Introduction

The scope of a country’s welfare state is often measured in one of two ways. One way is to calculate the amount of money a country commits to social welfare. Another is to examine the scope of social rights the country’s welfare state guarantees to its citizens. By either measure, the welfare states of North America are less generous than most European welfare states. In terms of social spending, the United States spent 19.0 percent of its gross domestic product (GDP) on social welfare in 2015. Canada spent less: 17.2 percent (OECD 2017). All of the wealthier countries of Western Europe during that year spent more than 20 percent of their GDPs on social welfare. This pattern has been consistent over time, and marks these two countries as among the least generous welfare states. This status as laggard also applies when North American welfare states are compared in terms of social rights. Canada and the United States are often classified among the “liberal” welfare states, those that outline a limited scope for state responsibility in providing for the welfare of their citizens (see also Chapter 16). This classification stands in sharp contrast to the wealthier European countries, most of which are classified as “social democratic” or “continental” welfare states.

When we speak of social rights, we speak of the normative principles that legitimate a welfare state. The notion of social rights was best first articulated by T.H. Marshall, who coined the term to describe the types of rights that allow citizens to share in the material and cultural heritage of their countries (Marshall 1981). A full discussion of Marshall’s notion of social rights is provided elsewhere in this handbook. For the purpose of examining the welfare states of North America, we focus on the liberal type of welfare state. Here the defining characteristics are a commitment on the part of states to provide a minimal level of social support to all citizens because they are members of the national community. Social rights are called universal, because they are rights held by all citizens. In addition, social rights are categorical, meaning that establishing a right requires that the state take steps to guarantee that its citizens can enjoy those rights. However, beyond the minimum, citizens are expected to take care of their own welfare needs.

Mexico, the third country in North America, occupies a special place. For most of the period since the Second World War, Mexico has been a developing country and consequently social
policy was not a priority for public funds. During the past 20 years this has begun to change, but Mexico does not yet have a welfare state worthy of the label. For example, in 2010, the last year for which the OECD has data, social spending in Mexico was only 7.5 percent of GDP (OECD 2017). Likewise, a concept of social rights is also only just beginning to emerge.

The objective in this chapter is to outline the basic characteristics of the welfare states of these three countries and to compare them with one another and with the more expansive European models. This comparison is conducted through the prism of social rights. For each country we examine the historical debates about social rights, and the efforts to expand them. Then, especially in the cases of Canada and the United States, we examine the efforts during the past two decades to retrench welfare states and limit the scope of social rights. The basic lesson of this comparison is that each of the three countries reached a golden age for the establishment of social rights. This came in the 1970s for the United States and Canada, but only recently for Mexico. Since the golden age, however, efforts to retrench welfare systems have circumscribed the expression of social rights. A desire to contain the rising costs of the welfare state has been an important driver of change, but more importantly, these reforms have been justified with new concepts of social rights. Instead of categorical rights that all citizens can claim, social rights in these countries are conditional upon the quality of one’s conduct as a citizen.

From social rights to conditional welfare in the United States

The origins of the welfare state in the United States is often traced to the Social Security Act (1935), one of the central pieces of legislation enacted by President Franklin D. Roosevelt to respond to the economic challenges posed by the Great Depression. Two major programs resulted from this legislation. The first was to create a universal program of public assistance called Aid to Dependent Children that provided income support for mothers with young children. The second major component of the law created a universal pension system that provided income assistance to the unemployed, the elderly, widows and orphans. These programs were modifications on a typical income insurance scheme. The premiums for the insurance programs were collected from working individuals in the form of payroll taxes, but the benefits were awarded to all those who met the standard of need, regardless of their history of premium payments. This provision was introduced because the Great Depression had destroyed the personal savings of millions of citizens, at a time when records of employment histories were not easy to reproduce. Thus, to respond to the need, Roosevelt devised the program to provide assistance and called it an insurance scheme to avoid the stigma that was then associated with charity assistance.

These programs are often cited as the beginning of the American welfare state because prior to this time, social programs were based either on the organizing ability of certain groups in society to press for assistance (such as war veterans), or on charity assistance whereby those who received assistance usually depended on the discretion and generosity of program officers. The Social Security Act was important for the expansive responsibility it assigned to the state, but it did not establish universal social rights. Women were only eligible for assistance if they had children to support, and men were not eligible at all unless they qualified for unemployment, disability or retirement assistance (Katz 1996).

