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Internal Variations in Health-care Federalism in Canada and the United States

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Abstract :

Federal systems are prone to dividing health benefits inconsistently across subnational jurisdictions. In this article, we examine how federalism intersects with economic and social factors, particularly gender and immigration status, to create structural barriers to accessing and receiving necessary healthcare. Drawing on insights from the historical institutionalist literature and the experiences of immigrant women in the Canadian and American health systems, we find significant subnational variations in access to health services and insurance coverage. Gaps in service – which are filled (if at all) by costly, inaccessible private provision – are the product of piecemeal policymaking, as new programs and services are layered onto existing systems which are themselves outdated and anachronistic. Our analysis demonstrates the need to move beyond analyses of federal state architectures to an intersectional approach to better understand the differential negative impact of subnational variations on equity between social groups and their ability to access to basic health services.

Studies have suggested that federal systems are prone to dividing welfare benefits in an inconsistent manner, and this becomes particularly evident during times of austerity[1]. Both Canada and the United States have long grappled with questions of publicly-paid health insurance for various population groups, particularly those below the poverty line, and employer-provided insurance for those above it[2]. Both systems began from similar roots in the early 20th century, with insurance offered to individuals, coordinated by employers in certain sectors (logging and mining in Canada, retail, mining and railroads in the US)[3]. In Canada, the federal and provincial governments took steps to «universalize» a range of hospital, medical and diagnostic services funded by federal and provincial tax revenues beginning in the late 1950s. The US also introduced plans for particular population groups: Medicare for those over age 65, Medicaid for those living below a state-determined poverty line, and the Children’s Health Insurance Program for children living in impoverished families. In both countries, these programs were layered onto existing federal and sub-national arrangements, yielding opportunities for constituent governments to effect access barriers. These programs were also layered onto existing local health system infrastructures, dominated by physician-led practices and private insurance markets[4]. As a result, the healthcare systems that emerged in both countries include a large role for both private and individual spending, alongside the publicly-paid components.

This article examines institutional features of federalism to understand and explain how the Canadian system surpassed the US to expand tax-financed health insurance to near universal levels for some services, whereas the US did not. In particular, we explore the economic and social factors that intersect with gender to create structural barriers to accessing and receiving necessary healthcare. Low incomes, precarious work status, lack of social supports are significant risk factors for poor health status and unmet need. Many migrant women, therefore, are particularly vulnerable to gaps in coverage at the interface of public and private health insurance created by sub-national variation in health policies. In this article, we will focus on issues raised by women's mobility across national and sub-national boundaries. The challenges this group faces in accessing care will be highlighted to demonstrate the equity impacts of federalized healthcare systems, particularly for vulnerable populations.

Historical institutionalism is premised on the idea that institutions will persist and create both opportunities and constraints which influence the behaviours of political actors, and which in turn will affect the policy process[5]. Policy and political change occurs at «the intersection and interaction of different ongoing processes»[6]. On the one hand, institutions may create positive feedback and lock-in effects which constrain policy change. On the other, the cumulative impact of small changes can actually unlock the effects of path dependence over time[7]. These small changes, as categorized by Streeck and Thelen, can occur through the processes of layering, drift, and conversion. Layering includes adjustments to existing institutions – in the form of amendments, additions or revisions – that are framed by actors as simple correctives, but which may bring about major change in the future[8]. Drift involves the failure of an institution to adapt or be adapted to changing social realities. The underlying premise is that if institutions are not «tended to», they may be subject to erosion and atrophy. Drift is not inadvertent, but rather may be the product of deliberate non-decisions and may be particularly misleading insofar as it suggests some stability on the surface but masks deeper problems and changes[9]. As its name implies, conversion is a rather large change in the institution's goals and functioning, with «new and different ambitions and purposes come to be connected to the same institution»[10]. Institutional resources are redirected from the purposes for which they were originally intended.

Over the next sections, we will trace the historical evolutions of health insurance in the US and Canada, which have been typified through the dynamics of layering, drift and conversion. We thereby examine the impact and long-term implications of layering universalistic frameworks onto private health system insurance and delivery in the US and Canada (first section), and the implications of this layering for the (failed) capacity of public programs to adapt to new social risks experienced by migrant women with each federation (second section).

1. Historical Developments

Prior to the introduction of state-sponsored health insurance programs in the 1950s and 1960s, both the US and Canadian systems were dominated by small-scale private fee-for-service medical practices, locally-run private, non-profit or charitable hospitals, and to a lesser extent, piecemeal coverage through voluntary private insurance and/or government subsidized care[11]. Large gaps in access to medically necessary services remained, especially for the poor and indigent. High rates of communicable disease, poor maternal health outcomes and high infant mortality gave government the impetus to take action to address gaps in private coverage[12].

