd. ed., s.v. "Inflation").

<sup>16</sup> Scutchfield et al. state that in order to "control the rising cost of health care many industries have turned to a controlled form of financing and delivery of health care — often referred to as managed care." Although there are many types of managed care programs available, it generally involves a series of contracts between insurance companies, hospitals, physicians, and enrolled patients which determine which health care services will be provided in return for specific monthly premiums. There is competition between the organizations as well as financial incentives for the patients, physicians, and hospitals to control costs (1997, 251). Folland confirms that economic matters are playing an increasing role in "how health care markets function" (1997, 1).

#### Chapter 4

<sup>1</sup> Ham and Hill (1993) note that the relationships between state and societal actors are highly complex and that the changing relationships, including the use of power, affect the causes and consequences of policy formulation and implementation. They believe that in developing policies, "elite power may be based on a variety of sources: the occupation of formal office, wealth, technical expertise, knowledge and so on" (1993, 32). Utilizing organizational theory, Marshall asserts that power is directly related to dependency and uncertainty. He maintains that all organizations function in uncertain environments and thus "the more vital an area of uncertainty is to the life of an organization, the greater is the power of the group which is responsible for its control. Power, therefore, derives from a situation in which one group is dependent upon the services of another. Dependency is, in effect, the obverse of power" (1986, 19).

<sup>2</sup> In many important respects, these concepts reflect Kingdon's "windows of opportunity" (1984), which permitted some policy initiatives to succeed and others to fall off the policy agenda.

<sup>3</sup> Gray notes that the federal government took this action during both world wars, after which this emergency federalism was discontinued (1991).

<sup>4</sup> Kernaghan and Seigal describe a Crown Corporation as "a corporation in the ordinary sense of the term, whose mandate relates to industrial, commercial, or financial activities but which also belongs to the state" (1995, 681). CMHC was established to assist private and public organizations with all aspects of house financing and building. Public housing occupied a relatively small percentage of its overall annual budget.

<sup>5</sup> Part 1 of the NHA "provided that the Government of Canada would provide 25 per cent of the capital amount of an approved NHA mortgage loan at a relatively low interest, namely, 3 per cent" (Rose 1980, 19).

<sup>6</sup> Other federal government institutions were also involved in the development of health policy plans at this time. The "pensions" portion of the previous Department of Pensions and National Health became a new department, the Department of Veterans Affairs, and was made responsible for implementing what became known as the "Veterans' Charter." This provided "extensive pensions, medical care provisions, and resettlement benefits for all members of the armed forces" (Morgan 1961, 138). The federal government remains responsible for veterans' affairs.

<sup>7</sup> The following table summarizes the activities associated with these pieces of housing legislation:

Act	Period	No. of Loans	Housing Units	Cost (\$000)
Dominion Housing Act 1935	1 Oct 1935 - 31 Jul 1938	3,083	4,899	19,619
National Housing Act 1938	1 Aug 1938 - 31 Jan 1945	18,625	21,414	67,519
National Housing Act 1944	1 Feb 1945 - 30 Sep 1946	11,664	16,211	73,518

(Source: Central Housing and Mortgage Corporation 1946).

<sup>8</sup> The attempt by Bennett's Conservative government to pass the Employment and Social Insurance Act in 1935 failed because, challenged by several provinces, it was deemed to be unconstitutional by the Judicial Committee of the Privy Council. This *ultra vires* ruling from Great Britain reminded the federal government of its constitutional boundaries.

<sup>9</sup> The Advisory Committee on Reconstruction strongly supported the introduction of social security and welfare for Canadians which included comprehensive health and education programs. It stated that "both of these matters must be incorporated into any comprehensive public policy that is developed to provide for the welfare of Canadian citizens" (1944, 32). More specifically, the Committee declared that it "would be partial and inadequate planning to envisage health insurance without better facilities for public hygiene, infant and maternal care, school medical service, hospital and sanitarium facilities and so forth. . . The more these implementations are developed, the clearer it will be that social security legislation is not something sufficient to itself but part of a broad program for the improvement of the human resources of the nation, in which such things as housing, nutritional policy, and education have important places" (1944, 33). Despite these recommendations, the federal government introduced social policies in a fragmented and piecemeal manner (Maioni 1997b).

