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Gregg M. Olsen  
*University of Manitoba*

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# Toward Global Welfare State Convergence?: Family Policy and Health Care in Sweden, Canada and the United States

GREGG M. OLSEN

University of Manitoba  
Department of Sociology

*Accounts of the welfare state and the dynamics governing its development have been pivotal and highly contentious in the social policy literature over the past few decades. Since the 1980s, research has suggested that, as a result of domestic pressures and strains and/or the impact of globalization, welfare states were declining in tandem. However, most of these studies were quantitative, focusing upon 18 or more advanced capitalist nations and, in their search to uncover broad cross-national trends, utilized narrow welfare state indicators. This study investigates the extent to which the social democratic welfare state in Sweden, the social liberal welfare state in Canada, and the liberal welfare state in the United States have converged. It takes a qualitative approach, examining the character of the income security and social service programs in two broad policy domains—family policy and health care—and concludes that the welfare states in the three nations remain distinct, while acknowledging some broadly similar trends and new developments.*

**Keywords:** *convergence, globalization, policy domains, programmatic and structural change, crisis, family policy, health care policy, income security/maintenance, social services*

## Introduction

Accounts of the welfare state and the dynamics governing its development have been pivotal and highly  
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contentious in the social policy literature over the past few decades. In the 1980s numerous studies from across the political spectrum declared that they were everywhere in crisis, beset by new unrelenting pressures and constraints which would ultimately lead to their demise. Subsequent research, however, disputed these bleak accounts of inevitable cross-national convergence, highlighting significant variation in the face of widespread and broadly similar cutbacks and reforms (cf. e.g., Alber, 1988; Mishra 1984; O'Connor, 1973).

Since the 1990s the focus has shifted toward the impact of global integration, but the debate has been very similar. Studies describing or predicting a cross-national race-to-the-bottom suggested that increasingly permeable borders in the spheres of commerce, production and finance have set increasingly stringent limits on state autonomy and national policy options, whatever the nature of domestic public opinion or political stripe of incumbent governments (Clayton and Pontusson, 1998; Fulcher, 1994; Gilbert, 2002; Goodman and Pauly, 1993; Mishra, 1999). But the conclusions of these studies have also been challenged. Some researchers were skeptical of the globalization thesis itself, noting that most developed welfare states have often been found in nations, such as the Nordic lands, with the most open borders because comprehensive networks of social policies can greatly minimize economic uncertainty and socio-political instability (Cameron, 1978; Garrett and Mitchell 2001; Rodrik, 1998). Others largely accepted the idea of a downward pressure exerted by economic integration but argued that the forces of globalization are refracted through very different conditions, institutions, and historical traditions across nations, rendering welfare states more or less vulnerable to these forces and preventing any form of meaningful convergence (cf. Bradley et al., 2005; Castles, 2004; Huber and Stephens, 2001; Navarro et al., 2004; Olsen, 2002; Swank, 2002).

Despite their varying conclusions, most studies addressing the fate of welfare states to date have been quantitative, utilizing large aggregate data sets and narrow welfare-state indicators amenable to statistical analysis, such as levels of social expenditures as a percentage of GDP, replacement rate levels for major transfer programs, or public employment as a

percentage of total employment. Although they have proven invaluable, these studies are limited by their restricted range of indicators. As often pointed out, a higher level of social welfare spending in a nation does not necessarily indicate greater welfare commitment; rather, it might simply reflect greater need spurred by higher levels of unemployment, population aging, or increases in the costs of program delivery. Moreover, the inclusion of 18 or more nations in most of these studies precludes a close examination of the general character of welfare states, including their commitment to social equality and social justice, and some their key social policy components, such as social services. In response, this study provides a close, qualitative account of two central social policy domains in each of three nations with different policy approaches—Sweden, Canada and the United States.

The U.S. welfare state has often been characterized as rudimentary. It is the quintessential liberal “social safety net,” providing a relatively restricted range of social protections and services, meagre income benefits, and few programs as a right of citizenship or residence. The restricted nature of the U.S. welfare state reflects a commitment to a narrow conception of equal opportunity, a negative expression of liberty—freedom *from* the state—and limited government, helping to explain its higher levels of poverty and smaller middle class (cf. Esping-Andersen, 1990; Korpi and Palme, 1998; Olsen, 2002).