1.1. Canadian Medicare and the Evolution of Interprovincial Variations

In Canada, following the Great Depression a number of limited health insurance programs were established at local and provincial levels. The Trans-Canada Medical Plan – a voluntary prepayment plan sponsored by the Canadian Medical Association – was the most significant in a number of respects: it offered nation-wide, portable coverage; its medical benefits were extensive; and its enrolment increased rapidly to cover over 15% of Canadians by 1955[13]. Commercial plans also expanded quickly, offering comprehensive medical and hospital benefits, and coverage for catastrophic expenses. By the time the first universal public plan was introduced at the federal level in 1957, about 45% of Canadians had some voluntary insurance coverage[14]. A number of provincial governments also introduced plans to cover the costs of hospital care for their populations, including the continent’s first tax-financed universal hospital insurance program in Saskatchewan. These programs were layered onto existing private schemes, in order to fill gaps in coverage for indigent and low income groups. In effect, they instituted public payment for services provided by existing networks of providers, including global payments to hospitals. Together with partial public plans in four other provinces, by the mid-1950s, about one-third of Canadians had some form of public hospital insurance[15].

In a classic case of institutional conversion, the federal Hospital Insurance and Diagnostic Services Act was passed in 1957, introducing universal hospital insurance in all provinces, essentially transferring all hospital bills from private plans to provincial governments. The costs of the program were to be equally shared between the federal and provincial governments on the condition that all patient-related hospital costs were covered on a first-dollar basis for all residents of the province. These conditions enabled provincial governments to take over existing plans, precluding a role for private hospital insurance. The new legislation also gave both levels of government a significantly more active role in hospital planning and management[16].

The 1966 federal Medical Care Insurance Act, and its Saskatchewan precursor, introduced public insurance for physician-provided medical care over the vehement protests of providers and insurers. However, they conceded to the profession’s demands that individual physicians be permitted to extra-bill patients, beyond the government fee schedule and that «voluntary plans be retained as billing and payment conduits»[17]. As a result, although physician-sponsored insurance plans were almost immediately dismantled, new provincial insurance programs were simply layered onto existing professional networks, substituting public payment for private on a fee-for-service basis. Under the terms of the Medical Care Act federal funds would flow to provinces that abided by four key principles: publicly administered, universal programs providing access to medically necessary services for their citizens, with benefits that were portable across provinces when people moved[18]. Left out of mandatory universal coverage were all non-hospital and non-physician services, such as homecare, prescription drugs, eyeglasses and dental care, as well as the services of allied health professionals (such as psychologists, chiropractors and physiotherapists). These omissions resulted in important coverage gaps that the commercial sector quickly filled with employer-based and/or individual insurance plans. Although the stated intention of political leaders was to gradually incorporate all health services into the publicly-paid system, this incremental approach led to insurmountable political and economic barriers to their inclusion later on[19].

Within a decade, drift in the commitment of physicians and numerous provincial governments to the principles of the Medical Care Act led to an increasing prevalence of patient charges for publicly insured services. These charges created financial barriers to accessing necessary care and

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thus violated conditions for federal health funding. In the same period, the federal government withdrew from its shared cost commitment to provincial health programs and instituted a block transfer of funds, giving provincial governments’ greater autonomy in allocating health-related resources. To remedy the politically volatile issue of patient charges and maintain its own presence in a publicly popular program, the federal government introduced the Canada Health Act in 1984. The Act consolidated the existing medical and hospital insurance legislation into a single act, and added provisions that would allow Ottawa to financially penalize provinces that continued to permit such charges. However, the Canada Health Act did nothing to incorporate the growing array and volume of services that remained excluded from mandatory coverage. Therefore, as Hurley and Guindon note: «Canada’s ‘single-payer, universal’ system of public finance accurately applies only to physician and hospital services»[20]. About 30% of total health expenditures in Canada come from the private sector – the second highest among the G7. By way of comparison, the US is found at the highest level, at 52%[21].

The relatively broad principles of the Canada Health Act mean that a great deal of variation exists between provincial health programs. At the intersection of publicly- and privately-financed care, provincial governments have significant room to manoeuvre in determining who and which services are part of publicly-paid care[22]. Although most hospital and physician services are nearly uniformly covered, as mandated by the Canada Health Act, there is a patchwork of other services that may also be covered. These vary in range and scope, and are available to different groups based on different conditions and circumstances, depending on where they live[23]. For example, children in low income families in Alberta are eligible to receive dental care, eyeglasses and prescription drug coverage through a provincial program[24]. In Ontario, local public health departments offer school-based dental screening programs, and may refer children from low income families to government assistance for dental care. No comparable program exists in Ontario for funding eyeglasses for children, and access to drug benefits for children is determined on the basis of family income and total out-of-pocket expenditures[25].