<sup>10</sup> For example, Bacher (1993) informs us that W. C. Clark, Deputy Minister of Finance, and T. D'Arcy Leonard, solicitor for both the Dominion Mortgage and Investment Association and the Canada Permanent Mortgage Corporation, and their associates made the final decisions about the design of housing legislation .

<sup>11</sup> The global economic system was created by the agreements made at Bretton Woods. The General Agreement on Tariffs and Trade (GATT) was designed to reduce barriers to trade by encouraging the reciprocal trade agreements, the IMF was responsible for granting loans and establishing exchange rates, and the World Bank also acted as an international financial resource (McCormick 1996).

<sup>12</sup> Even with the general public support for the New Deal initiatives, the structure of the US presidential-congressional system and its separation of powers had a constraining effect on the passage of social policy legislation (Breckenridge 1998).

<sup>13</sup> Even though the dominant political culture promoted individualism and was strongly antistatist in sentiment, the ideas of Keynes were accepted as a strategy to help resolve enormously complex economic and social problems in the post war years (Private communication from Stein 1999).

<sup>14</sup> By the end of 1944, the FHA had provided \$6.4 billion for private and rental house building. Approximately 1,200,000 houses were built, and loans of \$1,600,000 had been insured for 4,800,000 home improvements. USHA established the concept of local responsibility for planning, constructing, and managing buildings. Several members of the US Public Health Service were seconded to assist with the implementation of the Act, which was designed to prevent "slums, blighted areas, or unsafe, unsanitary or overcrowded dwellings, or a combination of these conditions" (US Public Health Service 1951, 393).

<sup>15</sup> Although Taft strongly supported conservative approaches to federal government intervention, he facilitated compromises with the Democrats on the issue of housing. He insisted that funding should be limited and that program administration should be left to the states. Taft's proposal was designed to provide aid and to minimize federal involvement and cost (Private communication from Breckenridge 1999).

<sup>16</sup> Although the Wagner-Murray-Dingell Bill of 1943 failed to be passed into law and hence cannot be included as an example of inherited policy, it is important as an illustration of the ongoing efforts that were made to increase federal government activity into the area of health. The bill proposed sweeping revisions to the SSA in order that national health insurance, funded through a payroll tax, could be introduced. Like several other bills proposed by Senator Wagner over the years, it was soundly defeated by the powerful Congressional and private lobbying coalitions. Unlike the Canadian parliamentary system which rarely passes private member bills, the US Congress, by virtue of its institutional structure and process allows groups and individual members to introduce bills and amendments to legislation. In many respects, this has facilitated innovation but, as will be discussed below, it also leads to incremental policy making (Marmor et al. 1996). Further discussion of this Bill will be found in "Decision Making."

## Chapter 5

<sup>1</sup> In particular, Quebec was active in its "struggle for national survival and expansion [which] led inevitably to a proposal that its constitutional powers be extended." Social policy was to become a crucial element of these federal-provincial negotiations which ultimately failed at the Victoria conference in 1971 (Stein 1989, 14, 15). In many respects, Quebec's demands reflect the concept of "competitive state building" as Quebec and Ottawa worked to establish and to gain credit for social programs (Pierson 1995, 458).