Over the years, the U.S. federal government expanded the criteria to provide income assistance for more individuals, such as the parents of dependent children and some disabled adults in the household. However, individual states, which were responsible for administering the program, were also allowed a great deal of latitude in setting criteria for eligibility. As a result, the program provided assistance for poor individuals, but did not meet the condition of universality that is part
of the definition of a social right. Depending on where in the United States one lived, the level of assistance varied dramatically.

Moreover, in 1996, this program of assistance was replaced by legislation, introduced by President Bill Clinton, called Temporary Assistance for Needy Families (TANF). The major change introduced by TANF was to place a five-year lifetime limit for receiving assistance. For many years prior to the passage of this legislation, a vigorous public discussion took place in which critics argued that public assistance created a culture of dependency. The lifetime limits were designed to address this concern by creating firm incentives for able-bodied, working-age people to find jobs and come off public assistance. This change, more than any other in the United States, dramatically altered the notion of social rights. By placing lifetime limits on assistance, this program dispensed with the notion of public assistance as a categorical right one could claim. Instead, the right to assistance became conditional upon one's efforts to find work and keep a job. This reform also gained international attention, and similar programs were adopted in many other countries (Wincott 2011).

In contrast to public assistance, the system of social insurance expanded dramatically in the United States, and each expansion solidified the contributory notion of entitlement that was the foundation of the program. This is because unlike public assistance, social insurance was based on the notion that citizens earned their benefits by making contributions. The irony of this perception is that successive expansions of the programs increased the benefits to levels far greater than one would receive based on their contribution histories alone. The program has always been funded on a pay-as-you-go basis, meaning that current benefits are funded with the taxes collected from current contributors. Nonetheless, the public perception that people earn their social security has helped make this program immune from major cutbacks. Indeed, during the 1960s and 1970s, most of the amendments to the program made the criteria for eligibility and the levels of benefits more generous, allowing for early retirement options and introducing cost-of-living adjustments. This is not to say that the benefits were generous. Consistent with the idea of a liberal welfare state, the pensions provided by social security were intended to provide a basic income to keep elderly citizens out of poverty. Those who desired to live comfortably in retirement needed to secure other pension income, either from their own savings or through programs sponsored by their employers. Unlike many European countries, such programs that provide income beyond the basic social security have never been mandatory.

Beginning in the 1980s, the rising cost of social security led to concerns about its long-term viability. As a result, the levels of contributions have been increased, and the retirement age has been extended from 65 to 67 years. Early retirement options, which offer a reduced pension for those who retire younger than the normal retirement age, have been made less generous to encourage people to stay in the workforce longer. These changes have done much to ensure the long-term solvency of the program, but social security is still a modest income support. The amount of support provided to an elderly couple is about 90 percent of the US federal poverty level.

Healthcare in the United States has had a troubled history and has never been elevated to the status of a social right in the way that it has in other countries. The first public programs for healthcare were introduced in 1965 as part of President Lyndon Johnson’s “Great Society.” Like the Social Security Act, this program consisted of two parts: a program to provide medical care for the elderly (Medicare), and a program to provide medical care for people without an income (Medicaid). It should be noted that these programs did not provide healthcare as a universal right, but rather they identified target populations to support. All citizens who were not yet 65 years of age, and who had incomes beyond a minimum threshold, were responsible for securing their own healthcare needs. As a result, a complex system of private and non-profit insurance has developed to provide numerous health insurance options to the working population.
This healthcare system always provided sub-optimal results. Private insurers were able to restrict access to their programs by imposing conditions, such as "pre-existing condition" clauses, that allow them to deny coverage to people with substantial healthcare needs. The result has been that fully 25 percent of the population lack any type of healthcare coverage, and this group largely comprises children and the "working poor," meaning people in low-wage jobs.

