

THE POLITICAL ECONOMY OF HEALTH CARE REFORM: A CROSS-NATIONAL ANALYSIS

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I. INTRODUCTION

Under the fiscal pressures of the 1980s and 1990s, governments in most advanced nations sought to make changes in the way health care was financed and/or delivered. Across OECD nations, the rate of increase in public spending on health care slowed on average through much of the 1990s. Potentially more significant than this fiscal restraint, moreover, was the development of a set of agendas for re-designing health care programs and institutions. While these reform agendas varied, they had in common a concern with the structure of incentives embedded in programs of health care delivery and finance, and the declared objective of re-designing programs to provide incentives to efficiency and effectiveness.

This type of reform agenda has profound implications for the health care arena. Pursuing this agenda meant moving beyond the blunt instruments of budget constraint and cost-shifting that governments had relied upon in the past, and attempting to change the systems of decision-making in health care -- the systems through which day-to-day decisions were made about the production and consumption of health care services. As the Organization for Economic Cooperation and Development (OECD) noted in 1994, this represented an expansion of policy perspective from a macro-level focus on global budget allocation to include micro-level considerations of the relationships between providers and purchasers of care.¹ And in confronting these relationships, policy-makers had to deal with the structures of decision-making in health care, and with issues unique to the health care arena -- notably, the central position of providers of health care, especially the medical profession.

Perhaps only post-secondary education rivals the health care arena in the level of education and technological expertise required of providers, and the extent to which those providers can insist upon their autonomy to make decisions according to the norms of their disciplines, regardless of the source of their remuneration. Unlike many forms of post-secondary education, moreover, health care delivery rests upon the individual encounter between the highly skilled practitioner(s) and the recipient of care. It is a system in which trust networks -- between patients and providers, and among providers themselves -- have traditionally characterized the decision-making system.

Given these dense and complex networks, it is not surprising that attempts to implement health care reform agendas met with widely varying degrees of success across nations. Nor is it surprising that the agendas and strategies themselves varied across nations, despite some common themes. Strategies for enacting and implementing health care reform fell into three broad categories:

- a) "Big-bang" reform (that is, attempts to make major, comprehensive changes to the roles of key actors in the system) within a short time frame
- b) "Blueprint" reform: (that is, enactment of a comprehensive framework for change to be implemented in phases)
- c) Incremental reform: no sweeping re-design, but marginal adjustments to the roles of some key actors

These different approaches resulted from quite different political circumstances, as will be discussed shortly. Interestingly, however, no one of these approaches seems in itself to have been more successful in achieving its intended result (Table 1). Among the nations reviewed in this study, three (Britain, New Zealand and the United States) attempted "big-bang" reform of the

health care system in the 1990s, one (the Netherlands) took a “blueprint” approach, and two (Australia and Canada) attempted changes that were incremental in comparison. Of the nations that attempted big-bang reform, one (Britain) succeeded in implementing a somewhat tempered version of the changes originally proposed; one (New Zealand) enacted sweeping change from which it successively retreated; and one (the US) failed to enact reform proposals at all. Of the jurisdictions that took a blueprint approach, one (the Netherlands) found itself stalled after having achieved change in a sub-sector of the health care arena. And those nations that attempted incremental change (Australia and Canada) had mixed success in different sub-sectors.

Table 1: Strategies of Health Care Policy Reform

| <i>Strategy Type</i> | <i>National Example</i> | <i>Result</i> |
|----------------------|-------------------------|---|
| Big-Bang | Britain | Tempered adoption of “internal market” Unanticipated take-up in one sub-sector: GP Fundholding |
| | New Zealand | Successive roll-back of “internal market” Unanticipated take-up in one sub-sector: GP Budget-holding |
| | US – federal | Failure to enact “managed competition” |
| Blueprint | Netherlands | Stalling of comprehensive “managed competition” Implementation in social insurance sub-sector |
| Incremental | Australia | Public subsidies to private insurance |
| | Canada | Horizontal integration in hospital sector |

In fact, regardless of whether the strategy relied on a big bang, a blueprint or an incremental approach, change appears to have been most effective where governments succeeded in engaging a sub-set of actors in the health care arena in the process of implementing health care reform – albeit in ways that had not been specifically anticipated at the outset. This paper will look at attempts to enact and to implement reform in the health care arena in these selected nations, with an eye to drawing lessons for Canada.

II. ENACTING HEALTH CARE REFORM: BIG-BANG, BLUEPRINT OR INCREMENTAL APPROACHES

Whether or not a nation attempted bold policy change in the 1990s, let alone the likelihood of success, bore little relationship to overall levels and trends in spending on health care, or to the share borne by the public treasury (Table 2). Of the two nations with the highest spending levels and the greatest rates of cost increase in the previous decade, one (the US) took a big-bang approach while the other (Canada) took an incremental approach. The other two nations which took a big-bang approach (Britain and New Zealand) were relatively modest spenders with different records of cost increase.

Table 2: Expenditure on Health Care, 1992

| <i>Nation</i> | Total Expenditure on Health Care as % GDP, 1992 | Public Expenditure on Health Care as % GDP, 1992 | Annual average increase in total per capita health care spending, 1980-92 |
|----------------|---|--|---|
| Australia | 8.6 | 5.7 | 6.7 |
| Canada | 10.2 | 7.6 | 8.6 |
| Netherlands | 8.8 | 6.8 | 6.3 |
| New Zealand | 7.6 | 6.0 | 5.6 |
| United Kingdom | 6.9 | 5.9 | 8.0 |
| United States | 13.9 | 5.9 | 9.3 |

Sources:

OECD Database 1999

George Schieber, Jean-Pierre Poullier and Leslie M. Greenwald. 1994. "Health System Performance in OECD Countries, 1980-1992." (1994) 13:4 Health Affairs 102

Rather, the approach to enacting health care reform adopted in a particular nation depends heavily on factors in the broader political environment. Given the entrenchment of interests in the health care arena and the high public salience of health care, making such changes carries great political risk. Hence governments are likely to approach health care reform with varying degrees of caution, depending on their political circumstances. These circumstances in each of the nations under review here are summarized in Table 3 and elaborated in the rest of this section of the paper.

Table 3: Conditions for Enacting Reform

| <i>Strategy Type</i> | <i>National Example</i> | <i>Political Conditions</i> |
|----------------------|-------------------------|---|
| Big-Bang | Britain | Unitary (non-federal) government structure Majority government in third successive mandate |
| | New Zealand | Unitary (non-federal) government structure Majority government |
| | US | Federal government structure Presidency and both Houses of Congress controlled by same party by narrow margins |
| Blueprint | Netherlands | Unitary (non-federal) government structure Coalition government |
| Incremental | Australia | Federal government structure – relatively strong central government Majority government |
| | Canada | Federal government structure – poor climate of federal-provincial relations Majority government |

a) The Big-bang approach: Britain, New Zealand and the United States

The decision by a government to attempt big-bang reform is a rare event. The government of the day must believe that it can muster its authority on a scale that will allow it to succeed; and health care reform must be sufficiently central to its political agenda that it is willing to incur the risk of moving on this front. These two factors rarely coincide.

Nonetheless, at least one of these conditions for a big-bang approach – the ability of the government of the day to muster authority on a broad scale – is more likely to occur in some systems than in others. It is most likely in systems that provide relatively few “veto points” for opponents, and therefore in systems with features such as: a unitary (non-federal) structure; a parliamentary model that concentrates authority in the executive; an electoral system that favours the emergence of a majority party; and a tradition of party discipline that minimizes intra-party dissent. Even in such systems, the mere ability of government to mobilize authority is not a sufficient condition for it to proceed with big-bang change. It must also form the will to take the political risks involved – because systems that concentrate authority also concentrate accountability, and it is difficult for governments in such systems to diffuse the blame for unpopular reforms.² Nonetheless, it is not surprising that in two of the three nations under review here in which big-bang change was attempted – Britain and New Zealand – all of these structural features were present.

It is more rare but not impossible for big-bang change to occur even in systems that lack these features. Even in the United States, with a federal structure, a congressional system that divides authority between the legislature and the executive, and a tradition of very weak party discipline, big-bang change has occurred on a number of occasions. Most notably, in the health care arena, it occurred in the 1960s when the Democratic landslide in the 1964 federal elections gave that party the Presidency with a super-majority in the popular vote, as well as supermajorities in both houses of Congress, and governmental health insurance in the form of Medicare for the elderly and Medicaid for the poor was introduced. It is also possible for sweeping change to occur through the mobilization of bipartisan support in the US system, as occurred with the passage of tax reform legislation in 1986. Nonetheless, it is clearly more difficult for big bang change to be enacted in the US system; and an attempt to do so in the form of President Clinton's health care reform proposals in 1993 failed spectacularly.

A brief review of the experience of each of these three systems in the 1990s is instructive. Consider first Britain and New Zealand. As they had done in the initial establishment of their systems of universal health coverage half a century earlier, each of these countries adopted remarkably similar approaches to the reform of those systems in the 1990s, with certain key variations. Both sets of reforms were centred around the replacement of established hierarchical structures for managing hospital services with separate "purchasing" and "providing" entities. The reforms were characterized as creating an "internal market" – that is, a market internal to the publicly-financed sector. They were intended to strengthen the role of the state as purchaser and to tame the providers by requiring them to compete for public contracts. But the reforms were not (with some exceptions to be noted in the New Zealand case) intended to shift the boundary between public and private finance.