<sup>2</sup> The differences in Canada's social programs reflect the distinctive characteristics inherent in Canadian federalism. These differences have emerged over time as a result of negotiations between the federal and provincial governments. For example, income maintenance programs, including pensions, are generally considered to be *liberal* (in keeping with Esping-Andersen's 1990 typology) in that they provide a minimal level of direct government support through payments as well as indirect support through the tax system, and also rely on private benefits and income supports. Health, on the other hand is a universal program, which permits circumscribed market activity. Tuohy believes that the

Canadian welfare state has evolved into these "two worlds" because of its federal provincial arrangements and intergovernmental relationships (1993). Banting adds that the differences may also be explained by the

forms of multitiered decisionmaking through which the country makes choices in these two sectors. Health care is governed by a system of *multiple, independent action points*, which allows both the national and provincial governments to take independent action, without the concurrence of other governments. Contributory pensions, however, are governed by a system of *joint decisionmaking*, which requires agreement of a substantial number of governments before any action can be taken (1995, 275).

Thus, the federal-provincial arrangements in health policy have encouraged innovation at the provincial level, whereas intergovernmental tensions in Canada's federal system have inhibited the joint decision making process in the field of contributory pensions (Banting 1995).

As with health, Canadian assisted housing policies have been determined through federal-provincial negotiations. In addition to the cost-shared programs established by agreements with the federal government, most provinces have also developed their own publicly funded housing initiatives (Hulchanski and Grieve 1984, Streich 1985).

<sup>3</sup> Strong opposition to the federal government action initially came from the Ontario government which had embarked on a policy path favoring private health insurance. In the long run, however, the federal government had the financial clout to implement the national plan and, because of its constitutional and spending powers, could override Ontario's own policy plans (Taylor 1987).

<sup>4</sup> The headlines in the Canadian newspapers provide an indication of the vigorous debates (Hulchanski and Grieve 1984) that occurred in the wake of the Hellyer Report: "Like a Cavalry Charge," Says Expert, Criticizing Hellyer Housing Report" (*The Ottawa Journal*, 4 February 1969), "Illusion to think that private market can house all decently" (*The Financial Post*, 8 February 1969, 17).

<sup>5</sup> Even though the CWC claimed to represent the diverse views of social policy consumers, Haddow notes that it essentially monopolized access to the decision making process. A considerable number of its members were also federal and provincial bureaucrats. Thus many of the independent consumer groups effectively had limited access to the policy making process and "when they did manage to meet a minister, federal welfare officials convinced the minister to ignore their advice" (1990, 218).

<sup>6</sup> Concerns about urban decay and paucity of health care were being voiced in all parts of the nation. By the 1960s "the gleaming palaces of modern science, replete with the most advanced specialty services, now stood next to neighborhoods that had been medically abandoned, that had no doctors for everyday needs, and where the most elementary public health and preventive care was frequently unavailable" (Starr 1982, 363).

<sup>7</sup> Three mechanisms were developed within the FHA. A mortgage insurance program — described in Section 221(d) (3) — encouraged commercial financial institutions to lend money to cooperative and nonprofit groups as well as to public agencies for building. Rent supplements were given to assist designated individuals and families (such

as the elderly, handicapped, or displaced people) to meet their rental payments, the amount of the subsidy being the difference between 25% of the family income and that of the fair market rent for the area. Finally, nonprofit groups were encouraged to rehabilitate substandard housing and sell the renovated units on the commercial market (*CQ Almanac* 1969, 217).

<sup>8</sup> By 1968, the US was spending 6.8% of its GDP on health care and 9.10 % of its GDP on social programs (OECD 1994).

<sup>9</sup> Aspects of the civil unrest were documented in newspaper headlines such as "Bomb Rips Birmingham Church: 6 Negroes Die in Race Terror" (*The Globe and Mail*, 16 September 1963, 1) and "Paratroopers roll into Detroit; toll is \$150 million, 16 dead" (*The Globe and Mail*, 25 July 1967, 1).