Another problem with healthcare in the United States is that it is expensive for the level of coverage. The US spends more per person on healthcare than any other country. According to the Organization for Economic Co-operation and Development (OECD 2017), the US spent $9,024 per person in 2015, while second-place Switzerland spent $6,786 per person. In recent years, rising costs of healthcare in the United States have been addressed by increasing the amount paid by individuals, with the result that people on limited incomes find it difficult to afford coverage. One notable exception was the Medicare Modernization Act, passed in 2003 by President George W. Bush. This law was the first major reform of the Medicare program, the healthcare program for elderly citizens. Its most notable change was to expand prescription drug benefit at a projected cost of $400 billion in its first ten years (Congressional Budget Office 2005). Thus, one of the major challenges for healthcare spending in the United States is to reduce cost, but efforts to expand coverage have proved to be extremely expensive.

Reforms introduced by President Barak Obama in 2009 sought to address the inadequacy of healthcare coverage in the United States and rein in costs by dramatically altering the fundamental structure of the system. The legislation required all citizens to carry health insurance, and provided public funds to pay the enrollment fees for citizens who lacked an adequate income. To do this, it placed restrictions on the abilities of insurance carriers to limit coverage. The program was extremely contentious and, before it was passed in 2010, its scope was reduced substantially during legislative debates. Nonetheless, it went far in broadening healthcare coverage. The legislation placed substantial limits on the ability of insurance carriers to deny coverage, and it allowed uninsured citizens to elect health insurance from among a number of public as well as private schemes. A major goal of the Affordable Care Act, nicknamed "Obamacare," was to reduce the rapid increase in the cost of healthcare, though this does not seem to have worked as effectively as had been originally hoped. Moreover, as of this writing, the administration of US President Donald Trump is trying to pass legislation that would rescind Obamacare. The current proposal for this legislation, which has passed the U.S. House of Representatives, would cause 24 million American citizens to lose the health coverage they gained under Obamacare (Congressional Budget Office 2017). Efforts to establish healthcare as a social right are not yet fully secure in the US.

Thus, when measured against the metric of social rights, the American welfare state has never had a complete system of social rights. During the 1960s and 1970s, efforts were made to expand the various programs by creating a guaranteed floor of income support. However, healthcare was only recently considered to be a basic part of the set of entitlements enjoyed by citizens of the United States, but the right to healthcare is hotly contested in America. Then, as the era of austerity prompted reforms in the 1990s and 2000s, the effect has been to transform categorical rights into conditional rights, where the condition for receiving assistance is participation in the workforce. Citizens unable to maintain a consistent employment history will have a basic claim to either income or health assistance.

A social liberal welfare state in Canada

Among the advanced industrial societies, Canada was relatively late in establishing comprehensive welfare programs. Prior to the Second World War, social programs in Canada were
largely handled by the provinces, and most were based on the same principles as private charity, providing assistance to the “worthy poor,” or those individuals who were deemed by public officials to have lived morally proper lives. Beginning in Manitoba in 1916, and quickly copied by other provinces within the following five years, programs of mothers’ aid were established that were the forerunners of today’s poverty assistance program. Yet public pressure continued to mount for a system of social security and in 1927 the first programs to fund public pensions were adopted. These early programs comprised block grants awarded to provinces by the federal government for the purpose of creating pension schemes. However, they were administered like the mothers’ aid programs – pensions were given to “the worthy poor,” and only based on a means-test.

The Great Depression of the 1930s had an enormously devastating effect on the Canadian economy, but it did not lead to the kinds of sweeping reforms that were adopted in the United States at the same time. In 1935, Prime Minister Richard B. Bennett introduced a “New Deal” that was similar to the package of support which President Roosevelt created the same year in the United States. Bennett’s plan created a federal responsibility for unemployment, social insurance and a minimum wage. However, because the legislation was passed without the approval of the provinces, it was declared unconstitutional. The reason for this was that the British North America Act (BNNA), the agreement with the British Crown that served as the Canadian constitution, awarded responsibility for health and social welfare issues to the provinces.

Instead, it was the Second World War that proved to be the watershed for the expansion of the Canadian welfare state. During the war the provinces agreed to transfer responsibility for unemployment insurance to the federal level, and the BNAA was revised to allow this. Also, Canadian officials were inspired by the ideas circulating among allied countries that laid the groundwork for post-war expansion of welfare states in a number of European countries. The British Beveridge report, which inspired many countries to create plans for expanding social policy, found its Canadian equivalent in the Marsh report of 1943. Also, in 1944 Canada adopted its first universal program for income support: a child allowance. This program required that eligible citizens apply for the benefit, rather than awarding it directly. This innovation was repeated for other federal income assistance programs (Béland 2005).