Drug coverage is the largest source of policy drift in Medicare, as both federal and provincial governments have time and again resisted calls for a comprehensive national pharmaceutical insurance program, which was left out of the original framework in the 1960s[26]. Drug costs are the largest and fastest growing category of private health expenditures in Canada: almost 74% of all expenditures on drug expenditure occur in the private sector, in the form of out-of-pocket costs to consumers (such as premiums, deductibles, user fees and over-the-counter medication) and private insurance. Two-thirds of Canadians have some form of private insurance for prescription drugs, either through their work or individual policies. Public drug plans typically cover the elderly and people receiving social assistance, but in some provinces, potentially everyone is eligible for coverage. British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec offer programs with high deductibles for the non-poor[27]. Morgan et al. have noted that provincial drug benefit programs finance between 26 and 45 percent of total prescription drug expenditure[28].

The second-largest share of private-sector health spending in Canada is on dental services: $11.2 billion on private dental care in 2011, of which 59% was paid for by insurance firms and 41% by households[29]. In 2001, 75% of Canadian families living above the working poor threshold had access to dental insurance, while only 26% of the working poor (incomes between $15,000 and $30,000 per year) reported such access[30]. Canada performs poorly on income inequality in dental visits: «The rate of inequality for dental visits in Canada is higher than in most OECD countries, with low-income individuals being nearly half as likely to visit a dentist as those with higher incomes»[31].

The limited scope of public coverage for non-physician and non-hospital services has resulted in a heavy reliance on private financing for these services, whereby low-income individuals end up opting out of both public and private health services. The Health Council of Canada reports that about 8% of Canadians did not fill or skipped a dose of prescription medication due to cost, with a low of 5% in Saskatchewan and Quebec, and a high 15% in New Brunswick. Nationally, 6% skipped a medical test or treatment and 15% to 24% skipped dental care due to cost. Between 2% to 7% said cost prevented them from visiting their doctor, and 4% to 11% reported serious problems paying medical bills[32]. Tuohy, Flood and Stabile suggest that low-income individuals who lack prescription drug coverage may be subject to a bundling effect whereby they may forgo an insured doctor visit because they are unable to fill a prescription due to unaffordable drug costs and fees[33].

Drift in the scope and enforcement of the Canada Health Act has resulted in the emergence of duplicative insurance – that is, private insurance for services covered by Medicare – particularly since the Supreme Court of Canada’s 2005 ruling in Chaoulli[34]. Private health care provision has begun to expand to include a wide range of publicly insured services, ranging from joint replacement surgeries to general practice medicine. Although six provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island, and Quebec) have laws that prohibit duplicate private health insurance for these services, a number of them are moving to consider allowing it[35]. In their review of the research on the utilization of health services, Hurley and Guindon determine that «greater reliance on private finance, including private insurance, is associated with less equity in the utilization of health care services»[36]. These research findings suggest that layering and drift in the architecture of Medicare in Canada has compromised equitable access to necessary care for low-income groups and those with compromised health status. Furthermore, patterns of compromised access are vary across provinces, and are related to specific financing arrangements in each jurisdiction.

1.2. The Incrementalist, Layered US System

Unlike the generally broad-middle class nature of benefits under Canadian Medicare, the US Medicaid program, for those below the poverty line, is always open to demonization by political actors. When combined with specific factors about the US health-care system’s history, «welfare medicine» as some have called it is a potential tinderbox[37].

In general, even the lauded New Deal programs of President Franklin Roosevelt of the 1930s were controlled as to their intended recipients. The cornerstone omnibus Social Security Act of 1935 contained eleven different titles authorizing seven different programs[38]. Title II, the contributory retirement insurance program, only included those in industry or commerce, excluding agricultural and domestic workers. It should be no great surprise that agricultural and domestic jobs have been among the most open to migrants, since employers have sought to avoid employment taxes. Relatedly, most purportedly national social programs in the US require built-in flexibility for state administrative requirements to ensure Congressional approval. Also, even in publicly-funded programs such as those related to health, national and state governments have been committed to protecting and shoring up the private-sector insurance system[39]. The conclusion to draw is that even national welfare-state programs have winners and losers inherently constructed in them.

As Olson shows, through amendments made in 1950 to the original Social Security Act of 1935, «Congress sidestepped direct federal intervention by offering states some limited cost-sharing for hospitals, nursing homes, and certain health professionals serving families and individuals on public assistance»40. In 1962, Congress passed an amendment, Section 1115, allowing state-based waivers to Medicaid at the urging of President Kennedy. As Rosenbaum and Hurt noted, «S. 1115 allows the Secretary of Health and Human Services to waive requirements for Social Security Act programs tied to need (i.e. Medicaid) enabling states to test innovations»41. There are numerous requirements to the S. 1115 programs, including that a state's participation must be revenue-neutral towards the federal government. As the law is written, if a state is chosen by the federal Secretary of Health and Human Services to participate in the waiver program, the net burden to the federal government cannot increase by more than it would without the demonstration waiver for the particular state. The waivers were designed to put states in the category of social policy laboratories, trying to assess more efficient means of using federal money than the federal government might decide.