The political circumstances in which these reforms were enacted also bore some similarity. In both cases a governing party with a strong ideological bent, which had initially focused on other arenas, formed the political will to take on health care. In the British case, the governing Conservatives under Margaret Thatcher were initially reluctant to tamper with health care, famously declaring "the NHS [National Health Service] is safe with us."³ It was not until her third successive majority mandate that the Prime Minister, provoked by criticisms from the Presidents of the medical Royal Colleges, personally decided that the risks of inaction on the NHS now outweighed the risks of action. In 1988-89, she chaired a review of the NHS which, after a period of floundering, seized upon an approach that the Conservative government had recently enacted in the education arena and recommended a set of "internal market" reforms.

The central aspect of British internal market reform was the splitting of the purchaser and provider roles of the District Health Authorities which had formerly been responsible for managing and financing all the public hospitals in their respective districts. In the reformed system about 100 Health Authorities (HAs) were expected to be transformed into active purchasers and to engage in hard bargaining for the supply of cost-effective hospital and other secondary services from a range of health care providers. On the supply side, public hospitals were transformed into self-governing "NHS trusts" (which were not trusts in the legal sense but crown corporations) with the power to vary salary packages for employees and to borrow capital within annual financing limits. They were expected to compete with each other for contracts with the Health Authorities to supply services.

An initially small component of the reforms, but one that gained increasing importance, was related to family doctors (general practitioners) – namely, General Practitioner (GP) Fundholding. Indeed, in this particular dimension the British approach was somewhat closer to a blueprint than a big-bang model, in that it was designed to be phased in. Initially, general practices with more than 11,000 patients could apply to a Health Authority to become a Fundholder. A Fundholding practice received a capitated budget with which to buy drugs and approximately 20 percent of hospital and community services for the patients that it enrolled.⁴ Consequently, the existence of GP Fundholders provided some competition for Health Authorities in their role as purchasers of health care. The Fundholding option was successively opened up to smaller practices, and extended to a broader range of services. By 1997, there were 3,500 Fundholders, involving around 15,000 general practitioners, acting as purchasers for approximately 50 percent of the population for a limited range of health care services.⁵

The process of implementing these reforms will be discussed below. By 1997, they were sufficiently entrenched that the newly-elected Labour Party, which had initially been a vitriolic critic of the reforms, chose to maintain their essential structure. In December 1997, six months after assuming power in a landslide victory, the Labour government issued its own policy proposals for the structure of the NHS, which while abolishing the language of the internal market retained its essential features. The purchaser/provider split was maintained. The centrepiece of the proposals was the development of “Primary Care Groups” -- consortia of general practices and community nurses that would “grow out of the range of commissioning models that have developed in recent years”⁶ and that would be granted authority and budgets by the HAs to enter into long-term “service agreements” with providers of hospital and community care. The role assigned to nurses in this structure is notable, and builds upon a tradition of nursing involvement in the governance of the British National Health Service. On 1 April 1999, 481 PCGs were instituted in England, with a patient population ranging from 46,000 to 257,000 but with the average being 100,000. Governed by boards with representation from GPs (typically the majority), nurses, social services, and Health Authorities, the PCGs are initially to remain under the managerial umbrella of the Health Authorities, with the expectation that they will come to assume more independence as Primary Care Trusts.

In New Zealand, internal reforms were also adopted by a majority government with a strong ideological bent, after a period of experimentation with market-oriented reforms in sectors other than health care. The difference in New Zealand, however, was that the initial experimentation in other arenas occurred under one party – Labour – while the health care reforms were undertaken by the successor National Party government. The period of the 1980s had been a dramatic one in New Zealand politics. The Labour government, notwithstanding its leftist roots, embarked in 1985 upon a sweeping market-oriented reform agenda aimed at de-regulating what was then among the most highly regulated economies in the OECD. This agenda, driven by an influential group of advisors centred around the Treasury department, nonetheless left the health and social services sectors largely untouched. The National government which assumed office in 1991 continued this agenda (drawing to a large extent on the same set of advisors) and extended it aggressively to health care.⁷ It established a review team which reported in 1991, whose recommendations were enacted in 1992 to come into force in July 1993.

The reforms were cast deliberately in the British “internal market” mold. They required government-appointed purchasers (initially four Regional Health Authorities and subsequently one central Health Funding Authority with four branches) to bargain and enter into contracts with competing public and private health service providers. The management structure of public hospitals was re-organized on a crown corporation model. Accordingly, 29 hospital boards were replaced by 23 “Crown Health Enterprises” (CHEs), which were intended to operate on a for-profit basis and to compete with each other and with New Zealand private providers for contracts with the Health Authority. New Zealand also adopted its own version of GP Fundholding, known as “Budget-holding.” In the New Zealand version, physician groups of varying size were given capitated budgets by the relevant Health Authority to cover the cost of specified services for their patients such as drugs, diagnostic tests, x-rays etc. – but not hospital services in the British mold. Unlike GP Fundholders, moreover, New Zealand Budget-holders continued to function on a fee-for-service and effectively private basis for the bulk of their practice.

The New Zealand reforms also included a number of elements that fostered private components of the system, and that were not present in the British reforms. User charges in public hospitals were introduced. And a path toward “managed competition” was charted: it was envisaged that the newly-established health authorities would compete with private insurers for enrollees (who would bring with them a risk-adjusted share of public funding) and would be required to cover a basic package of benefits for all enrollees. New Zealand's National Advisory Committee on Health and Disability was initially constituted with the intention of defining a list of prioritized core services to enable better comparison of competing purchasers.⁸

The fate of the New Zealand big-bang was very different from that of its British counterpart. As we shall see in a later section of this paper, the process of rolling back the reforms began almost as soon as they were enacted. A big bang approach in itself, then, is no guarantee of success.

The difficulties of even enacting big bang reform, furthermore, are demonstrated by the case of the US. President Bill Clinton clearly had the political will to introduce universal health insurance through “managed competition” as a central component of his “New Democrat” agenda. His reforms built upon the existing employer-based model, mandating employers to provide health insurance for their workers. They also required state governments to establish regional health alliances to contract with private insurers to offer insurance to those without employer-based insurance.

In at least one sense, the conditions for success of such proposals appeared promising. A newly-elected Democratic president had made a commitment to health care reform central to his presidential campaign. His party, moreover, not only controlled the White House but also had a majority in both Houses of Congress. By the early 1990s, the phalanx of medical, hospital, insurance and business interests that had opposed universal health insurance in the past had been fragmented into multiple competing interests by the turbulent changes in the health care market in the 1980s, including the rise of a for-profit-dominated managed care sector. Indeed, in the face of the threats to their own autonomy and influence posed by these developments, a number of medical groups endorsed all or part of the Clinton proposals.⁹

But Clinton's ability to mobilize the necessary authority was highly tenuous. He entered office with only a 43% plurality of the popular vote and with a Democratic majority in the Senate less than the 60% necessary to prevent effective Republican vetoes through procedural maneuvering. In this relatively weak position as President, he could succeed in a major initiative such as health care reform only through bipartisan compromise or through creating a "bandwagon" momentum that would draw supporters to a winning cause. Strategic judgments made by the Clinton administration, however, militated against either of these outcomes. They chose to develop the proposals through a lengthy and exclusionary process that dissipated momentum as Clinton was forced to expend his limited political capital on other issues – notably his first budget, and the North American Free Trade agreement. In the end, Thomas Jefferson was right – in the American system "great innovations should not be forced on slender majorities,"¹⁰ – and the Clinton health care reform proposal went down to defeat.

b) The Blueprint approach: the Netherlands

In the Netherlands, government structures militate against a big-bang approach. Coalition governments, with their reliance on constant compromise, are the norm. Moreover, long-standing tradition has legitimized a so-called "social middle ground" populated by bodies that span state and society. Van der Grinten describes this social middle ground as "the area between the state and the citizen in which providers, health insurers, employers, employees and other private organizations are concerned with the public interest in conjunction with the government. Private organizations play a notable double social role in this system: on the one hand as a pressure group for the promotion of private interests *vis-à-vis* the government, and on the other as an agency of government concerned with the implementation of public responsibilities on behalf of its own rank and file."¹¹

In this context, the blueprint approach to health care reform adopted by Dutch governments appears rational. Blueprint approaches are typically adopted where no one set of political actors (such as a majority government) can mobilize sufficient authority to take a big-bang approach, yet comprehensive reform is still the goal. In such circumstances, agreement on a blueprint, incorporating elements desired by different parties and interests, may be negotiated, to be implemented on a phased basis. This is just what occurred in the Netherlands. (It was also the approach adopted by several American states in the early 1990s in attempts to achieve bipartisan compromise.) In the Netherlands, the intent was to replace the existing system, in which health insurance coverage was structured by region and by income category, with an overarching framework of "managed competition" integrating all insurers. Under the existing system, "sickness funds"¹² with regional monopolies had been mandated to provide coverage to all below a given income level (together comprising about 62 percent of the population), while upper-income groups relied on private insurance. The entire system was underlain by a universal public program covering "exceptional" medical expenses, such as hospital care exceeding one year, long-term nursing home care and long-term care for the mentally and physically handicapped.

In 1987, a commission established by the center-right coalition government of the day produced a set of proposals that would replace this system with one of compulsory national health insurance based on "regulated competition" among both sickness funds and private insurers. The "basic benefits package" to be offered by these insurers, as outlined but not precisely defined, was estimated to include about 95 percent of health care expenditures. Individuals would pay a flat-rate premium to the insurer of their choice; and the insurer would receive a risk-adjusted amount

for each insured directly from a central pooled fund. Sickness funds were to be freed from the requirement to contract with all physicians in their regions; and physicians, in turn, were to be freed to set up practice wherever they wished, without seeking a municipal licence.