The foundation for universal assistance laid during the war was expanded substantially in the post-war years. This was made possible in part due to a dramatic growth in the Canadian economy in the decades following the war, but another important factor was the expansion of the ideas of federal universal assistance to more areas of support. Legislation that gave organized labor a stronger voice led to an increase in the size of the unionized workforce, and they became a strong proponent of expanded social insurance. This is not to say that the programs were always warmly accepted. Although popular among the public, the expansion of a federal role was resisted by conservatives on ideological grounds, and by French-speaking Québécois on national grounds (Béland and Lecours 2008).

After the Second World War, however, social policy in Canada began to expand. The hated old age scheme was replaced in 1951 with an old age pension (Old Age Security (OAS)) which provided a universal benefit to all Canadians aged 70 or older who had lived in the country for at least ten years. Benefits vary depending on how long one has lived in the country. A full benefit requires 40 years of residency. Initially, the program also provided a means-tested benefit for those aged 65 to 69, but this was ended in the 1960s and now the full universal benefit is provided beginning at the age of 65. In addition to OAS, pensioners with limited resources are eligible for a means-tested Guaranteed Income Supplement (GIS). Both OAS and GIS represent a basic, universal pension. In contrast to the social security program in the United States, the
Canadian program did not require a work history for a full benefit. However, these programs are subject to taxation, with the effect that pensioners who have other sources of income find their pension benefit washed out by their tax obligations (Marier 2008).

In addition to the basic pension, Canada goes further than the United States in having a mandatory, earnings-related pension for people in the workforce. The Canada Pension Plan (CPP) was adopted in 1966, as was a separate but coordinated program in Quebec (RRQ). These are like “second-tier” pension schemes in other European countries, and do not have an equivalent in the United States. CPP/RRQ pensions are contributory and are designed to replace up to 25 percent of the average wage. Unlike European second-tier programs, and more consistent with the objectives of a liberal concept of social rights, the income replacement rates are modest. As a result, Canadian pensioners rely heavily on private pension insurance. Moreover, taken together the Canadian pension plans do not go far in protecting the elderly from poverty. As late as 1982, nearly 30 percent of the elderly were living on pensions below the Low-Income Cut-Off, a poverty level among the elderly that placed Canada near the bottom among OECD countries (Mahon 2008).

The CPP/RRQ underwent a major reform in 1997 intended to respond to growing concerns about the long-term solvency of the program. Contribution rates were increased substantially. The result was that the program continues to provide the targeted 25 percent replacement income, but introduced a significant intergenerational inequity, as current workers were paying higher contributions to fund the pensions of current retirees.

Social assistance also underwent two important changes in the 1990s and 2000s. The first was an increase in the federal cost-sharing, whereby provincial governments were given more room to adjust levels of benefits and qualifying criteria. Unsurprisingly, this led to increasing differences in the levels of support across Canadian provinces. The second change was the introduction of a “social investment” attitude in reform efforts, whereby reforms were framed as supporting people’s return to the labor force, and were designed to reduce disincentives to work. Variations in the level of support across provinces resulted, due to differences in the partisan composition of provincial governments (Boychuk 2015).

Healthcare is one area where Canada has gone far beyond the United States in establishing a social right. All provinces in Canada provide universal, publicly funded healthcare for those services which are considered “medically necessary.” The Medical Care Insurance Act, adopted in 1966, systematized what had up until that point been a piecemeal system of provincial healthcare. It established the principle of the state as a single-payer, universality of entitlement and portability of services across provincial lines. The program provides a list of medical services that are covered. Individuals are allowed to purchase private insurance for services not on the list. However, Canada is alone among single-payer healthcare systems for banning people from purchasing private insurance for services that are already covered by the public plan. This was designed to prevent the creation of a two-tier program whereby wealthier citizens could pay for private care, leaving poorer citizens in the public schemes. To a degree, however, wealthy citizens were already able to do this, as they only needed to cross the border into the United States to pay for an unlimited array of services.

The Canadian healthcare system has been chronically underfunded, with the federal government providing only 50 percent of the actual costs incurred by provincial authorities. This has produced a rationing of care by default that has engendered complaints about long delays for necessary services. As a result, the Supreme Court of Canada ruled in 2005 that the ban on private care could be unconstitutional if it caused unreasonable delays for patients.