In 1965, Medicare and Medicaid were passed as amendments to the Social Security Act, containing parts A & B, the first two parts of what House Ways and Means Chair Wilbur Mills referred to as the two tiers on his three-tier cake42. Medicare is viewed by the elderly as an earned benefit since they pay taxes throughout their lives to support it. The third and least politically-supported amendment was Medicaid. From the 1960s onward, Medicaid was a mandate in name only, since as Olson notes, nearly 2/3 of all such spending is at their discretion. Its coexistence with the waiver program has meant that states are basically in control as to whether they will promote a race to the top or one to the bottom. Some states, such as New York, offer many non-mandated services so as to maximize their federal funding inflow. It is also the case that another more well-organized and well-respected constituency for Medicaid dollars has been the elderly, «newly-impoverished white middle-class elders relying on the program for long-term care, especially nursing-home services»43. The elderly and «mainly white, younger» low-income disabled adults are among the «protected» sector of Medicaid, where these groups comprise about one-third of Medicaid program costs. As Olson also notes, «the coalition of interest between the nursing-home industry and the families of frail elders who need care is a strikingly powerful force at the state level»44.

Since Medicaid is the politically- and financially less resourced of the 1965 Social Security Act amendments, it is probably not surprising to know that state barriers to availability of providers exist45. Specialists in particular are difficult to find, and far fewer dentists than physicians participate in the program. Olson states that in the US, access to the vast majority of the optional benefit aspects of Medicaid has everything to do with the geographic location of providers and virtually nothing to do with clients' needs. These include services such as speech and hearing therapies, psychiatric care, occupational and physical therapy, dental services and dentures, optometry, eyeglasses, hearing aids, medical equipment and supplies and prosthetic devices. The default position under Medicaid has become one where clients must access public hospitals or community clinics to provide their needs46. Serving mainly the undocumented, but not limited to them are Federally-Qualified Health Centres (FQHC's) and Migrant Health Centre sites47. In 2012 there were 1214 of the former and 159 of the latter, operating 700 service sites. These are federally-funded centres and accept patients without regard to insurance or immigration status. FQHC's tend to be clustered east of the Mississippi and in California, leaving out some major immigrant-receiving states such as Texas and Nevada.

Since about 2/3 of all Medicaid spending belongs to the discretion of the states, the picture for low-income new residents (immigrants) to the US became even more complicated in 1996 with the passage of the national Personal Responsibility and Work Opportunity Reconciliation Act (PROWRA). As paraphrased from Wasem, PROWRA «met at the intersection of two major policy areas: immigration and welfare policy»[48]. The legislative package was also called a «back-door» way to amend immigration policy. For analyzing changes to social- and health-policy federalism since the 1990s, PROWRA was crucial. First and foremost, it ended the historic Aid to Families with Dependent Children (AFDC) program, passed as part of the New Deal Social Security Act legislation of 1935. While AFDC had been described as an entitlement program, providing cash benefits to poor families with children, it was wholly replaced by the Temporary Assistance to Needy Families (TANF) program[49]. Unlike AFDC, which involved federal and state-level negotiations (and gave about 2/3 of its funding to needy children), TANF is a block grant whose priorities are determined by the states. As Page and Larner note, «An early sign of the shift of authority from the federal government to the states came in the increased use of legislative provisions allowing states to request waivers of specific federal program requirements to carry out welfare demonstration projects. Waiver applications from 44 states had been approved by the federal government by mid-1996»[50].

Two important conclusions follow from Page and Larner’s observations. Since PROWRA was signed into law by President Clinton in August 1996, the fact that 44 of the 50 states had applied for waivers under TANF by mid-1996 is significant. According to Moffitt, PROWRA created TANF benefits that are much narrower than those under AFDC, including the fact that TANF does not pay for childcare, there are lifetime limits for recipients and they must demonstrate that they are working up to thirty hours per week[51]. Singer has noted that AFDC treated «legal immigrants and citizens alike» in allowing them to access benefits; this was discontinued under PROWRA[52].

TANF waivers were layered onto a system already allowing for waivers of social benefits, specifically the Section 1115 amendments to the Social Security Act in 1962. Under the George W. Bush administration, federal funds were used to help people purchase insurance, very much like the Affordable Care Act (ACA). The Section 1115 state-based demonstration waivers on Medicaid were expanded to «encourage states to adopt private market approaches, such as enrolee cost-sharing and premium assistance for individuals to purchase private insurance»[53].

The shifts to more subnational autonomy over social policy, gradual since 1960 and then more drastic concerning immigrants since the 1990s, is an important marker of devolutionary «new federalism». The «new federalist» model was begun by President Ronald Reagan in the 1980s, with the express purpose of increasing states’ discretion and funding responsibilities for social program funding, while increasing military spending at the national level. The discursive institutionalist framework of Lombardo, Meier and Verloo is also helpful[54]. While this theory was developed specifically to analyze whether gender equality was being implemented sincerely or not, it is useful for policies which are not formed by people innately sensitive to their gendered outcomes, such as social security and immigration policy. From Lombardo et al., the relevant examples are shrinking, whereby the policy interpretation is confined to a specific interpretation of an issue, and bending, whereby the concept at hand is distorted to make it fit a goal which can be opposite that of the policy. Particularly when looking at the gender-based implications of social and immigration policy, we can see that narrowing the pools of potential Medicaid recipients took place in a political rhetorical exercise of shrinking the deserving recipient pool. Also, changing AFDC to TANF and the resulting categorization of previously-eligible immigrants as outside the scope of public benefit is an example of discursive bending.