These proposals bear the mark of a coalition government. The end – universal scope – appeals to the left, while the means – regulated competition – appeals to the right. (Indeed, just such an attempt at left-right appeal, though not the process of negotiated compromise nor the phased approach, underlay the Clinton reforms in the US.) And, in a foreshadowing of what would occur in Britain in 1997, the center-left coalition government (with a social-democratic health minister) that assumed office in 1991 essentially endorsed the reforms while tempering the pro-market language used to promote them.¹³

Nonetheless, there were reasons for various interests to oppose the reforms. Employers feared that a broad-based basic benefits package would increase health costs. Private insurers opposed essentially turning over to government the risk-adjustment of their revenue, and the expansion of the scope of the regulatory bureaucracy. Technical dimensions of the definition of the basic benefits package, moreover, had the potential to pit certain providers of care against others. Even the sickness funds had some concerns about the expansion of the scope of coverage and other details of the proposals.¹⁴

As it turned out, the reforms were stalled in their early stages. Van de Ven and Schut astutely point out the reason why. The reforms were adopted as a compromise package at the outset. But what was not appreciated at the time was that, in a succession of coalition governments, progress would be very difficult unless *each step along the way* were as balanced as was the full package – an almost impossible design problem.¹⁵ Some elements of the reforms – notably those relating to social insurance – were accomplished through alliance with particular interests in the health care arena, as will be discussed below. But the grand scheme of universal health insurance through managed competition was abandoned in 1994, when a complex coalition led by Labour, but including the rightist Liberals and excluding, for the first time in 20 years, the center-right Christian Democrats, assumed office.

Similar problems with a phased blueprint approach to health care reform were experienced by some American states in the 1990s. In the late 1980s and early 1990s, a number of states sought to extend coverage to a number of uninsured and underinsured segments of the population through insurance reform and/or the expansion of state plans. Typically, these reforms involved planned steps within an overall framework. In all such cases, however, these plans were stalled or rolled back as a result of partisan change in government and the fraying of political support over time. In Washington State, for example, framework legislation for insurance reform enacted in 1993 was not implemented, and was replaced by more modest legislation in 1995. In Minnesota, staged increases in coverage for low-income individuals as well as other steps toward universal health insurance, enacted in 1992, were subsequently scaled back. In Kentucky, plans to extend state coverage to all those below the federal poverty line were not implemented. It must be noted, however, that one state that adopted a version of a big-bang approach – Tennessee, which attempted to extend state-subsidized coverage to all uninsured residents – encountered severe implementation difficulties and closed enrolment in the program.¹⁶ In Oregon, an ambitious plan to extend public coverage to a broader range of low-income beneficiaries by “rationing” the scope

of services covered was implemented, as will be discussed below – but further steps toward insuring the “working poor” through employer mandates were forestalled.

c) Incrementalism: Australia and Canada

In both Australia and Canada, changes in the public policy framework for health care financing and/or delivery followed a more incremental pattern than in any of the nations discussed so far. The conditions for a big-bang or a blueprint approach were simply not present. Both of these nations are federal states, in which responsibility for health care is shared between national and sub-national governments (states in Australia, provinces in Canada). Hence the process of mobilizing the authority necessary to make comprehensive reforms is more complicated than in nations with unitary governments. There are, however, important differences between the two federal systems in this regard. While provincial governments in Canada have far greater fiscal leverage in the health care arena than does the federal government, Australian state governments are largely dependent on the Commonwealth for health funding.¹⁷ Canadian provincial governments operate hospital and medical insurance plans under criteria established in federal legislation as conditions for federal financial transfers; in Australia the medical insurance plan is operated by the Commonwealth government, while state governments own and operate public hospitals with Commonwealth funding.

In Australia, then, the federal (Commonwealth) government has a stronger role in health care than is the case in Canada and is more able to take unilateral action – and Australia has over time experienced sharp shifts in the policy framework under successive Labour or Liberal-National Coalition governments at the Commonwealth level. In the 1940s a Labour government instituted a system of government coverage for hospital services. In the 1950s, the Coalition government reversed these changes. In 1974 the Labour government established a universal hospital and medical insurance scheme, Medibank, ostensibly modeled on the Canadian system. Only a few months later, however, a Liberal-National Party Coalition government was elected at the Commonwealth (federal) level, and began a series of changes that effectively dismantled the universal public scheme. Upon returning to power, the Labour government re-introduced a universal public plan (Medicare) in 1984.

In the 1990s, however, for the first time in decades a change in government at the Commonwealth level did not lead to a comprehensive change in health policy. Perhaps as a result of a certain fatigue from the policy oscillation of the past, the Liberal-National Party Coalition government elected in 1996 (and re-elected in 1998) chose not to dismantle the policies of its Labour predecessors. Rather, it sought to strengthen private elements of the system on an incremental basis – largely through increasing public subsidies for private insurance – as will be further discussed below.¹⁸

In contrast to Australia, the policy parameters of the Canadian system remained essentially stable in the decades following the establishment of Medicare. The most significant development in the federal legislative framework governing the system, indeed, was the *reinforcement* of the universal single payer model with the banning of user charges and “extra-billing” for publicly-insured medical and hospital services in the mid-1980s. Following the passage of the *Canada Health Act* in 1984, which provided for financial penalties for provinces that allowed such charges, all provinces brought their plans into compliance.

In the 1990s, policy change in Canada could be characterized as “incrementalism under fiscal duress.”¹⁹ As is described in other papers for the Senate Committee, Canadian federal and provincial governments exercised a degree of fiscal constraint that was dramatic in both historical and comparative perspective. The mechanisms of fiscal constraint were blunt, and left the essential design of the system unchanged. There was no experimentation with “internal market” reforms as in Britain and New Zealand, and no deliberate shifts in policy to favour private finance as in Australia (although the system underwent a degree of “passive privatization” as discussed in other papers for the Senate Committee). Any substantial change to the policy framework would have required federal-provincial negotiation. This was a political as much as a constitutional requirement. In theory, a majority government at either the federal or provincial level could have acted unilaterally. The federal government could have changed the conditions for its transfers, as it arguably did in 1984. And any given province could have chosen to incur the fiscal penalties of non-compliance with the federal criteria. But in fact no government was willing to bear the political risks of “going it alone” to tamper with Canada’s most popular social program, without the political cover provided by a federal-provincial agreement. And in the highly strained climate of federal-provincial relations in the 1980s and 1990s, no such agreement was possible. Rather, governments focused largely on blunt fiscal constraints. At the federal level, transfer payments were reduced in a series of federal budgets beginning in 1985. In the mid-1990s, the federal Liberal government rolled a number of social transfers, including that for health, into a Canada Health and Social Transfer (CHST), reduced the overall amount while guaranteeing of a stable floor of federal funding, and left in place the conditions to be met by provincial plans to qualify for this transfer.

At the provincial level, governments also confined themselves primarily to blunt budget instruments to slow the growth of the health care budget and to re-allocate within it. They did intervene to restructure the hospital system; and in all provinces except Ontario (a large exception, representing about 40 percent of the Canadian health care system) governments drew the hospital sector somewhat closer to the state by establishing or increasing the authority of governmentally-appointed or elected regional boards for the governance of hospitals and other institutions. These boards continued to function at arm’s length from the provincial government, however; and members were more likely to see their roles as that of community representatives rather than agents of the provincial government.²⁰

In summary, the basic parameters of both the Canadian and Australian systems remained largely intact in the 1990s, while incremental changes were made. Choices about the nature of those changes, and the course of their implementation, were very much shaped by the design of the existing systems, in ways that will be discussed in the next section.

III. IMPLEMENTING HEALTH CARE REFORM: STRATEGIC ALLIANCES

Regardless of whether governments adopted a “big bang,” blueprint or incremental approach to health care reform, their success was contingent on their ability to find allies within the health care arena itself. And the nature of those alliances shaped the course of implementation.

The possibilities for such alliances depend upon the structure of interests in the health care arena – a structure that in turn depends upon the design of the prevailing policy framework. In

particular, it depends upon the way in which the boundary between public and private finance is drawn. Different ways of drawing that boundary have important implications for the balance of influence across the state, private finance, and key health care providers. Elsewhere in papers for the Senate Committee, four ways of drawing this boundary are set out:

1. Parallel public and private systems: For a given range of services, a separate privately financed system exists as an alternative to the public sector, and without direct public subsidy. Typically, the private system embraces only a small sub-set of services in profitable “niche” areas. Hence the primary axis of accommodation in the arena is between health care providers and the state, with private insurers playing a relatively marginal role.
2. Co-payment: Across a broad range of services, financing is partially subsidized through public payment, with the remainder financed through out-of-pocket payments and/or private insurance. The degree of co-payment may be scaled according to the income of the patient. In such systems, providers deal with a mix of sources of finance for any given patient, and the basis for accommodations between providers and payers is more fragmented.
3. Group-based: Certain population groups are eligible for public coverage; others rely on private insurance. In such systems, providers move from one type of payer to another as they move from patient to patient. This also fragments the basis for accommodation between providers and payers, although it may provide the basis for separate accommodations around particular patient populations.
4. Sectoral: Certain health care sectors are entirely publicly financed; others privately financed. In such systems, there is a strong base for accommodation between the state and those providers whose services are publicly funded, while fragmenting the base for broader accommodations.