Sweden’s welfare state, in contrast, has often been heralded (or condemned) as archetypal, the apex of social policy evolution to date. Categorized as institutional, social democratic and encompassing, it covers a wider range of social contingencies than most nations and provides generous social transfers and a dense network of high quality social services. And many of the benefits it furnishes are provided as a right (or a proto-right) to all permanent residents. Its relatively large middle class, longstanding concern with full employment and the elimination of poverty, and broad range of “family-friendly” and “women-friendly” social programs reflect a greater commitment to equality of condition and freedom *for* the state.

Although often classified with its U.S. counterpart, the Canadian welfare state has been characterized as “social liberal,” reflecting a greater commitment to state intervention

and lower levels of inequality. Canada's welfare state also provides more universal social program entitlements, and more comprehensive risk coverage. And while Canadian transfer programs have been less generous than those in most of Europe, they have typically been more supportive than those in the U.S. (Olsen, 2002, 1994; Olsen and Brym, 1996).

Welfare states are comprised of a comprehensive network of protective legislation, income transfers and social services across a wide range of policy domains. It would be virtually impossible to determine if there has been a convergence across welfare states, even if the focus is upon only these three nations. Therefore, this study focuses on the central income transfer programs and social services in two central policy areas—family policy and health care policy. It is argued that, despite some notable changes and trends in all three nations, the character of their welfare states has remained distinct in these policy domains.

### Family Policy

Family policy is a broad, encompassing area that is not as clearly demarcated as other policy domains, especially in Sweden where it has been very closely linked to labor market and gender equality policy. Family policy typologies have tended to place Sweden in a "pro-egalitarian" category. Swedish policies have sought to create greater opportunities for women to enter and remain in the labor force and to reconstruct traditional gender roles by, for example, encouraging men to play a larger role in childcare. While the family policy approaches in the U.S. and Canada are more noted for their "gender neutral" approach and for targeting poor families, there are also important differences between these two North American nations (Gauthier 1996; Ergas, 1990). Although Sweden provides a much wider range of supports for families than Canada and the U.S., the discussion here will be largely limited to the two central family policy transfers—family allowances and maternity/parental leaves—and one key social service, childcare.

#### *Income Security I: Family Allowances*

Family allowances are among the most important income

transfers provided to households with children. They provide a basic income supplement to all families with children (typically under 16 years of age). Sweden's universal, flat-rate, tax-exempt allowance provides benefits which have been among the most generous in the advanced capitalist world since it was introduced in 1948. The per-child monthly benefit level was lowered in 1996 from 750 SEK (\$US 109) to 640 SEK (US \$93), but was raised again to 950 SEK (\$US 138) in 2001. Families are also entitled to an extended allowance for children who turn 16, provided that they are still in school (until they complete their secondary education) as well as several other allowances for children who require special care.

Canada implemented its universal family allowance system in 1944, but benefit levels were comparatively low, encouraging a reliance upon supplementary means-tested transfer programs and other fiscal measures. Moreover, Canada's family allowance benefits were de-indexed in the 1980s, abolished in 1992 and replaced by a refundable tax credit, the Child Tax Benefit (CTB) the following year. This development marked the end of universal *income* benefits and an increasing reliance upon fiscal measures in Canada (Myles 1998).

Virtually alone in the advanced capitalist world, the U.S. has never provided a universal family allowance program, relying instead upon targeted, means-tested programs such as Aid to Families with Dependent Children (AFDC), a central and long-standing measure that was replaced with the Temporary Assistance to Needy Families program (TANF) in 1996. However, unlike AFDC, TANF is not an entitlement available to all who meet eligibility requirements, and it has a maximum five-year, lifetime limit. The most central means of assistance in the U.S. today is the Earned Income Tax Credit (EITC), but it only assists the working poor and requires a tax form to determine eligibility (Goldberg, 2001; Karger, 2003). Thus, unlike Sweden, where family allowances actually have been improved, the programs in Canada and U.S. have become less inclusive and support levels have deteriorated for many recipients.