Unfortunately, the passage of the Affordable Care Act in 2010 was layered onto the already shifting sands of Medicaid entitlement and TANF block grants, as well as the emphasis on keeping private insurance economically healthy. The equation of waivers plus ACA in the twenty-first century has generally meant that while some childless adults were given more access to care, they were also charged higher co-pays. Enrolment and benefit packages were also limited, as found by a 2014 Kaiser Health study[55]. The study also noted that, «since the ACA expands Medicaid to nearly all low-income adults with significant federal funding, the need for and role of waivers to cover adults fundamentally changes»[56]. While the ACA intended to require Medicaid inclusion for all adults at 133% of the federal poverty line (defined as $16, 105 annual income in 2014), the Supreme Court's Sebelius decision of 2012 quashed that mandate, keeping Medicaid as a voluntary measure implemented by states[57]. As of March 2014, the Kaiser Foundation reported that 19states were not progressing to raise the eligibility level for individuals and families without children[58]. As Arloc Sherman reported for the US, public benefit programs typically cut poverty rates almost by half.

In sum, the negative layering of federal funding cutbacks for both Canadian Medicare and US Medicaid, on top of the growing variations and limitations in the services covered by these programs, suggests that policy drift has taken place in both health programs. The potential for drift has been ensconced in both systems from the beginning, since they allow widespread policy discretion both among sub-national governments and private insurers. With the austerity present in national-level health funding frameworks in both countries since the 1990s, this drift is likely to continue. The implications of policy drift are especially felt by those who face restrictions (either internal, as citizens, or newly-arrived immigrants) upon their access to health insurance enacted by public and private-sector plans. It is to this group that we now turn to.

2. Health Insurance and Access to Care for Migrant Women

The decline in the health of previously healthy migrants, and specifically the accelerated decline of female migrants' health, is of increasing concern to the global community. Studies document the decline in the overall health status of migrants in their first ten years of residence in various countries[59]. Given the social and economic hardships faced by many new immigrants, «the health system plays an important role in mediating the differential consequences of illness in people's lives»[60]. While gender and migration are separately addressed in health research, the unique needs and concerns of immigrant women are often overlooked[61]. As Newbold finds, «access to health services, and ultimately overall health, may be especially limited among immigrant women whose family, job, or cultural expectations and roles may make it difficult to access and use resources. Poor access and service use may lead to a worsening of health status over time owing to the relative under-use of preventative health screening and under-diagnosis and treatment of health problems»[62].

2.1. Layering and Drift: Female Migrants at the Interface of Public and Private Insurance in Canada

For migrants to Canada, especially those making claims for asylum and refugee status, health insurance coverage is far from uniform. Some provinces impose a three-month residency requirement before providing health insurance coverage to new residents of the province while others do not – although some international migrants may be exempted in the latter group[63]. Interprovincial migrants are covered by their province of origin until the minimum residency period in their new province is reached, so their insurance status is relatively unaffected. International migrants are subject to myriad conditions and restrictions, further magnified by recent changes to the Interim Federal Health Program which have substantially reduced if not eliminated health benefits altogether for many of these individuals[64] [65].

Notwithstanding the complexity in determining the status of and benefits associated with refugee claimants, there are a number of important barriers to receiving entitlements even for legal migrants. Administrative delays, such as the three-month waiting period as well as complications associated with changing immigration status (such as from refugee to permanent resident) mean that some people may wait months and years to receive benefits to which they are legally entitled[66]. During that period, they may not be allowed to access temporary benefits programs or they may face other barriers associated with private insurance: prohibitive costs, limited benefits and selective coverage[67]. Temporary foreign workers and students are also subject to varying conditions depending on their province of residence. They may be covered by provincial insurance in some jurisdictions; in others, they or their employers may be required to pay for private insurance.

Although more and more women are migrating in search of employment and economic opportunities, the majority of women seeking permanent residency in Canada are family class immigrants, or the spouses or dependants of (male) economic applicants[68]. Chen et al. report that women who immigrate as dependents are more likely to experience mental or psychological problems than other groups of migrants[69]. These women may be subject to the authority of their husbands and fathers for sponsorship to obtain legal residency status, on which their ability to access settlement services often depends[70]. A woman’s immigration status influences her ability to access the labour market and her rights to safe employment conditions; her ability to acquire legal citizenship; and her right to receive health and social services, education, language training, and income support programs – all of which are essential in settlement[71].