The nations under review here exemplify these models to greater or lesser degrees (Table 4). And their experience with implementing health care reform reflects those differences, as is discussed in this section of the paper.

Table 4: Conditions Affecting the Implementation of Reform

| <i>Strategy Type</i> | <i>National Example</i> | <i>Public-Private Boundary</i> | <i>Structure of Interests</i> |
|----------------------|-------------------------|--|---|
| Big-Bang | Britain | Parallel public and (niche) private systems | Central axis of accommodation between state and medical profession |
| | New Zealand | Hybrid: Parallel public and (niche) private systems plus wide-spread co-payment in ambulatory sector | Divided: state/providers/private insurers/individual payers |
| | US | Group-based plus wide-spread co-payment | “Hyper-pluralism” |
| Blueprint | Netherlands | Group-based | “Social middle ground:” social insurance funds, physician associations, private insurers |
| Incremental | Australia | Hybrid: Parallel public and (niche) publicly-subsidized private systems plus wide-spread co-payment | Divided: state/providers/private insurers/individual payers |
| | Canada | Sectoral | Central axis of accommodation between state and medical profession re medical and hospital services |

a) The Implementation of Big-bang Reform: Britain and New Zealand

Prior to their attempts at big-bang reform in the 1990s, the British and New Zealand systems showed some important similarities and differences – and the differences were to prove crucial to the dynamics of change in the 1990s. In both Britain and New Zealand, hospitals were publicly owned and managed as well as publicly financed, offering universal access to hospital services on a first-dollar-coverage basis, although private hospitals offering a limited range of services existed in a parallel private system. Specialist physicians practised in public hospitals on a salaried basis, but most also supplemented their incomes through fee-for-service private practice. Private insurance was available for patients opting to be served in the private sector. Beyond these fundamental similarities, however, the most important differences concerned the organization and financing of general practitioner services. In Britain, general practitioners, while formally maintaining the status of “independent contractors,” were funded on a capitation basis through local bodies, and patients faced no user charges for GP services. In New Zealand GPs (family doctors) practiced on a fee-for-service basis. Public payment for general practitioner services was conceived from the inception of the system in 1938 as a means-tested subsidy to patients, and always left upper-income patients responsible for a significant proportion of the fee. Over time, the level and extent of public subsidy failed to keep pace with the growth of medical fees, until by the 1980s public funding accounted for only about half of total expenditure on primary care. Beyond certain targetted services such as maternity care, public subsidies for

primary care services covered less than half the population; and even for those patients eligible for coverage the subsidy covered only about half of the fee charged. General practitioners in New Zealand, then, deal with a greater mix of payers than their British counterparts.

A second difference between the two systems concerned the governance of the hospital system. The nationalization of hospitals and their re-organization within a structure of regional hierarchy constituted a key feature of the establishment of the British NHS – one that was highly contested at the time but which perdured through several re-organizations of the NHS in subsequent decades. The hierarchy had corporatist dimensions that were seen to be key to the maintenance of professional discretion. Consultant physicians, for example, were not employees of individual hospitals – rather, their contracts were held at the regional level. In New Zealand, in contrast, existing local structures of hospital governance were left in place when the system was nationalized in the late 1930s.

These differences in financing and organizational design had important implications for the political dynamics of each system. The comprehensiveness of the British system bound health care providers into a close accommodation with the state, defined by what Rudolf Klein has termed an “implicit bargain,” in which the profession accepted the state’s authority to determine the overall budgetary parameters of the system while the profession retained autonomy to make resource allocations through the exercise of clinical judgment within those parameters. This was most true for general practitioners, whose services were almost exclusively publicly financed. But even those consultant (specialist) physicians who practiced for part of their time in the private sector had to maintain their base in the public sector, on which their professional legitimacy and their access to broader health system resources depended. The system was webbed with clinical and accountability networks that, while complex, reached levels of maturity that reduced transaction costs for decision-makers – an important feature in a budget-limited system.

In New Zealand, in contrast, the accommodation between providers and the state was much less embracing. The relationship between local structures of hospital governance and central decision-makers was a tense one, marked by periodic failed attempts by the centre to re-organize the hospital system.²¹ Even more significant was the fact that family doctors (general practitioners), who accounted for well over half of New Zealand’s practising physicians, became more and more dependent over time on private sources of finance, whether from patients out-of-pocket or from private insurers. Under the terms of their respective accommodations with the state, physicians in New Zealand have fared relatively better than their British colleagues in income terms. In terms of purchasing power parity, average physician income in 1990 was about 28 percent higher in New Zealand than in Britain,²² even though the specialty mix was weighted more heavily to general practitioners in New Zealand than in Britain.

In these two national contexts, the attempts at “internal market” reform discussed above played out quite differently. In Britain, a broad policy blueprint outlining dramatic change was moderated in its implementation as it was absorbed by established networks. In New Zealand, the process of policy change itself was highly volatile, as a number of policy shifts and reversals followed in rapid succession.

To explain these differences between the British and New Zealand experience with internal market reforms we need to look to the nature of the accommodation between health care providers and the state that characterized these two systems prior to the reforms. In Britain, the process of *introducing* the “internal market” reforms certainly constituted a rupture in the established accommodation between health care providers and the state. But in the process of *implementation* that accommodation was resurrected and re-defined. Health Authorities were formally broken up, but the component pieces re-established their networks even as their negotiations became more explicit. And General Practitioners, an important part of the profession-state accommodation since their reluctant participation had been won in 1948, moved to a more central position with the surprising popularity of GP Fundholding. GP Fundholders, indeed, became allies of the government in cementing the irreversibility of the internal market reforms. When Labour assumed power in 1997, it maintained the essential features of the purchaser/provider split while changing the language in which it was described. Moreover, Labour universalized the concept of GP Fundholding under another name with the establishment of Primary Care Commissioning Groups, which are to become even more central to the system.

A defining feature of the internal market was, of course, that it was *internal* to the public, tax-financed system. The state remained the source of finance. And that meant that a range of state actors, political as well as bureaucratic, with different roles and objectives, had a stake in the decision-making system. However much the institution of the internal market reforms might have been intended to provide an impartial buffer between political actors and decisions about rationing and restructuring of health care services, it remained the case that the ultimate accountability for the implementation of the reforms rested with the Secretary of State for Health. And as one astute observer put it, the difference between the process of developing the reform framework and the process of implementing it was the difference between a *blitzkrieg* and an occupation.²³ It meant that actors in the system, most centrally physicians, had to be maintained within a coalition of support.

The Labour proposals also sought to do what the internal market had failed to accomplish -- to integrate responsibility for clinical and financial decision-making, in this case through structures of “clinical governance.” This rich but ambiguous phrase could be read, in various parts of the document, to connote increased authority and accountability for both administrators and clinicians. A National Institute for Clinical Excellence (NICE) was established to develop clinical protocols and conduct technology assessment. (The first set of protocols embarked upon by NICE concerned indications for GP referrals to specialists for a number of common conditions.) If the experience of the 1990s is any guide, however, these proposals will be greatly shaped and molded in the process of implementation. If the medical profession responds strategically as it has in the past, it will maintain *de facto* control over the structures of clinical governance as they evolve. In this context, the greatest challenge to the profession is likely to be in the area of general practice where, given the tradition of “independent” practice, collegial mechanisms are least well developed.²⁴

In New Zealand, in contrast, a more tenuous accommodation between health care providers and the state was further strained by dramatic attempts at reform. The institution of the purchaser/provider split was seen as yet another episode in the on-going contest over the organization of hospital governance. The purchasing bodies, moreover, were created from scratch, and not through the re-structuring of established entities as in Britain. This meant that there were no established networks to mediate the implementation of the reforms. Even more

important, the GPs who had increasingly fallen outside the scope of the provider-state accommodation could not easily be recruited to the support of the reforms. Budget-holder status offered them some increased influence within the system. But it did not extend to the purchase of hospital-based services as in Britain, and in any event the bulk of GP services continued to fall outside the scope of public coverage. Without a substantial base of support among health care providers, the New Zealand reforms were vulnerable to rising public concern about the impact of the reforms.

The result was a very rocky implementation process marked by a series of policy reversals. The most private-market-oriented and least British-like dimensions of the reforms were the first to go. The institution of user charges in public hospitals was abandoned within a year. The proposal for managed competition between Regional Health Authorities and private purchasers was also abandoned relatively quickly. The National Advisory Committee on Health and Disability nonetheless continued with its work and engaged in broad-based public consultation as to what are cost-effective services, what sorts of general health care services should be given priority, and what services should be excluded from the publicly-funded sector.²⁵ While this consultation did indeed contribute to the public debate about coverage, it did not yield a prioritized list or basket of services as originally intended.

The election of October 1996 was the first to be held under a new electoral system of proportional representation, which ushered in an era of coalition or minority governments. Under the coalition government elected in 1996, the process of dismantling the reforms accelerated. The four Regional Health Authorities were replaced by a single Health Funding Authority; the focus of the Crown Health Enterprises (CHEs) was shifted from profit to an increased community and regional mandate, and free primary care for all children under the age of 6 was introduced. With the election of a minority Labour government in 1999, the process of dismantling the internal market reforms promised to proceed to completion. The government announced its intention to subsume the functions of the Health Funding Authority within the Ministry of Health and to replace CHEs with 22 locally-elected District Health Boards, thus largely returning the system to its pre-1993 configuration. The early indications are, however, that the latest reforms will continue to place a heavy emphasis on governance and accountability mechanisms including performance expectations, incentives and sanctions, and mechanisms to ensure delivery of government's goals, targets and service standards.