### *Income Security II: Maternity/Parental Leave Programs*

Programs which enable parents to stay at home to care for young children are another central income security

component of family policy. Sweden, a pioneer and leader in this policy area, has provided support for mothers via state subsidies to voluntary sickness societies since 1891. In 1900 a new *Workers Protection Act* ensured that women did not have to return to factory work for four weeks (extended to six in 1912) after giving birth and the nation's first *paid* maternity insurance scheme was introduced in 1931. Although it provided modest economic support for new working mothers at first, it became increasingly generous over the ensuing years. By 1974 it was converted from a maternity leave program into a parental leave program, and both the benefit period and the income replacement levels were incrementally raised over the next two decades.

Today Sweden's parental leave program is extremely generous by international standards, providing income support for 16 months. Each parent must take at least two months of leave and the remaining months can be shared between both parents as they see fit. Parents receive an income replacement rate of 80% for the first thirteen months of leave and a flat-rate for the last three months. Parents without any income receive the flat-rate for the entire 16-month period. All parents are also entitled to an additional three months of unpaid leave. Moreover, they are free to take the benefit at any time before the child's eighth birthday. Universal paternity leaves are also provided in Sweden, entitling fathers to ten days of paid leave (at 80%) after the birth or adoption of each child to allow them to share in the care of new family members.

While space limitations prevent an examination of several related Swedish programs, three other entitlements should be acknowledged here: (1) a "pregnancy benefit" paid to expectant mothers with physically demanding jobs so they do not have to work; (2) ten paid "contact days" per child, per year, allowing parental involvement in their child's daycare or elementary school activities, and (3) up to 60 days per child, per year of "sickness benefits" to enable parents to stay home to care for sick children under the age of 12 (or 16 years under special circumstances). Like parental and paternity leaves and other insurance programs in Sweden, all three of these entitlements replace 80% of the recipient's income.

Programs for parents in Canada have not been nearly as

supportive or had as long a history as those in Sweden but they provide considerably more support than those in the U.S. Canada unconventionally introduced its maternity leave program within the framework of its unemployment insurance (UI) scheme in 1971 (1984 for adoptive parents) providing only fifteen weeks of benefits and leaving parents to rely upon other forms of support in the private sector. Because maternity leave has been part of the UI scheme (styled EI, employment insurance, since 1996), income replacement rates have fallen with cuts to this program (currently at 55%, up to a ceiling). However, in 1990 the length of the leave was extended by ten weeks to be shared between mothers and fathers (biological or adoptive) at the same income replacement rate. In 2001 the parental leave period was increased to 35 weeks, a significant program expansion during the period of globalization. And, in Quebec, arguably the nation's most European and social democratic province, parental leave became somewhat more generous and inclusive in 2006, providing higher earnings replacements, allowing recipients the option to claim higher benefit levels for shorter periods, and extending coverage to the self-employed.

Exceptional again, the U.S. is one of the few developed capitalist nations which does not provide statutory, paid maternity, parental or paternity leave. Twelve weeks of family leave have been available to mothers of newborns or newly adopted children through the *Family and Medical Leave Act* of 1993, but this is an unpaid scheme that only applies to employees who meet certain employment conditions and work in firms with 50 or more employees—roughly 46% of the employed population of the United States (OECD, 2001:151). Although the U.S. remains a notable laggard in this policy area, all three nations experienced some program expansion over the past 15 years, but the differences in the character and levels of support remained firm across them.

### *Family Services: Childcare*

The major social service provided in the family policy domain is childcare. Sweden has been actively committed to developing its existing childcare system since 1974. By 1995 all parents who were working or studying were legally



entitled to spaces for their children. Almost 75% of children aged 15 months to 6 years of age receive some form of childcare through the public sector. Most of these children (53%) are enrolled in municipal daycare centers, but some (12%) are cared for in family daycares by municipal childminders or in publicly-subsidized private daycare centers (7%). Although parents pay income-related fees to access Sweden's public childcare system, it is largely financed through municipal tax revenue and grants from the central government.