Thus, the Canadian welfare state conforms to the liberal concept of social rights. The state holds a responsibility for providing the basic welfare needs of the population. The programs are
universal, but they are minimal and leave large space for private welfare services to fill the gap between a minimum and a more generous level of support. In comparison with the United States, Canadian programs are relatively generous, a difference we can best describe as a social liberal concept of entitlement, in contrast to the more classically liberal idea in the United States. Social liberalism is a political philosophy that stresses the positive role which states can perform in guaranteeing the rights of citizens by establishing the conditions to help citizens better enjoy those rights, such as providing for basic needs of health, income and housing.

**Mexico’s emerging welfare state**

During the last half of the twentieth century, Mexico made tremendous progress as a developing country. One measure of this progress has been the emergence of a welfare state. In recent years, austerity has led the state to cut back on the generosity of these systems of support, but these retrenchments have been supplemented with programs that target assistance directly towards citizens in situations of extreme poverty. This system of support is beginning to look like a liberal welfare state, though the scope of coverage is still far below that of its northern neighbors, the United States and Canada. However, this welfare state is still in formation and the best description of it is a system designed to do little more than address the situations of citizens in extreme poverty.

Mexico did not participate in the first wave of welfare adoption that took place in Europe, the United States and Canada during the first half of the twentieth century. Priorities during this period were placed on nation-building. In the post-war period some small programs were created that reflected the clientilistic nature of the Mexican state. They provided benefits for groups deemed essential to shore up the legitimacy of the Mexican state, and to build support for its strategies of economic development. Pension and disability programs for the military and civil servants, for example, were extremely generous. Beginning in 1940, to build support for the state’s program of import-substitution industrialization (ISI), generous insurance schemes were created for workers in key economic sectors. The two major programs established at this time were the Instituto Mexicano del Seguro Social (IMSS), created in 1943 for industrial workers, and the Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE), created in 1960. These two programs provided old age and disability pensions, as well as healthcare benefits. However, they covered less than half the working population, and their coverage was concentrated in the cities, not in rural areas.

In 1973 a program was created to address the plight of the rural poor. The National Program for Depressed Areas and Marginal Groups created income and healthcare support based on one’s place of residence. However, the program suffered from chronic underfunding and by all measures failed to alleviate the grinding poverty in many rural areas. Moreover, the program was not based on a right to assistance. Rather, the grants were given to local governments to establish workfare programs.

In the 1980s there was a shift in economic thinking in Mexico. A shift in oil prices caused Mexico to default on its debt, leading to a recessionary “lost decade.” When circumstances began to improve in the 1990s, import-substitution industrialization was replaced with neoliberal thinking. This meant that Mexico never experienced the type of Keynesian thinking that had given rise to expansive social policies in many European countries. Neoliberalism sought to promote economic growth through trade, and did so by loosening the regulations on industry and promoting trade relations, notably through the North American Free Trade Agreement (NAFTA) with the United States and Canada. Neoliberalism brought change to the pension system. The main thrust of this has been a privatization of pensions. This will lead to lower
income replacement rates and more unequal incomes across pensioners, as actual pension income depends more and more on the private investment strategies of individuals.

A series of reforms to the rural assistance program have slowly moved it from a patronage to a more effective program of poverty relief. In 1988, President Carlos Salinas created the National Solidarity Program (PRONASOL) which changed the block grant assistance for rural communities into targeted benefits for the rural poor. The program was harshly criticized for being politically manipulated, so in 1997, President Ernesto Zedillo established a new program called Progresa (National Program for Education, Health and Nutrition). Progresa provided a conditional cash transfer. By 1999, Progresa covered 40 percent of all rural families and was praised for its efficiency and transparency (Dion 2008). Today, the program is called Oportunidades, and covers virtually the entire poor population. Its benefits are means-tested, but the rights are conditional, as recipients must meet certain conditions. For example, children must maintain good school attendance and mothers must attend health and nutrition workshops. In 2006, Oportunidades covered five million families, nearly a quarter of the population, 70 percent of whom lived in rural areas (Bayón 2009: 306).