Despite this general rolling back of the internal market reforms, it must be acknowledged that the reform attempt raised the level of public debate and the transparency of bargaining about health care services. In addition, there may prove to be one "sleeper" effect with some British echoes. General practitioner "Budget-holding" gained popularity over time. Substantial numbers of general practitioners voluntarily opted to be Budget-holders for laboratory services and pharmaceuticals, and many joined together in "independent practice associations," (modeled more on the British "multi-funds" than the US multi-specialty independent practice associations). By the end of 1996, 60 percent of general practitioners were Budget-holders in IPAs.²⁶ While not as comprehensive as the British Fundholding model, the spread of Budget-holding did slowly begin to provide a base for primary care reform. In March 2000 the Labour government released a discussion document on primary health care reform based on an extension of the Budget-holding model. The reform proposals envisioned a system whereby patients would enroll with a given practice, and practices would receive a capitation-based subsidy for each patient. The reforms were greeted with cautious support from the medical profession.²⁷

b) Reform in the Wake of Big-bang Failure: the United States

In the wake of the failure of the Clinton proposals in 1994, health care reform reverted to “politics as usual.” That is, it revolved around changes to already established programs, and particularly around the Medicare program for the elderly and disabled (which accounts for about 40 percent of total public spending on health care). Since the early 1980s, the politics of Medicare, with its huge fiscal implications, had been intimately bound up with Congressional budgetary politics. In the 1990s, these budgetary politics were played out on a terrain of intense partisan hostility and what Allen Schick has termed a “hyper-pluralism” of interests resulting from turbulent change in the American mixed market for health care.²⁸

The failure of the Clinton health care proposal had contributed to a fundamental re-shaping of the partisan landscape. The 1994 Congressional elections brought about a circumstance that had not existed since 1946: a divided government in which both houses of Congress were controlled by the Republicans, while the White House was controlled by the Democrats. Given the centrality of a balanced budget to the Republican agenda, it was inevitable that budgetary politics would loom large in the battles between the House and the President. Medicare was inexorably drawn in to the politics of developing a Balanced Budget Act. What ensued was a period of intense partisan conflict, which led to a budgetary stalemate and a government shut-down in the fall of 1995. That stalemate shaped the landscape on which the 1996 Presidential and Congressional election was contested. That election in turn re-shaped the partisan landscape in Washington, along lines that boded somewhat better for bipartisan budgetary compromise. The House Republicans remained in the majority, but the leadership was somewhat chastened by the net loss of three seats and by the recognition of the extent to which that result could be attributed to negative public reaction to their role in the budget stalemate.

The Balanced Budget Act (BBA) that emerged in 1997 preserved many of the features of its ill-fated predecessor, with some of the thorns in the side of bipartisanship removed. The 1997 BBA extended coverage to seven new areas of service, and could do so because it provided for greater reductions in payments to providers than the 1995 BBA would have done. Savings were also to be achieved by expanding the participation of “non-traditional” providers by formally establishing an additional component of the program, named “Medicare+Choice,” under which beneficiaries could choose to be covered by private insurance or managed care plans, within a revised regulatory framework, which would be remunerated by a discounted capitation fee. The fiscal effects of the BBA 1997 were dramatic: in 1998 for the first time since 1992, the rate of increase in Medicare expenditures was less than the rate of increase in the private sector.

In summary, the budgetary politics of Medicare in the 1990s led to a focus on reducing payments to providers as the common denominator of a bipartisan consensus. In simplest terms, Republicans opposed increases in expenditures; Democrats opposed reductions in benefits or a shifting of the financial burden onto beneficiaries other than through a more progressive premium structure. Only a reduction in payments to providers could satisfy both of these criteria. Those who supported the traditional single-payer model, moreover, saw it preserved for the majority of beneficiaries; those who wanted to open up Medicare further to private insurers got Medicare+Choice, on the condition that those insurers would accept discounted payments.

Providers, however, are not without political resources – why were they not more effective in fending off these provisions for budgetary restraint? Why, indeed, did the American Medical Association actively endorse the legislation? There are several complementary answers to this question. First, the 1997 BBA, like its 1995 predecessor, contained a number of compensatory gains for providers. Second, providers continued to exert their influence within the Byzantine arena of the technical design and computation of payment formulae; and there they tend to fragment into discrete groups and indeed individual institutions in pressing their own interests. Third, providers in the late 1990s were operating in an economic context in which private payments were more tightly constrained than were those in the public sector. They thus faced a delicate calculus: opposing too vigorously a general constraint on provider payment under fee-for-service and prospective payment could lead Congress to place yet greater emphasis on encouraging the shift to private managed care organizations under the Medicare umbrella. Such a shift, experience under private insurance suggested, could well lead to even greater constraints on payments to service providers. And finally, not all providers fared equally under the BBA changes – those most negatively affected were hospitals and home care agencies. Most significantly, of all categories of providers, physicians fared best under the BBA, at least as indicated by initial data.

The BBA of 1997 did not mark the end of the debate about the fiscal viability of Medicare. On the contrary, it marked the beginning of a new wave of debate about the transformation of Medicare through the adoption of a form of “voucher” system. Such a system would enhance the role of private finance by essentially providing beneficiaries with “premium support” for the selection of private policies offered within a regime of managed competition. This was, indeed, the option championed by George Bush in his 2000 presidential campaign. However, as new data suggest that the apparent advantage of private insurers in constraining costs may have been a temporary phenomenon due to aggressive price discounting, and as private insurers increasingly exit the Medicare+Choice market, the “premium support” option appears less saleable.²⁹ The fragmented political economy of American health care seems likely to continue to generate political paralysis and market turbulence.

c) Implementing a Blueprint: the Netherlands

As noted earlier, progress toward implementing a comprehensive framework integrating social and private insurance stalled in the Netherlands in the mid-1990s. Nonetheless, significant progress has been made in certain sub-arenas – notably social insurance and prescription drugs. Again, these reforms were shaped by the structure of interests in the Netherlands. In the Dutch group-based system, providers move from the world of social insurance to the world of private insurance as they move from patient to patient. But these two worlds are quite well-defined within an overarching regulatory framework. Accommodations occur within the “social middle ground” populated by relatively large and cohesive bodies: the sickness funds, the physician associations, private insurers, etc.

The most significant change in the 1990s was the abolition of regional monopolies for sickness funds, which were freed to compete with each other for subscribers and to contract with physicians across the country. On a phased basis, retrospective payment to sickness funds³⁰ was partially replaced by a prospective risk-adjusted capitation payment for each subscriber, and the risk adjustment formula was elaborated to include employment/social security status and region of residence as well as age and sex. From 1993 to 1999 the percentage of sickness fund revenues

received in the form of these risk-adjusted payments increased from 3 percent to 35 percent.³¹ In addition, sickness funds were allowed to charge a premium (which must be “community-rated” – that is, set at the same level for all subscribers). Price competition led to a spread of 40 percent in premium levels by 1997, which narrowed to 25 percent by 1999.³²

The major effect of these reforms was a re-shaping of the “social middle ground” in health care. A number of sickness funds merged; a number of hospital mergers occurred; some sickness funds acquired hospitals; and regional cooperation among providers was reinforced and extended.³³ It is negotiation among these emerging horizontal and vertical alliances that is now driving developments in Dutch health care. This process has also yielded a promising experiment in influencing drug prescribing by general practitioners (family doctors). The association of general practitioners has developed its own formulary, and together with government and the sickness funds is now implementing a system of electronic prescription, containing information intended to aid clinical judgment. Evaluation studies are underway to assess the overall results of the system. Hence the reforms, though not as embracing as originally intended, have been driven forward by entrepreneurs among both sickness funds and providers in a dynamic that promises to transform the social insurance sector.

d) Implementing Incremental Change: Australia and Canada

In Australia and Canada, as noted above, political circumstances generated neither a big-bang nor a blueprint approach to health care reform, but rather led to a series of incremental changes. The nature of the changes needs to be understood in the context of the structure of interests in the health care arena, and particularly in terms of the relationship between the medical profession and the state.

Canada’s sectoral distinction between public and private means that the health care providers traditionally at the core of the system – physicians and hospitals – are bound into an exclusive relationship with the state in a system of effective bilateral monopoly – even more closely than in Britain, where the public system itself is proportionately larger but the boundary is differently drawn. In the Canadian version of the foundational bargain between the profession and the state, prices for medical services are centrally negotiated and publicly paid. In return for giving up individual discretion over price, physicians have secured a level of remuneration which is generous – not in comparison with the United States, but in comparison with the other Anglo-American countries treated here.³⁴ They have maintained a system in which the level of clinical autonomy is high and transaction costs are relatively low. (Fees are paid promptly by the public payer, with limited paperwork, no bad debt, and utilization review confined to extreme outlier cases.) They have also maintained pivotal influence in the system, not only at the level of individual practices, but through structures of effective co-management at both hospital and central levels. Although the relationship has been marked by on-going tensions, the medical profession has been a key component of the political coalition in support of the system to medical income and influence are so intimately tied.