Like most public services in Sweden, childcare is administered at the local level by municipal authorities but closely regulated by the central government to ensure that the provision of care is consistent across the nation's 289 municipalities. Childcare in Sweden is of a uniformly high quality, serviced by highly-educated and well-trained workers. Childcare group sizes are relatively low and have relatively low child-to-staff ratios. And most childcare centers have adequate space, meet high health and safety standards, and have well-developed activities and programs. They also foster close links with parents and have flexible hours to accommodate the need and demands of parents' work and school schedules.

Again contradicting the suggestions of many globalization/convergence theorists, Sweden's public childcare system has grown dramatically over the past few decades—a remarkable development given the substantial increase in the number of children born in the early 1990s. Waiting lists have virtually disappeared and the number of spaces provided largely conforms to current needs. Moreover, childcare has become increasingly formal, collectivized, and public, reflecting declines in unpaid and unregulated care, private-sector daycare, and public and private residential/family care. And, while the number of publicly-subsidized private childcare spaces has increased in recent years, most of these have been in parents' cooperatives, worker cooperatives and other non-profit organizations, a development that does not reflect a marked trend toward privatization or marketization.

Despite this expansion, there were some jarring cutbacks to the Swedish childcare system in the 1990s. For example, some municipal childcare centers moved to smaller, less expensive quarters and/or offered reduced flexibility in their hours of

operation. Larger groups of children enrolled in public daycare and a reduction of personnel increased the average child-to-staff ratio in some childcare centers from 4:1 to 6:1, increasing stress levels among childcare workers. Parental user fees also increased, comprising over 17% of the gross costs of public childcare in Sweden by the end of the 1990s. And, amidst record-high levels of unemployment in the early 1990s, many municipalities (40%) adopted new rules denying childcare spaces to families with an unemployed parent. As in other parts of the Swedish welfare state, central government control over childcare was weakened. Although the national government continued to set goals for the municipalities, decentralization and the abolition of state regulations gave local authorities somewhat greater freedom to decide how to meet those goals, resulting in less uniform provision and costs across the nation (Bergmark, 1997; Palme et al., 2002; Szebehely, 1998). However, the government instituted a maximum fees reform in 1993 to contain the cost of childcare and limit variation across municipalities while respecting their autonomy. It also strengthened the right of the unemployed and those on parental leave to access childcare.

If Sweden's network of universally accessible childcare services best approximates a "maximum public responsibility" childcare model, the approach taken in Canada and the U.S. more closely approximates the "maximum private responsibility" model according to one OECD study (Ergas, 1990). Governments in both of these nations have been reluctant to assume full responsibility for the provision of services; neither of them has introduced national childcare legislation or universal childcare programs. Informal unlicensed, unregulated childcare in its various forms is more widespread in Canada and the U.S. than in most other developed nations. Indeed, private (non-profit and for-profit) fee-for-service childcare programs accessed through the market constitute the major component of formal care in both nations. Parental fees cover most of the childcare costs in these nations. And, various fiscal measures—tax deductions, credits, allowances, exemptions and other forms of relief—are typically utilized to help parents purchase childcare services in the market and to encourage the provision of employer-sponsored care to a significantly greater

degree than they are in Sweden and most other nations.

Childcare in Canada, like the majority of other social services, is a provincial/territorial responsibility. But, unlike healthcare or education, it is not a mandatory service, so the provinces and territories rarely operate childcare programs or ensure that they are in place. Coverage rates in formal childcare settings across age groups are relatively low in Canada, and there are wide variations in accessibility as well as in the affordability and quality of childcare centers across the nation. One prominent counter development in Canada in this area, however was the creation of a \$5-a-day CDN (now \$7-a-day) public childcare program in the province of Quebec which has been steadily increasing its number of spaces since its introduction in 1997. Outside of Quebec, however, there has been little evidence of improvement on the Canadian scene. Indeed, the minority Conservative government that assumed power in the 2006 federal election scrapped the previous Liberal government's plans to establish a universal, accessible child-care program and instituted a monthly 'Child Care Allowance' of \$100.00 CDN that covers only a small fraction of childcare costs and does not address the urgent need for more spaces.