Employment, in particular, is an important gateway to necessary basic resources such as income and social and health care benefits[72]. However, the employment rate among recently arrived (within 5 years) immigrant women aged 25 to 54 is lower than their Canadian born counterparts – 56.8% v. 78.5% in 2006, despite significantly higher levels of educational attainment. The incidence of low income among recently arrived immigrant women and girls in 2006 was 20% – double that of Canadian born females of all ages[73]. Even once in the workforce, recently-arrived immigrant women are more likely to be employed in part-time and/or service jobs than all Canadian women. They are also more likely than immigrant men to be working in the underground economy or in precarious work, meaning they may be more vulnerable to poor working conditions, poor wages and few benefits[74]. Female temporary foreign workers are more likely to be in lower-skilled positions than men, have lower incomes and experience precarious access to benefits[75].

Given their income and employment status, women in this group are less likely to have access to supplementary health insurance associated with employment benefits. Jenkins also notes that women who are insured as dependents for supplementary health benefits may be vulnerable to losing coverage «should their spouse lose his job, or if an employer drops family coverage or raises premiums and/or out-of-pocket expenses to unaffordable levels»[76]. This is particularly a concern in recent years, as employers are becoming less likely to provide supplementary benefits to their employees.

Research demonstrates that equitable access to necessary health care – even those services to which individuals are entitled – is compromised when related goods and services pose cost barriers[77]. The implications of increasing private costs and private health insurance are particularly important for women because, as Jenkins notes: «Women as a group have less access to PHI [private health insurance] due to their lower incomes and employment status. They also often face higher premiums and even outright denial of coverage. In addition, they risk unstable PHI coverage with changes in employment and personal status, such as divorce. Different women have different relationships to PHI, with those marginalized on the basis of factors such as class, race, sexuality, age, health status, ability and geographical location less likely to have this form of coverage»[78]. Immigrant women, especially those who have been settled in their new countries for less than 5 years, are even more likely to suffer inequities in access to necessary care associated with the patchwork of public and private services that exists in Canada.

2.2. Layering, Drift and Conversion in the US and Effects on Women Migrants

PROWRA formally categorized immigrants into «deserving» and «undeserving» categories. While lawfully present immigrants pre-1996 had been eligible for federal cost-shared benefits, this was usually untrue after PROWRA. The statute parsed the lawfully present into «qualified», including lawful permanent residents, refugees, and asylees[79]. The new framework divided immigrants into those arriving before August 22, 1996 (qualified), and those after (usually unqualified). The exemptions to the «unqualified» post-August 1996 arrivals included the protected statuses previously mentioned, military and veterans (including spouses and children), and long-time permanent residents with forty quarters of qualified work. Forty quarters would normally take ten years of residence to achieve[80]. However, a quarter of qualified work would be deducted from the overall necessary total if the person received unauthorized public benefits during that quarter[81]. Since it would be impossible for a person resident fewer than five years to have ten years of qualified work in the US, it was amended to include parental work for a child who arrived under the age of 18 or spousal work[82].

Another part of PROWRA laid out which funding could be provided by the federal government, which by the states and which on a cost-shared basis. For example, states could use their own funding to cover qualified immigrants falling under the five-year ban for the social benefits of the Supplemental Nutrition Assistance Program, Medicaid, and TANF benefits. Unqualified immigrants since 1996 could also be covered under state-only-funded assistance. Other legal developments have included the fact that since 2005, proof of citizenship is required to access Medicaid benefits (other than certain emergency-room visits). Also, since 2009, children and pregnant women normally excluded under the five-year ban can be eligible for Medicaid and the Children's Health Insurance Plan if they live in one of the states that has expanded these benefits by using its own funds. As of 2010, twenty states had chosen to provide prenatal care, labour and postpartum care to qualified and unqualified immigrant women by using federal matching funds[83]. As of 2013, twenty-five had extended health care to children[84]. As of 2014, only ten states provided health care benefits to unqualified and qualified immigrants, not in the categories of mothers or children[85]. Regarding TANF, cash assistance was provided to qualified immigrants only as of July 2009 in 44 of the 50 states. Of the five states which do provide TANF money to unqualified immigrants, only two of them are in the short list of major immigrant-settling states, New York and California[86].

As Gusmano has also noted, the US spends far less on health care for undocumented migrants (since there are so few programs covering them) than on either legal migrants or US citizens. National health expenditures for immigrant adults were 55% lower than for U.S. born adults[87]. In addition, «Use of health care services is lower among undocumented adults and their children – regardless of the immigration status of those children – than it is among adult U.S. citizens and their children. Undocumented adults and their children are less likely than U.S. citizens to use emergency department care, visit a physician or nurse on an outpatient basis, or use mental health or dental services.A 2007 survey of undocumented Latinos reported that they are less likely than U.S. born citizens to have a usual source of care (58% vs. 79%) or to have their blood pressure (67% vs. 87%) and cholesterol (56% vs. 83%) checked annually.When undocumented immigrants do use health care services, they are more likely than U.S. citizens to pay out of pocket for this care»[88].