A key feature of Australian health policy, on the other hand, is the extent to which it has deliberately sought to maintain a tripartite system of finance involving public finance, out-of-pocket private payment, and private finance across a broad range of services. In Australia, therefore, the terms of the profession-state bargain have been quite different. Individual

physicians maintain discretion over price, as well as considerable clinical autonomy. They are not wholly dependent on the state for remuneration: they can bill patients at rates of their own choosing above the insured benefit. In return, however, they have accepted a considerably lower level of public remuneration than is the case in Canada. Even when private sources are added, this means that medical incomes are well below those in Canada.³⁵ Transaction costs are also higher, although physicians have increasingly accepted the trade-off of avoiding these costs through “bulk billing” (that is, billing the Medicare plan directly, and agreeing to accept the Medicare rebate as payment in full).³⁶ The Australian bargain thus fractured the base for an accommodation between the profession and the state. It divided those physicians who dealt exclusively with the government plan from those who sought payment as well from patients and private insurers. And by leaving open the private finance option, it obviated the need for a key *quid pro quo* such as exists in the Canadian bilateral monopoly – namely, a central place for the medical profession in policy-making bodies.

Incremental policy changes in Canada and Australia reflect these different structures of interests. In Canada, the approach was to constrain payments to providers even while increasingly involving them in joint policy-making bodies. In Australia, reforms were focused primarily on increasing the role of private insurance. Australia, uniquely among OECD nations, had moved back and forth between universal and mean-tested approaches to health insurance in the latter decades of the twentieth century. Australia’s attempts to blend public and private financing of medical and hospital services had resulted in an unstable system marked by economic uncertainty for private payers, be they individual patients or insurance funds. There had been a steady decline in the percentage of the population who took up private insurance, from 80% in 1970 to 50% in 1984 to 30% in December 1998.³⁷ Generally, it was the younger and healthier members of the population who were less inclined to purchase private insurance, with the result that the risk pool became increasingly composed of those with greater health risks, and premiums accordingly rose faster than health care costs in general.³⁸

Declining rates of take-up of private insurance, then, could be attributed to at least three related factors: premiums that were escalating at rates well above the CPI, a perception that the benefits from taking out private insurance did not warrant the cost,³⁹ and the fact that private insurance for medical services covered only the gap between the Medicare benefit and the agreed schedule of fees, leaving the patient at risk for an unknown potential charge above the agreed schedule. In the late 1990s, in an attempt to staunch the flow away from private insurance and to preserve a blended tripartite structure of finance (public, private insurance, private out-of-pocket), the Coalition Commonwealth government sought to address each of these disincentives. Somewhat paradoxically, these responses involved unprecedented levels of public subsidy.

First, to deal with the disincentive created by rising premiums, the government instituted a system of rebates for private insurance premiums, initially income-related and then, as of 1999, available to all, regardless of income, as a 30% refundable tax credit. Second, to deal with the disincentive for low-risk individuals to take out insurance at community-rated premiums, the government instituted a regulated system of “lifetime health cover,” effective July 1, 2000. Under this system, individuals are guaranteed a premium set at a given percentage of the “base rate premium” offered by the fund for their entire lifetime, as long as they maintain continuous coverage. Third, to deal with the lack of incentive for people to take out coverage for treatment as private patients in public hospitals, the Commonwealth-State funding agreements of 1998 for the first time allowed preferential access to public hospitals for private patients. Fourth, to deal with the

residual uncertainty for patients facing unknown out-of-pocket charges beyond that covered by private insurance, the legislation establishing the 30% rebate provided that, in order to qualify for the rebate, plans had to offer “no-gap” or “known gap” coverage by July 2000.

The “no-gap”/ “known gap” provision sparked a major confrontation with the medical profession. The legislation required each physician to enter into a contract with an insurer, agreeing that the physician’s charges would either be according to the Medicare schedule or would exceed the schedule by a set amount, in order to receive remuneration. This provision caused fierce controversy within the medical profession, as to whether contracts between physicians and insurers should be resisted as a leading wedge for “American-style” managed care arrangements. After the leadership of the Australian Medical Association (AMA) survived a vote of no confidence, and after protracted negotiations between the AMA and the Minister of Health and Aged Care, the rules were changed to allow for mechanisms other than contracts to implement “no gap” or “known gap” provisions.

These policy changes appear to have stemmed the exodus from private insurance and may even have reversed the trend.⁴⁰ However, it is questionable whether the very large public subsidy (estimated in 2000 at A\$2.19 billion per year, equivalent to about 6% of total public spending on health care) is an effective use of public funds. Duckett and Jackson have shown, for example, that directing an equivalent expenditure toward public treatment in public hospitals could fund a shift of about 47-65% of private hospital patients into the public sector.⁴¹

In Canada, incremental change amounted to attempting to elaborate the accommodation with medical and hospital providers even while constraining their budgets. The dramatic nature of fiscal constraint in Canada from 1993-1997 has been noted above. Canada’s distinctive way of defining the boundary between public and private finance exacerbated the effects of this fiscal constraint. It meant that the brunt of the reductions in public spending was borne by those elements – medical and hospital services – that had traditionally been publicly perceived to be at the core of the system. Fiscal constraint, indeed, amplified the effects of the “passive privatization” of health care that was already occurring as technological changes shifted services out of hospital, and care accordingly migrated from the world of universal, first-dollar coverage to a world in which private finance played a much larger role. And it placed the central accommodation between health care providers and the state under unprecedented pressure.

As noted above, all provincial governments embarked upon horizontal integration in the hospital sector in the 1990s. In this process, they found allies within the hospital sector itself, among those institutions who stood to gain through re-structuring. But hospital budgets were still essentially based on historical experience and across-the-board changes (albeit with some attempt to develop formulae rewarding efficiency in performance) and not on negotiated packages of service. With the exception of the re-structuring of hospital facilities, governments relied on the blunt exercise of their monopsony power through budget-capping. With limited exceptions⁴² they did not adopt contracting mechanisms. Furthermore, the hospital-physician relationship, based on independently constituted medical staffs, remained unchanged.

Medical practice remained outside the scope of re-structuring exercises; and independent private fee-for-service medical practice remained the cornerstone of the system. Bargaining relationships

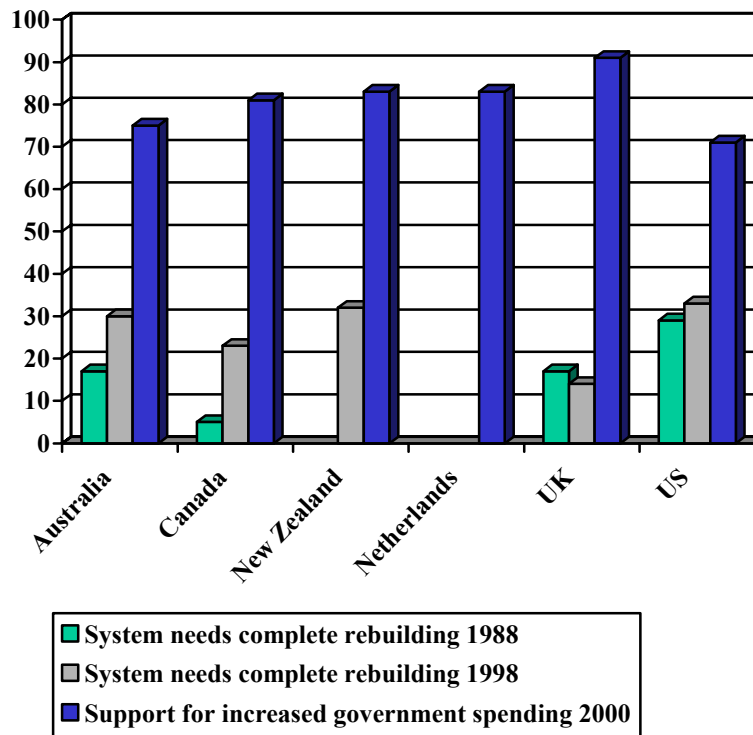
remained essentially between provincial governments and provincial medical associations. The agenda of those bargaining relationships, however, expanded in the 1990s as provincial governments sought to elaborate their accommodations with the medical profession. Following the past pattern of blunt budgetary controls which left the fine levers of decision-making to physicians, governments sought to negotiate (and where they could not negotiate they imposed) global caps on their physician services budgets. As Hurley and his colleagues have noted, global caps on a fee-for-service system create “common-property resource” problems: individual physicians had no incentive to restrain their billings, since the penalty for exceeding the budget cap would be equally shared by all.⁴³ The management of these incentive problems was left to provincial medical associations, whose role proved crucial, and whose success in dealing with them varied considerably across provinces.⁴⁴

In instituting these budget controls, moreover, provincial governments also moved to expand the role of professional bodies. By the mid-1990s, bipartite joint management committees with equal representation from government (including in most cases a representative of the finance ministry) and the medical association had been established in seven provinces. (A functionally equivalent arrangement had existed in Quebec since the early 1980s.) Under the aegis of these bodies a variety of initiatives relevant to health sector planning were undertaken. In Ontario, for example, well before the establishment of the British National Institute for Clinical Effectiveness, an Institute for Clinical Evaluative Sciences (ICES) was established under a Joint Management Committee of the Ontario government and the Ontario Medical Association. Such joint management arrangements formalized and arguably increased the influence of the medical profession; but they also involved the medical associations in controversial decisions that led to fissurous tendencies within their memberships.⁴⁵ Despite periodic flirtations with support for private-sector options, however, medical associations at both the federal and provincial levels remained formally committed to the principles of the *Canada Health Act*, and have in general focussed their arguments on the need to increase public investment in the health care system.