Childcare provision in the U.S. is uneven across the states, but the proportion of children in formal care is greater there than in Canada. Childcare quality is generally inadequate, in part due to the low pay provided to child care workers and the consequent difficulty in recruiting or retaining qualified personnel. High quality childcare is very costly in the U.S., where parental fees cover 76% of childcare costs. As in Canada, the use of the tax system to offset childcare costs to parents has disproportionately benefitted higher-income earners. Because fiscal measures do not fund childcare services directly, they do little to increase access or significantly reduce costs for most families. Affordable, accessible, regulated childcare that meets even minimum standards remains in severe shortage in both Canada and the U.S. (Boushey, et al., 2001; Kamerman, 2000; OECD, 2001; Prentice, 1999). The situation in these two nations contrasts markedly with the general expansion that occurred in Sweden during the same period.

## Health Care

Health care is another central social policy pillar and one of the most costly. The health care policy domain includes two broad kinds of measures—sickness insurance, the income security component, and health care, the social services component. The three nations examined here have taken unmistakably different health care approaches. Canada and the U.S. have lagged behind Sweden and most of Europe in this policy area. However, while comparatively late, Canada, unlike the U.S., *did* mount a national health insurance plan in the 1970s, and many of its provinces had begun to introduce hospitalization and medical care insurance programs much earlier.

### *Income Security: Sickness Insurance*

Although much less familiar in the North American context, sickness insurance is a central social insurance program with a long history in many European nations. Sickness insurance provides benefits to ensure financial security for people whose ability to work is reduced due to illness for relatively short periods (after which work injury or disability insurance may apply). Sweden's universal sickness insurance scheme was established in 1955, replacing the existing state-subsidized, but voluntary sickness fund scheme. It is among the most generous schemes in existence today, providing 80% income replacement levels for those who must take time off from work when they become ill. Moreover, employees do not have to endure the long uncompensated waiting periods common in many other nations. Sickness insurance regulations were repeatedly adjusted in the 1990s, largely at the request of employers who believed the benefits were too easy to access. Since 1998, employees have not received *public* benefits during the first 14 days of illness but their employers are legally required to provide sickness compensation during this period, except for the first day which, since 1993, is unpaid. Perhaps most remarkably, there has been no formal limit on the duration of the sickness compensation period. However, claimants who are incapacitated for over a year may be considered for a temporary or permanent disability pension. Occupational rehabilitation programs, including assessments, work testing,

and work training and other cash benefits have also been available to those on sick leave. The only significant change to the Swedish sickness insurance scheme was a decrease in income replacement levels from 90% to 80% (in 1993) and then to 75% (in 1996). But, as with UI and parental insurance, benefit levels were returned to 80% in 1998.

Unlike Sweden, Canada has not established a separate sickness insurance program. However, time-limited sickness benefits have been available in Canada since 1971 through its UI program. Of course, this has meant that income replacement rates, the duration of the benefit period, the number of waiting days before compensation begins, and other rules and conditions of Canada's sickness insurance scheme, as with its leave programs, have moved in lockstep with changes to UI. Moreover, unlike UI, sickness benefits have been means-tested in Canada, taking into account certain other income that beneficiaries might be receiving (such as sickness benefits from an occupational plan, for example). Despite these limitations, and a decline in benefit levels, Canadians remain much better off than their counterparts in the U.S., where there has been no national public sickness insurance program. A few states, such as California, Hawaii, New Jersey, New York, and Rhode Island, have introduced programs to protect loss of income during illness. But most Americans wishing to have such protection must turn to the private sector, and many simply cannot afford adequate or even any coverage (Kangas 1991; RFV 1999).

### *Health Care Services*

The provision of health care services in Canada, Sweden and the U.S. is even more strikingly different than that of sickness insurance. Of course, at a highly abstract level, the health care services in these three nations look somewhat similar; they all emphasize curative intervention over health promotion. However, the three models differ in the range and quality of the primary and specialty services they furnish, the extent to which they challenge or defer to market forces, their emphasis on prevention, and extent of population coverage. Here we will focus primarily upon the general character of health care services and the way they are financed and delivered in order to contrast the three national models and track recent

developments.