Healthcare in Mexico is another area where legislative goals have moved faster than the resources needed to meet those goals. In 1984, a universal right to healthcare was written into the constitution but these rights were granted without any infrastructural investment to make them effective in practice. Some healthcare services had been made available to the poor through Oportunidades and its predecessor programs. However, these focused assistance on the poor, and were not well resourced. In 2001, the creation of People’s Health Insurance (Seguro Popular) was a major reform to create a public, voluntary insurance scheme, targeted at low-income families who have no entitlement to social security benefits. The program was enacted over the stiff opposition of private insurance companies. As a result, Mexico now has healthcare for the poor, a public, voluntary health insurance program for low-income workers and their families, and an extensive system of private health insurance. One could say that the guarantee of health insurance to low-income workers is an expansion of the Mexican welfare state that is only now being introduced in the welfare state in the United States.

The net effect of recent reforms in Mexico may best be summarized as the creation of a floor for universal social rights, but a residualization of the benefits that once were enjoyed by well-placed workers. Moreover, a persistent problem for the Mexican welfare state is the scope of coverage. Despite the improvements, by 2006 less than half of the urban, employed population was covered by pensions and healthcare. The scope of coverage in rural areas was higher but not complete (Moreno-Brid, Pardinas Caprizzo and Ros Bosch 2009).

Comparative observations

The North American welfare states are difficult to compare with one another. Canada and the United States experienced a historical development familiar to patterns in Europe. However, Mexico’s history as a developing country marked its social policy as different. This difference is abundantly clear if one looks at the spending patterns. As Figure 18.1 illustrates, Canada was a clear front runner in public spending in 1980, but spending has remained relatively stable since then. The United States devoted less public money to social welfare in 1980 but has had a faster growth rate, and in recent years has surpassed Canada in public spending on social welfare. The data are less complete for Mexico, but the pattern is one of rapid “catch-up” with public spending on social welfare more than doubling during the period since 1980.

Yet, despite the differences in spending, two trends seem to be taking place in each country. First, there has been an improvement in the universality of social programs, and a gradual embedding of the concept of social rights in each country. On this point, Canada exemplifies the country...
that was first to embrace social rights across all major programs of the welfare state. In addition, despite efforts to residualize some of the Canadian benefit programs in the early part of this century, the universalistic core is still intact and proving resilient (Béland et al. 2014). The United States still remains one of the more limited welfare states in the developed world, but the passage of the Affordable Care Act awarded an entitlement to the “working poor” – a group that was effectively unable to obtain healthcare coverage due to the high costs of private insurance. The expansion of healthcare in the United States explains its rise in social spending. Finally, Mexico demonstrated a dramatic leap forward. In the period after the Second World War, Mexico established programs that, in clientilistic fashion, were targeted at groups who were important for the electoral fortunes of the ruling political party. Then, it transformed these programs into conditional cash assistance programs that not only established universal entitlements but were touted as a model in the region for addressing the needs of the poor (Díaz-Cayeros et al. 2016).

The second important observation is that each of these countries is a federal state, and the expansion of social rights has been achieved within this federal structure. Much of the literature on universalism suggests that universal social rights are best achieved when programs are centrally established and administered, but in North America, subnational governments are involved in creative ways to help achieve the goals of universal assistance. In Canada, provinces have a fair degree of discretion. As a result, levels of spending, and expansions in the scope of entitlement, vary from one province to another, driven as much by economic conditions and local political preference as by national policy (Boychuk 2015). In the United States, the expansion of healthcare was achieved by providing incentives for individual states to establish their own insurance exchanges, and with promises of money to expand state-level programs of healthcare for the poor (Medicaid). In Mexico, a program of block grants awarded by the national governments to local governments has allowed the country’s most populous metropolitan region, the Distrito Federal, to create a program of poverty assistance that extends to the urban poor the rights earlier granted to rural poor people through the program called Oportunidades (Lucciasano and MacDonald 2014).
Conclusions

Thus, the three countries of North America bear a striking similarity in one respect. All have welfare states that are relatively limited in their scope. Compared to European countries, they spend less per capita, and less as a percentage of their GDP. In terms of social rights, they identify a relatively limited responsibility for the state in providing for the needs of the population. Cultural values, and in the case of Mexico sheer limited resources, have led these three countries to devote less to the care of their citizens. Instead, in each country, citizens rely more on the market, or on private especially family networks of support to provide their welfare needs.

References