IV. IMPLICATIONS FOR PUBLIC OPINION

I have made the point throughout this paper that the approach to health care reform adopted in a particular nation depends upon factors in the broader political arena; and the implementation process depends upon the structure of interests in the health care arena. Public opinion does not play a direct role in this way of understanding health care reform. Nonetheless, it is worth briefly considering the implications of health care reform for public opinion about health care policy, and *vice versa*.

Figure 1 shows some broad indicators of public opinion about health care policy in the nations under review here toward the end of the 1990s. (Unfortunately, there are very few cross-national polls allowing for consistent comparisons.) Support for a “complete re-building” of the system remains low across these nations – nowhere does it exceed one-third of the respondents, although support for this view has risen in three or the four nations for which we have data over time.⁴⁶ (Unfortunately, the Netherlands was not included in the survey in which this question was asked; and New Zealand was included only in 1998.) Only in Britain, which came closest to implementing big-bang reform, did support for this option marginally decline – a finding that can be read either as an endorsement of reform or as “reform fatigue.” In all these systems, moreover, support for the public system, in the form of attitudes toward increased public expenditure, remains strong.⁴⁷ It is highest in Britain and lowest in the US.⁴⁸

Figure 1: Public Attitudes Toward Health Care Policy, 1988-2000

In fact, history suggests that public opinion is not a good guide to the understanding of how reform options are chosen. Public opinion is shaped as policy options are developed and presented by policy-makers. For example, polls in the US which found public support for an expansion of Social Security to provide health care coverage for the elderly in the 1960s were posing questions in which the policy options had already been framed, and did not include comprehensive universal health insurance. The adoption of Canadian medicare was not preceded by a groundswell of public concern about health care coverage or public pressure for policy action. Public support for a governmental program of universal comprehensive health insurance was considerably lower in the 1960s, when Canadian medicare was adopted, than it had been in the 1940s, when the attempt by the federal government to negotiate a national health insurance program with the provinces failed.⁴⁹ In the late 1980s and early 1990s, the policy direction taken by the Conservative government in Britain flew in the face of public opinion, which polls showed to be opposed to key features of the “internal market” reforms by substantial majorities.⁵⁰ And high levels of public dissatisfaction with the American system did not, in the end, provide sufficient momentum to carry any major policy change through to adoption in the 1990s. Intense media coverage of the health care reform debate and the development of a blizzard of competing proposals in Congress in 1993 and 1994 in the US paralleled, and arguably contributed to an increase in uncertainty and an erosion of public support for any major change in health care policy.⁵¹ At most, public opinion may pressure policy-makers that “something must be done,” and establish very broad parameters as to acceptable policy responses.

V. LESSONS FOR CANADA

Recently there have been a number of calls for a comprehensive review of Canadian medicare, perhaps in the form of a federal commission. Should such a commission be established, it would be well advised to consider the following:

1. Be cautious about a big-bang approach to health care reform, or even about a comprehensive blueprint to be phased in. There is no indication that conditions in the broad political arena, and particularly in the federal-provincial arena, are any more likely to generate agreement on big-bang reform than has been the case for the past two decades. It is possible that a provincial government could choose to go it alone, outside the parameters of the *Canada Health Act*, to enact some version of a “big bang.” But even if it were to do so, it would be successful only to the extent that the reforms could be absorbed by existing structures, as the contrasting experiences of Britain and New Zealand with “internal market” reforms demonstrate. The British re-organized existing structures; and long-established networks re-knit themselves. In New Zealand, some key structures were created from scratch, and never found a footing.
2. A phased-in blueprint appears more promising in a context in which a number of competing parties and interests needs to be accommodated, as was the case in the Netherlands and in some American states. Even here, however, there are a number of cautions. Do not ignore the fact that a coalition of support for the reforms must be maintained at each step along the way. This is both a political and a policy design problem. Political circumstances may change (as was the case in the American states). It is also very difficult to design policy steps in such a way that each can command support on its own, rather than as part of an overall package enacted at once. This was the experience of the Netherlands, which found itself stalled once reforms had been enacted in the social insurance sub-arena, before being extended to the sub-arena of private insurance.
3. In fact, there may therefore not be much difference in the end between enacting a phased blueprint or taking a *bolder approach to incrementalism* than Canada has adopted in the past. In either case the best likely outcome is significant change in a sub-arena.
4. In this light, the key advice is to find *champions and allies* within the health care arena itself, capable of leading significant change in the sub-arena. General practitioners in Britain drove Fund-holding to a central place in the internal market reforms. To a lesser extent, GP Budget-holders formed a leading wedge for primary care reforms in New Zealand. Social insurance funds drove change in the process of adjusting to managed competition in the Netherlands.

All of this suggests that *the most promising focus for health care reform in the Canadian context is in the sub-arena of primary care:*

- Experience in other nations (primarily Britain, but also New Zealand and the Netherlands) shows that primary care physicians can play a leading role in health care reform. A voluntary approach with appropriate incentives encouraged GPs in Britain and New Zealand to assume important purchasing roles on behalf of defined patient populations. In both nations, these models are in the process of being universalized, having won considerable acceptance through their “demonstration” effects. In the Netherlands, GPs are collectively developing a voluntary electronic drug prescribing system that is gaining increasing popularity.
- Primary care reform in Canada would build upon the existing accommodation between the medical profession and the state, albeit an accommodation strained under the fiscal pressures of the 1990s. Canada is more like Britain in this regard than is any other nation. As in Britain,

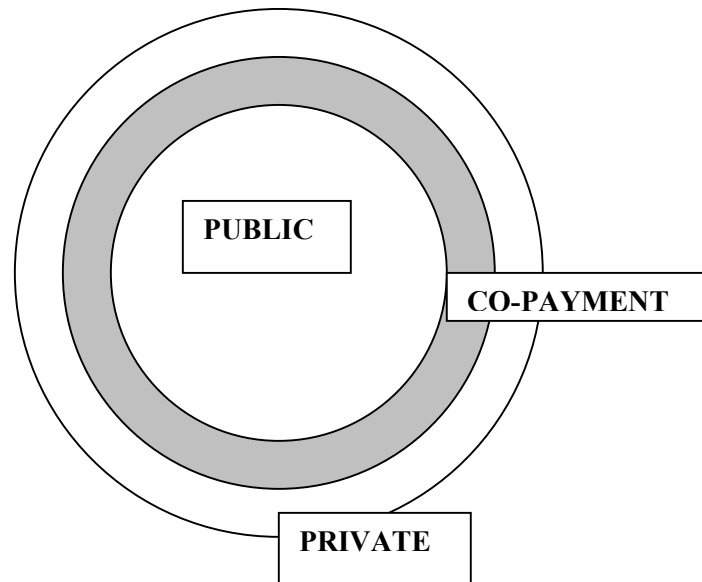
Canadian GPs receive almost all of their remuneration from the public treasury, while in both nations GPs retain the status of independent practitioners. The main difference lies in the form of remuneration – fee-for-service under a cap in Canada, capitation with fee-for-service for certain targeted services in Britain.

- Given the central role played by primary care physicians in referrals both in the acute sector (to specialists) and in the long-term and home care sectors, as well as in drug prescribing, a focus on primary care yields enormous leverage on the entire system – as is being recognized in the progressive extension of the “Fund-holding” and “Budget-holding” models in Britain and New Zealand.
- The importance of fully engaging the nursing profession in the process of primary care reform is underscored by the British case, where nurses are formally involved in the governance of Primary Care Groups. This builds upon a tradition of nursing involvement in the governance of the British National Health Service that is lacking in Canada.

VI. A FINAL CHALLENGE

In many respects, as evidenced throughout this paper, Canada can learn from the experience of other nations. But in one important respect, it has the potential to lead the international community. A key area for incremental reform in Canada, but one in which the international experience is less promising, involves adjustments to the way in which various categories of service are financed – by public finance exclusively, by a combination of public and private finance through co-payment, or through private finance. So a final point of advice takes the form of a challenge without, at this time, an answer.

The prevailing Canadian sector-based model can be thought of as comprising concentric circles (Figure 2). At its core are services that are exclusively publicly financed under the terms of the *Canada Health Act*: “medically required” physician services and “necessary” hospital services. In the next ring are services that fall, under a variety of provincial plans, into an area of co-payment (often income-scaled): home care, long-term care, pharmaceuticals for certain population groups, etc. Finally, there is an outer ring of services that are exclusively privately financed, at least for some population groups: amenities such as private rooms in hospitals, dental care, eyeglasses, cosmetic procedures, etc. The definition of services in each of these circles was set in the 1960s. It cries out for re-assessment in the light of technological change since then. Some services may belong in the central core regardless of the institutional setting (e.g. hospital vs. home) in which they are delivered. Others, currently exclusively publicly-funded, might be considered as candidates for co-payment, and move from the core to the intermediate ring. Yet other goods and services now privately financed, such as pharmaceuticals, could well move into the co-payment category.

Figure 2: Public and Private Finance in Canada: A Simplified Model

In embarking upon such a re-assessment, it must be recognized that international experience regarding the generation of a public consensus about which services are to be publicly-financed, and which privately-financed, is not particularly promising. Attempts in the Netherlands and New Zealand to define a basic benefits package got no further than developing criteria that might inform decision-making about the scope of coverage. Decisions made by Health Authorities in Britain have led to a marginal “de-listing” of some largely cosmetic services – indeed the candidates for de-listing in Britain were remarkably similar to those de-listed in several Canadian provinces in the 1990s.⁵² Even in Oregon, where an attempt to develop a prioritized list of procedures for coverage under the Medicaid program for the poor received intense international attention, the effect in the end was a marginal expansion of coverage financed made possible through increased revenues and through negotiations with providers.⁵³

But given Canada’s unique way of drawing the boundary between public and private finance, the question of what belongs in each of these circles is arguably more pressing in this nation than anywhere else. Canada needs to find a way, a legitimate process, by which to address these questions. Ultimately, decisions need to be made through a duly constituted, transparent and accountable process involving governments, providers, health scientists and others with relevant information and perspectives, with public consultation as an important input. Canada’s traditional axis of profession-state accommodation may provide the core for such a process. And if Canada can develop a process of “accountability for reasonableness”⁵⁴ in determining the scope of public coverage, building on its established strengths, it can provide a model for the international community.