Sweden has developed what is sometimes referred to as a "*national health service*" model of care. In many ways it is quite similar to Britain's more familiar public health care model because both the financing and delivery of health care services are carried out through the public sector. Most Swedish hospitals, local primary care health centers, child and maternity clinics and so on, are publicly-owned and administered. And the great majority of physicians, nurses, midwives, and other health care professionals, and about half of all dentists, are salaried, public sector workers. Comprehensive and high quality primary and speciality health care services are available to all as a right of residence (Holt and Cohn, 1995).

Unlike in Britain, however, the provision of health care in Sweden is highly decentralized, a hallmark of the Swedish welfare state generally. Health care is largely organized on a county basis and is clearly dominated by the county councils. Most hospitals, clinics and centers are owned by the county authorities and most health care providers are county employees. Moreover, health care is largely financed through income taxes levied by the county councils (about 61% of total costs). However, while the county councils clearly play the central role in the planning, provision and financing of health care in Sweden, the national government has also been a significant player, laying down key principles through the creation of directives, regulations, legislation, and ordinances. The Ministry of Health and Social Affairs draws up guidelines and sets national policy goals for the counties while several other national agencies monitor and evaluate developments and advise the government. The central government has also attempted to coordinate county health care systems by, for example, instituting a national pay scale for all hospital employees and restricting hospital doctors to salary only remuneration. Sweden's pharmacies were also brought under public ownership and control by the central government and combined into one agency, the National Pharmacy Company (Apoteksbolaget), which is responsible for the purchase and distribution of drugs. Finally, the national government also helps to finance the delivery of health care by the counties through health insurance and various forms of grants and payments (about 35% of total

costs).

While health care in Sweden is socialized—overwhelmingly financed and provided by the public sector—it is not always free. Certain services, such as birth control counseling, maternity care, and life-saving drugs, are provided without charge. But patients pay user fees for many other services, including hospitalization, a visit to a family practitioner or clinic, lab tests, and other forms of treatment from physiotherapists, occupational therapists, speech therapists and nurses. Set by county councils, user fees vary across the counties, but residents in Sweden generally pay about \$30 (US) for a visit to the hospital and approximately \$15 (US) to see the family doctor or use a primary care facility or clinic. These charges reflect incremental increases over the past few decades and an attempt to limit unnecessary overuse of the Swedish health care system. However, the fees are still relatively low, and those under 20 years of age do not pay for medical or dental care. Moreover, the relatively low annual ceiling or upper limit on the maximum amount a family pays for medical care, dental care, and pharmaceuticals remains in place (approximately \$170.00 US).

Much more significant than the increase in user fees has been the notably greater role of markets in the provision of health care in Sweden since the 1980s. Increased patient choice of healthcare providers and the adoption of purchaser-provider models that allow county councils to simply purchase services from other public or private providers that run and manage them, were among the first market reforms introduced. In some cases, county councils have even encouraged the public health care providers in their jurisdictions to foster a corporate management approach and compete with one another. In other cases, they have restructured their hospitals as joint stock companies in an attempt to transform them into managerially independent operations with responsibility for raising and spending their own budgets. The county councils have typically maintained control over all of the company shares, but three acute care hospitals were recently privatized. While this might be a symbolically important change, the vast majority of Sweden's hospitals are still owned and run by county authorities. The number of private, for-profit primary care centers, however, has expanded dramatically. Virtually

non-existent in the early 1980s, they now comprise almost 12% of the total number in the nation, but most of them are publicly financed via contracts with the county councils. Other legislative reforms have enabled doctors to work in private practices on a fee-for-service basis and fostered the introduction of private health care insurance schemes, although neither of these developments has been very widespread. While it may not represent the seismic or revolutionary shift claimed by proponents of market reform in Sweden and abroad, these developments are not insignificant. However, Sweden's health care system still maintains its definitive characteristics, including a considerably greater emphasis upon the public financing and delivery of health care than is found in most other advanced capitalist nations.