<sup>10</sup> Medicaid was a highly contentious addition to the health plan, and was seen to be "part of a political compromise to appease conservatives" (Litman and Robins 1997, 24). The Social Security amendments of 1965 contained

a broad health package that included three major components: Medicaid, subsidized medicine for most federally-assisted welfare recipients; hospital insurance, or Medicare Part A, intended for Social Security retirees; and the supplementary medical insurance program, known as 'Part B of Medicare,' which paid the doctors' bills and was also intended for retirees. This third program was optional, and beneficiaries had to pay extra for it. (Kingson and Berkowitz 1993, 47).

## Chapter 6

<sup>1</sup> The trigger to the interest in policy implementation was Jeffrey Pressman and Aaron Wildavsky's book *Implementation*. In it, the authors maintain that implementation "is worth studying precisely because it is a struggle over the realization of ideas" (1973, 180). Far from describing how ideas are realized, however, the book chronicles a series of disastrous policy actions and events that highlight government bungling, bickering, and red tape. The subtitle of this single case study probably summarizes the process most succinctly: "How Great Expectations in Washington Are Dashed in Oakland; Or, Why It's Amazing that Federal Programs Work at All, This Being a Saga of the Economic Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation of Ruined Hopes." Since then, interested academics have sought to dissect the whole policy process with attention now being paid not only to decision making and policy formulation, but to each component of the implementation and evaluation processes, as well.

<sup>2</sup> In 1978, through Proposition 13, Californians voted to amend the state constitution and thereby limit local property tax increases. Breckenridge believes that the "turn-around in public attitudes to government has been dated to the 'tax revolt'" (1998, 356).

<sup>3</sup> These data demonstrate what Lipset believes to be a contradiction in the "original creed with its emphasis on antistatism and individual rights," although he maintains that they also emphasize that from the 1960s on, there was an attempt to provide aid to those who had been discriminated against in the past. He further notes that even when societal

concerns about the economic and social upheavals after the 1960s grew, the US continued to be "exceptional among developed nations in the low level of support it provides for the poor in welfare, housing, and medical care" (1990, 37-39).

<sup>4</sup> Thus, the decision made by the activist Secretary and her advisors was to shift the emphasis towards providing financial aid to consumers. Newman and Schnare note that "[a]fter the 1973 housing assistance moratorium of the Nixon administration, a very different implementation strategy was introduced: housing certificates to qualified households who rent housing units from existing stock. By the early 1980s, essentially all new construction and rehabilitation programs were terminated, leaving the cash certificate for existing housing as HUD's main assistance approach" (1988, 9).

## Chapter 7

<sup>1</sup> Although space limitations preclude discussion of this matter, it should be noted that the Charter of Rights and Freedoms was adopted with the Constitution Act of 1982. Tuohy indicates that prior to 1982, the "express limitations on governmental action were almost entirely jurisdictional [whereas the] charter added another constitutional perspective, a set of limitations on governmental actions based on citizens' rights" (1993, 41-42). Simeon and Willis maintain that the charter was "a nationalizing instrument, and it gave status to a range of collective interests . . . that challenged the way in which federalism privileged territorially based identities" (1997, 177).

<sup>2</sup> Doern et al. emphasize the Conservative government's support for limiting state aid to protecting only the neediest members of society. They note that [t]he residual view of social policy embraces a number of political ideas closely linked to a belief in the need to revive the private sector and reform the public sector. . . [And] while there is a need to help the "victims" of the economy, many important social issues cannot be addressed until the economy recovers. In addition, the residual approach holds a particular view of the relationship between social policy and economic policy. Social development is dependent upon economic development and social policy is seen as a function of economic policy and growth" (1988, 158-159). Doern et al. also highlight the institutional view which is the alternative to the residual notion for government intervention in the social policy realm. They contend that

[t]he institutional view of social policy rests on a distinctively different set of beliefs about human nature, the relationship between social programs and economic programs and the adequacy of Canada's social welfare system. . . An institutional conception of social policy holds that society has an obligation to see that everyone's basic human needs for health, shelter, nutrition, education, security, and human dignity are met before the special wants of any particular group or individuals are considered (1988, 159-160).