While the 2010 Affordable Care Act was designed to improve the lives of the uninsured, the jury will be out for years as to its effect on immigrants. Those deemed unqualified, present for less than five years, are not allowed to access the lower-cost insurance exchanges to buy private health insurance. Similarly, with respect to Medicaid (public funding), the unqualified, (excepting the exempt populations previously cited), cannot access public funding unless states make explicit provisions for them. The Affordable Care Act was formulated on the premise that the Medicaid expansion requirement for states would happen without controversy. In hindsight, this view seems naïve, given the waivers enacted into public health and social benefits since 1962 and most especially since 1996 regarding immigrants.

As the Migration Policy Institute pointed out in 2014, the top five states in terms of absolute numbers of immigrants were California, New York, Texas, Florida, and New Jersey. For the top five states in share of immigrant population out of total population, four of the states remain the same with the exception of switching Nevada in for Texas[89]. Of these states, three of them, California, New York and New Jersey provide health-care benefits for unqualified and qualified immigrants as defined by PROWRA[90]. With respect to whether these states are in the category of expanding Medicaid to 133% of the poverty level or beyond as is now timidly possible under the ACA, California, New York and Nevada have committed to expansion of these benefits. This could help immigrants. True to form, Governor Christie of New Jersey first authorized the expansion and then vetoed legislation which made it permanent[91].

Amplifying the regional breakdown of states willing to expand eligibility for Medicaid versus those which are not, the Kaiser Family Foundation conducted a 2014 study of the Medicaid Coverage Gap. This gap refers to those who will not be covered under the ACA due to lack of Medicaid expansion in certain states. The regional breakdown is as expected, 86% of people in the coverage gap reside in the South. The authors note that this region has more limited Medicaid eligibility than other regions and is less likely to be expanding Medicaid eligibility over the poverty line under the ACA[92].

Other breakdowns from the Kaiser Report include the following. The ACA continues unchanged the historic deference shown in US social policy to small firms choosing not to provide coverage, with no employer penalties for companies employing fewer than 50. Thus, employees of these firms will disproportionately make up the coverage gap. They will be working but unable to access Medicaid. Also, «a majority of workers in the coverage gap also work in industries with historically low insurance rates, such as the agriculture and service industries»[93]. Needless to say, this is where immigrants, especially those without the required five years' residence, will often be found.

One development potentially helpful for qualified Latino(a) immigrants accessing Medicaid is that the states expanding their eligibility levels have higher populations among this group (California, New York, Arizona). What is not helpful overall is that unfortunately, the states with higher proportions of African-American residents are not expanding their Medicaid eligibility (Florida, Georgia, Texas). Finally, there is a gender difference slightly favouring women, likely due to their status in the categories of mothers or mothers-to-be. As the report states, of poor adults in non-expansion states who would have been eligible for Medicaid had their state expanded, 86 percent of males land in the gap, compared to 78 percent of females[94]. The immigrant category deemed qualified under PROWRA will likely benefit more than the unqualified under the ACA. This group can access Medicaid benefits (after their five-year mandatory wait) and will then also be able to buy low-cost health insurance[95]. Finally, the largest gender gap in work is among Hispanics, with men much more likely to be employed than women; African-Americans have a smaller gender gap[96]. Overall, women are about twice as likely as men to work part-time.

While it is clear that state enforcement discretion was a key part of the Medicaid amendments of 1965, this trend was continued both in the ACA and especially the 2012 Sebelius Supreme Court. The ACA was layered onto PROWRA which had converted the implementation neutrality of states regarding Medicaid and AFDC into a division of qualified and unqualified immigrants under Medicaid and TANF. Clearly, the picture has become more difficult for legal immigrants. Unauthorized immigrants (those in categories where they can never hope to become qualified) generally have poverty levels at least twice that of US citizens, especially for children[97].

3. Conclusion

Almost since their inception, there has been significant drift in the policy institutions governing Canada’s Medicare program. Interprovincial variations in coverage continue to grow. The private health sector continues to expand as the number and intensity of services not covered by Medicare grows – including pharmaceuticals, vision and dental care. As the private component of health care expenditures rises, a larger burden is placed on supplementary health insurance plans and out-of-pocket payments by individuals. However, access to supplementary health insurance varies considerably by province and interacts with gender, employment, income, and immigration status. This drift in Canada’s public health insurance programs has profound implications for access to necessary services for all Canadians, but as we have documented, particularly undermines the capacity of some of the most vulnerable groups in society to access necessary health services – especially immigrant women[98].