Canada's *national health insurance* model is similar to Sweden's in many ways. It too is based upon the idea of collective responsibility for shared vulnerabilities and ensures comprehensive coverage for all of its long-term residents. As in Sweden, health care is the responsibility of sub-central governments. Indeed, the Canadian model, better known as "medicare", is best described as an interlocking set of ten provincial and three territorial health insurance schemes which collectively comprise a national health care insurance system. And, health care is largely publicly financed by various levels of government through taxation and grants. The Canadian health care approach is based upon a single-payer system in which the government is the main purchaser of most of the primary and speciality health care services provided. However, the delivery of health care in the two nations is quite distinct. Unlike in Sweden, most health care services in Canada are not provided by the state. Rather, they are typically furnished by non-profit organizations and hospitals and physicians working from private offices (Olsen, 2002, 1994).

Constitutionally, Canadian health care falls under the jurisdiction of the provincial and territorial governments but the federal government sets national standards to ensure uniformity in quality and access across the nation. In order to qualify for federal funding, provincial and territorial health plans have had to comply with five familiar central principles: universality, comprehensiveness, accessibility, portability, and



public administration. However, the national government's presence has diminished over the years as federal funding has generally declined and taken the form of unconditional block grants rather than cost-sharing. Concomitant with this development has been a number of other significant trends, including a reduction in the number of hospital beds, the de-listing of drugs covered, the privatization of some services, the introduction or expansion of user fees for some services in some provinces, longer waiting lists, and lengthier waiting periods to access certain services (Armstrong and Armstrong, 1996; Fuller, 1998).

The U.S. has an *entrepreneurial health care* system. The private market is dominant in both the financing and the provision of health care, and state involvement is much less extensive than in the other two nations. Only about 20% of the U.S. population is covered by two major publicly-financed programs, Medicare (12%) for the elderly, and Medicaid (7%), for the poor. However, over 30% of the poor in the U.S. do not have health care insurance according to the U.S. Census Bureau. And 15% of the U.S. population—close to 45 million people—did not have any health care insurance in 2002, an increase of 1.5 million since 2001. The numbers with health care coverage have been declining in the U.S. in part because of reduced levels of employment-based coverage with the recent proliferation of low-wage, insecure jobs. Many families were also pushed off Medicaid with the elimination of AFDC. Although they were still eligible for Medicaid (with the exception of those who refused work), many families did not know they were eligible. According to the Urban Institute there were 500,000 fewer people participating in Medicaid in 1996, one year after AFDC was eliminated. However, since then, many states undertook to increase awareness of the program and the numbers of people using Medicaid increased significantly.

The health care approaches in all three nations are based upon a mainstream biomedical model which defines health as the absence of disease and views illness as primarily determined by genetics, external pathogens, degeneration associated with aging, and poor choices made by individuals rather than by poverty and socio-economic inequality. Consequently, their health care systems are all

physician and hospital intensive, emphasizing curative medical intervention over prevention. Of course, health care systems play a very important role relieving suffering, restoring functioning and prolonging life. In nations such as Canada, where health care is provided universally, life expectancy does not vary with income as much as it does in the U.S., where millions of people cannot afford any or adequate health care. But the socio-economic determinants of the symptoms which health care systems identify and suppress often go largely unaddressed. Not surprisingly, this is somewhat less true of Sweden than of Canada and, especially, the U.S. (Robbins, 1989; Wilkinson, 2005).

Most nations have increased their concern with prevention in recent years, passing laws, introducing educational campaigns to modify behavior, and encouraging medical testing for several increasingly common chronic diseases. Sweden has passed (and enforced) more protective environmental and workplace legislation, removed more barriers to affordable housing, and provided a wider range of other preventive programs—such as universal maternity care, child health care, school health services and other health insurance programs which make it easier for children and others to stay home when they are sick—than most other nations. In the U.S., in contrast, environmental programs and regulatory activities and agencies have been pared back markedly since the 1980s and a renewed emphasis has been placed upon changing narrowly-defined, individual “lifestyle choices”, such as tobacco use, drug use, and inactivity, while ignoring their class context. Convergence is least detectable in this policy area; while cutbacks to the Canadian health care system have been neither minor nor inconsequential, the approaches taken in the three nations remain distinct.