<sup>3</sup> In point of fact, however, Canada was spending the same as the average for OECD countries for health (Tuohy 1992).

<sup>4</sup> In 1985, 27 million people were covered by Medicare, as were 3 million people with disabilities (*CQ Almanac* 1986).

<sup>5</sup> For example, a study entitled *Homeless Families: A Neglected Crisis*, which was undertaken by the Intergovernmental Relations and Human Resources Subcommittee, brought home the depth of the problem which affected thousands of families that had neither shelter nor health insurance. Even so, dissenters argued that existing programs such as Medicaid were already in place to "serve the needs of the poor and medically underserved" (United States 1986, 37).

<sup>6</sup> This was an unusual strategy for introducing extensive policy change (Private communication from Breckenridge 2000). Nenko asserts that the Omnibus Act led to the "elimination of some programs, deep cuts in housing assistance, and new statutory language changing the shape and direction of existing programs along lines favored by the Administration" (1983, 137).

## Chapter 8

<sup>1</sup> In 1989, at a hearing of the House Committee on Banking, Finance, and Urban Affairs, HUD Secretary Jack Kemp indicated that the nation's complex housing issues needed multifaceted solutions which would "foster the most promising innovative and successful local solutions that provide not only basic shelter, but also jobs, permanent housing, health care and dignity" (United States 1989, 71).

<sup>2</sup> Highlighting the complexity of the interrelated social issues, Hungerford identified detrimental aspects of social isolation and crime in economically distressed inner-city areas, and confirmed that there are "important interactions between housing assistance and receipt of other public assistance [and that] policymakers have become alarmed at the number of people seeking to move into public housing units" (1996, 193).

<sup>3</sup> Managed care plans have become more popular as a result of two factors. First, HMO costs were starting to rise and, second, patients complained that they were restricted in the choice of physicians and therapies available to them. MCOs encouraged competition between organizations offering health insurance and provided a greater number of treatment options. Jost states that managed care "grew on the strength of its claims to provide better care at a lower cost" (1998, 7). As a result, many HMOs changed their restrictive treatment practices. (*CQ Outlook* 1998, Zelman 1996).

## ABBREVIATIONS

AMA	American Medical Association
BNA Act	British North America Act
CCF	Cooperative Commonwealth Federation
CDBG	Community Development Block Grant
CHA	Canada Health Act
CMA	Canadian Medical Association
CMHC	Canada Mortgage and Housing Corporation
CHST	Canada Health and Social Transfer
<i>Cong. &amp; Nat.</i>	<i>Congress and the Nation</i>
<i>CQ</i>	<i>Congressional Quarterly</i>
CPP	Canada Pension Plan
DHA	Dominion Housing Act
EPF	Established Programs Financing
ERISA	Employee Retirement Income Security Act
FHA	Federal Housing Administration
FNMA	Federal National Mortgage Association
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
HAA	Housing Assistance Administration
HCDA	Housing and Community Development Act
HCFA	Health Care Financing Administration
HEW	Health, Education, and Welfare
HHS	Health and Human Services

HMO	Health Maintenance Organization
HUD	Housing and Urban Development
IMF	International Monetary Fund
LSR	League of Social Reconstruction
MCO	Managed Care Organization
MSSD	Ministry of State for Social Development
MSUA	Ministry of State for Urban Affairs
NATO	North Atlantic Treaty Organization
NDP	New Democratic Party
NHA	National Housing Act
NHA	National Housing Agency
NHS	National Health Service
NH&W	National Health and Welfare
OECD	Organization for Economic Cooperation and Development
PHA	Public Housing Administration
PWA	Public Works Administration
SSA	Social Security Act
UN	United Nations
US	United States
USCM	United States Conference of Mayors
USHA	United States Housing Authority
USPHS	United States Public Health Service
WHL	Wartime Housing Limited
WHO	World Health Organization
WWII	World War Two

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