The US has never passed a broad publicly-paid system of hospital-based insurance such as seen in Canada. The most comprehensive attempt was that of the Medicare amendments for the elderly in 1964, but even that framework is a complicated balance between national and sub-national governmental funding participation. Medicaid is an even more contingent program, since a concomitant willingness to seamlessly cover the working and non-working poor by publicly-paid federal and state benefits has never been there. Finally, given the early presence of the private health insurers in the US and their deep roots in the political institutions, any attempt at a universal health system in the US could not be called a conversion. As in Canada, but in a significantly more limited manner, the United States has historically layered piecemeal solutions onto the dominant framework of private provision in place since the start of the twentieth century. While the ACA of 2010 is likely the closest that the US will ever get to universalism, two important factors mitigate its potential. The first is that the legislation relies primarily on private insurers, and the second is that the Medicaid vehicle it uses to deliver publicly-paid benefits is subject to state willingness to participate in the system. Lacking such willingness, no coverage for immigrants, either new or of long-term residence, will occur. The ACA, bound by precedents including in PROWRA, will continue to drift.

Our case studies of two federal health policy paradigms demonstrate the differential impact that fragmented, piecemeal policymaking has on the most vulnerable groups in society. Subnational variations create and magnify important gaps in service and insurance coverage, which have typically been filled (if at all) by private provision. As suggested by Vickers[99] and Haussman[100], highly decentralized and fragmented federal systems not only tend toward inequality in social provision, they are also gendered insofar as they limit the capacity of women's groups to mobilize nationally on strong, socially progressive issues, include access to basic health services.

The experiences of immigrant women in our two cases illustrate the need to go beyond an analysis of the effects of federal state architectures and the policies and provisions developed within these systems on women to consider an intersectional approach. Incisive critiques of the inability of US law and social policy to consider more than one ground of inequality at the same time have pointed to the lack of fit between differences based on sexuality and race and the predominant Anglo-American legal culture in which one has to prove «sameness» to get legal standing[101]. In Canada, scholars have pointed to the shortcomings of considering health and social inequities in singular dimensions such as gender or class or race, and transformative potential of an intersectionality paradigm to «better understand and respond to the 'foundational' causes of illness and disease»[102].

In a transformative piece, McCall described three approaches to intersectionality in the literature[103]. The first is most often found in the post-structuralist literature, which she called «anti-categorical», since its main focus was to deconstruct analytical categories. The second, from early intersectional theorizing acknowledges the mutual construction of categories. Crenshaw termed this «structural intersectionality», and McCall calls the approach «intra-categorical», where scholars focus on particular social groups at the point of intersection. Our study of the Canadian and US federations has taken this latter approach by focusing on the categories of gender and race as they intersect for immigrant women. However, McCall suggests a third approach, «inter-categorical» analysis, which requires scholars to focus on «relationships of inequality among social groups and changing configurations of inequality among conflicting and multiple dimensions»[104]. Using this last approach to intersectionality has the potential to broaden our work to analyze and document myriad dimensions of inequality that coexist and directly impact the health and well-being of women and men.

In addition to focusing on theoretical and empirical intersectionality, it is undoubtedly true that best conclusions can be drawn from multi-level analyses. Multi-level analyses can include both federalist and unitary states under supra-national frameworks. In their excellent recent study, Kriszan, Skjeie and Squires point out that due to revitalized EU treaties and a Charter of Fundamental Human Rights, that national policymaking (and supranational court decisions) have accomplished two major milestones. The first is that the equality approach in general has moved beyond the pre-2000 approach of anti-discrimination, towards the proactive, collective equality rights approach. The second is also that since 2000 policies on race and ethnic grounds have become equally as strong if not stronger than gendered grounds[105]. While the authors caution that the approach still has problems, the fact of a complex multi-level framework of accountability which exists nowhere else in the world on the same scale has pushed many European states along the spectrum of policy intersectionality.

It is crucial to note historical and discursive institutionalist policymaking frameworks to get a sense of the realm of the possible. Very little has changed in the US since legal theorists pointed out the inability of US federal courts to see people as female and worker, female and of a race, female, mother, worker, etc. While these tools seem to be open to opponents of equality, such as the invocation of the migrant mother trope by conservative Republicans in the name of diminishing immigrant benefits, they are not equally available to equality-seeking proponents. It is clear that the historical and discursive institutional history of the US, as well as the specific nature of decentralized health-care federalism and the lack of an EU supra-national framework to institute equality directives all combine to keep immigrant women, men and children less healthy and more poor than their citizen counterparts. In Canada, the modest and limited universalistic discourse around Medicare has weak institutional and legal roots but has succeeded in protecting against some of the most egregious inequities evident in the much more fragment American federal model. Mahon argues that the path dependent effects of post-war Canadian social liberalism has protected against significant departures in the direction of strong neo-liberalism seen in other liberal welfare states[106]. Nevertheless, our analysis points to important and growing inequalities at the margins of Canadian Medicare for many groups and individuals, as private financing and delivery mechanisms are increasingly relied upon to fill the gaps created by the failure to modernize, adapt and expand the existing provincially-fragmented system. This is further compounded by an ardently decentralist federal administration with strong neo-liberal social policy agenda. As a result, deliberate drift and the layering on of new programs and policies to address the most significant deficits in provincial health systems has made the challenge of addressing health and care inequities all the more difficult.

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