## Conclusion

Globalization theorists and resilience theorists have reached very different conclusions about the development of welfare states over the past two decades. While the former maintain that the economic logic of global integration has resulted in the erosion of national autonomy and strict social policy austerity

across the affluent capitalist world, the latter suggest that, for a variety of reasons, some nations have been much better placed to resist it. Sweden's still very powerful labor movement—reflected in virtually unparalleled unionization rates and the relatively steady incumbency of its Social Democratic Labor Party (SAP)—unitary parliamentary state structures with relatively few veto points, and more collectivist and state-friendly cultural traditions rooted in its feudal past have provided a good measure of insulation from the forces of globalization. The extraordinarily weak labor movement, highly fragmented presidential and federal state structures, and long-standing cultural traditions emphasizing individualism and antipathy toward the state in the U.S. have led it to embrace neo-liberalism and provided little resistance to economic integration. Canada's position between these two nations along these socio-political and socio-cultural dimensions no doubt helps to account for its continuing social policy position between Swedish social democracy and American exceptionalism (for an overview, see Olsen, 2002).

This examination of the major income programs and social services in two central social policy domains in Sweden, Canada and the United States here suggests that, despite some erosion and restructuring, there has not been a convergence. The character of the welfare state in each nation has generally remained intact, although the social policy patterns are considerably more complicated and subtle when Canada and the U.S. are closely contrasted. These two liberal nations have become more similar in certain policy areas while diverging markedly or remaining unchanged in others.

In the family policy domain, it is notable that all three nations actually expanded their provision of maternity/parental leave in the 1990s. However, Sweden has clearly maintained its position as a leader in this domain; it continues to provide an extensive and generous range of income support measures as well as high-quality, universal childcare. Both Canada and the U.S. eliminated their central family income entitlements and introduced new fiscal measures (CTB and EITC, respectively) in the mid-1990s. But Canada greatly extended the length of its parental leave program and now provides nearly a year of combined maternity/parental leave. While the U.S. may have

taken an unexpected policy step with the introduction of its family leave program in 1993, it remains out of step with most of the advanced capitalist world; the program covers only a minority of workers and provides no financial compensation, so many of those who need it most cannot take advantage of it.

It is in the health policy domain that there clearly has been the least convergence and the varied approaches in the three nations remain quite distinct. Nevertheless, several recent developments have pushed Canada somewhat closer toward the U.S. While Canada, unlike the U.S., still maintains a sickness insurance program, the benefit has become harder to access and income replacement levels have declined significantly. Even in area of health care services, where the differences between the two nations remain most stark, there have been some notable developments. In addition to the cutbacks and retrenchment in the Canadian health care system, some convergence has been set in motion by a failure to adjust the Canadian health care system to current needs and trends, as indicated by the recent Commission on the Future of Health Care in Canada (2002). In its early days, the Commission notes, medicare in Canada largely revolved around the provision of hospital care and the services of doctors. But the centrality of these healthcare components has been steadily declining over the past 25 years. Better drugs and improved day-surgery procedures have allowed hospitals to discharge patients much sooner and home care has increasingly become a substitute for longer periods of convalescence in hospital. But pharmaceuticals—once only a relatively small portion of total health care costs but now the second biggest expense—are not covered in Canada. And home care is only adequately covered. These developments and higher expenses mean that, as in the U.S., health care costs are more likely to bankrupt lower-income families today.

The trends observed across the nations in these two policy domains will not necessarily be the same across and within other social policy domains. In the area of old age policy, for example, more substantial restructuring appears to have taken place in Sweden and other social democratic nations (Olsen, 1999; Szebehely, 1998). Such variation across nations and

policy areas demonstrates that quantitative studies of numerous nations using a narrow range of indicators do not capture the complexity of policy shifts and provide an incomplete picture of the social policy landscape. Their breadth must be balanced by the depth afforded by qualitative research that can examine fewer policies in fewer nations, as the present study has shown.

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