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- ¹ Organization for Economic Cooperation and Development (OECD), "New Orientations for Social Policy" (Paris: Organization for Economic Cooperation and Development, 1994).
- ² P.D. Pierson & R. K. Weaver, "Political Institutions and Loss Imposition: the Case of Pensions" in R. K.W. & B.A. Rockman, eds., *Do Institutions Matter?* (Washington: the Brookings Institution, 1993) at 110-150.
- ³ R. Klein, *The New Politics of the National Health Service*, 3rd ed., (London: Longman, 1995) at 140.
- ⁴ See the report of the Audit Commission, "What The Doctor Ordered: A Study Of GP Fundholders In England And Wales" (London: HMSO, 1996) 6. Standard Fundholders did not purchase the following sorts of hospital care: emergency admissions, inpatient mental health, costs above £6,000 per annum for any patient, accident and emergency, maternity, and medical inpatients.
- ⁵ Department of Health, "The New NHS" (London: HMSO, 1997) at figure 1.
- ⁶ *Ibid.* at para. 5.8.
- ⁷ M. Brown, "New Zealand Health Care Financing 'Reforms' Perceived in Ideological Context" (1996) 4 Health Care Analysis 293; R.D. C. Gauld, "Big Bang and the Policy Prescription: Health Care Meets the Market in New Zealand" (2000) 25:5 Journal of Health Politics, Policy and Law 815.
- ⁸ NZ Health 1993 Act, s.6.
- ⁹ C.H. Tuohy, *Accidental Logics: the Dynamics of Change in the Health Care Arena in the United States Britain and Canada* (New York: Oxford University Press 1999) at 153-57.
- ¹⁰ Quoted in H. Heclo, "The Clinton Health Plan: Historical Perspective" (1995) 14:1 Health Affairs 86.
- ¹¹ T.E.D. van der Grinten, "Conditions for Health Care Reform: Changing the Policy System of Dutch Health Care" in "Proceedings of the 4 Country Conference on Health Care Reform and Health Care Policy", sponsored by Health Canada, Montebello, Quebec, May 16-18, 1996, at 68-9.
- ¹² Sickness funds are essentially administrative bodies for an insurance scheme financed by employer and employee contributions. The sickness funds enroll subscribers and contract with providers for the provision of care. Funding, however, is pooled in a General Fund administered by a Council representing all sickness funds. Traditionally, the General Fund reimbursed sickness funds on a retrospective basis.
- ¹³ P.M.M. van de Ven & F.T. Schut, "The Dutch Experience with Internal Markets" in M. Jérôme-Fôrget, J. White & J.M. Wiener, "Health Care Reform through Internal Markets" (Montreal: Institute for Research on Public Policy, 1995) at 95-118.
- ¹⁴ *Ibid.* at 107. See also K.G.H. Okma, "Restructuring Health Care in the Netherlands," in R. Williams, *International Developments in Health Care: A Review of Health Care Systems in the 1990s* (London: Royal College of Physicians of London, 1995)
- ¹⁵ *Ibid.* at 108.
- ¹⁶ For a discussion of these cases, see C.H. Tuohy, *supra* note 9 at 85-86 and works cited there.
- ¹⁷ The Commonwealth government provided about two-thirds of total public health expenditure in Australia in 1995-6. See A. Podger & P. Hagan, "Reforming the Australian Health Care System: the Role of Government" (Canberra: Commonwealth Department of Health and Aged Care, 1999) at 12. The calculation of the fiscal contribution of the Canadian federal contribution to health care expenditures was a matter of dispute between the federal government and the provinces. If one considers only the *conditional* component of the federal contribution, however (that is, the proportion of the Canada Health and Social Transfer which was notionally assigned to health care and conditional on compliance with federal legislation) federal fiscal leverage amounted to about 12 percent of total public expenditures on health insurance in the mid-1990s.
- ¹⁸ G. Gray, "Maintaining Medicare: Rhetoric or Reality" (2000) New Doctor.
- ¹⁹ C. D. Naylor, "Health Care in Canada: Incrementalism under Fiscal Duress" (1999) 18: 3 Health Affairs 9.
- ²⁰ J. Lomas, G. Veenstra & J. Woods, "Devolving Authority for Health in Canada's Provinces: III. Motivations, Approaches and Attitudes of Board Members" Working Paper 96-4 (Hamilton, Ontario: McMaster University Centre for Health Economics and Policy Analysis, 1996).
- ²¹ M. Laugesen, "Institutionalized Localism: The Politics of Hospital Reform in New Zealand, 1935-1995" Ph.D. thesis, University of Melbourne, Australia, 2000.
- ²² Average physician income in Purchasing Power Parity was \$66,286 in New Zealand and \$51,842 in Britain. OECD, OECD Health Data 1999: A Comparative Analysis of 29 Countries (Paris: OECD, 1999) [hereinafter called OECD Data 1999].
- ²³ M. Shock, "Medicine at the Centre of the Nation's Affairs" (1994) 309 British Medical Journal 1730.
- ²⁴ R. Klein, "Why Britain is Reorganizing Its National Health Service - Yet Again" (1998) 17:4 Health Affairs 111.
- ²⁵ "Core Services For 1995/96: Third Report Of The National Advisory Committee On Core Health And Disability Support Services" (Wellington: The National Advisory Committee On Core Health And Disability Support Services, 1994).

- ²⁶ L. Malcolm, "GP Budget Holding in New Zealand: Lessons for Britain and Elsewhere?" (1997) 314 *British Medical Journal* 1890.
- ²⁷ New Zealand Medical Association, "Health Strategy document welcome, but more details needed" Press Release, 1 June 2000.
- ²⁸ A. Schick "How a Bill Did Not Become Law," in T.E. Mann & N.J. Ornstein, eds., *Intensive Care: How Congress Shapes Health Policy* (Washington, D.C.: AEI/Brookings) at 227-72.
- ²⁹ J. Oberlander, "Is Premium Support the Right Medicine for Medicare?" (2000) 19:5 *Health Affairs* 84.
- ³⁰ van der Grinton, *supra* note 11.
- ³¹ E. van Doorslaer & F.T. Schut, "Belgium and the Netherlands Revisited" (2000) 25:5 *Journal of Health Politics, Policy and Law* 875.
- ³² F.T. Schut & H.E.G.M. Hermans, "Managed Competition Reform in the Netherlands and its Lessons for Canada" (1997) 20:2 *Dalhousie Law Journal* 451; van Doorslaer & Schut, *supra* note 31 at 880.
- ³³ Van der Grinten, *supra* note 11 at 72-76; van Doorslaer & Schut, *supra* note 31 at 878.
- ³⁴ Average physician income at PPP in 1990 was \$89,923 in Canada – almost 60 percent higher than the average for Australia, the UK and New Zealand, but only about 55 percent of the average in the US. OECD Data 1999, *supra* note 22.
- ³⁵ The average physician income in Australia in 1990 (PPP\$53,973) was about 60 percent of the Canadian average. OECD Data 1999, *ibid*.
- ³⁶ The proportion of services that were "bulk billed" rose from 49% in 1985/6 to 72% in 1997/8. J. Deeble, "Medicare: Where have We Been? Where are We Going?" The Gordon Oration, National Centre for Epidemiology and Population Health, The Australian National University, 1999, 4. See also "Country Profiles" paper prepared for the Senate Committee.
- ³⁷ J. Hall, "Incremental Change in the Australian Health Systems" (1999) 18:3 *Health Affairs* 99.
- ³⁸ Between 1990 and 1996, premiums rose on average 9.8% per year, while total health spending per capita rose by 5.6% per year on average, and the Consumer Price Index (CPI) rose by only 2.9%. *Ibid.* at 100.
- ³⁹ The decline in take-up of private insurance occurred almost entirely with regard to "basic hospital insurance," which covered treatment as a private patient in a public hospital. For this group of beneficiaries, the benefits of having private insurance (primarily choice of physician and private rooms) did not justify the cost of coverage, in a context in which care would be provided in the same institution at no charge on a public basis.
- ⁴⁰ The percentage of the population with private health insurance increased from 30.1% in December 1998 to 31.2% in December 1999 to 45.8% by September 2000. Private Health Insurance Administration Council, online: www.phiac.org.au.
- ⁴¹ S.J. Duckett & T.J. Jackson, "The New Health Insurance Rebate: an Inefficient Way of Assisting Public Hospitals" (2000) 172 *Medical Journal of Australia* 441.
- ⁴² Some provincial governments contracted with hospitals to provide specified volumes of a few given procedures, such as coronary artery bypass surgery. The contracting mechanism was most popular among regional health authorities in Alberta.
- ⁴³ J. Hurley & R. Card, "Global Physician Budgets as Common-Property Resources: Some Implications for Physicians and Medical Associations" (1996) 154:8 *CMAJ* 1161.
- ⁴⁴ J. Hurley et al., "A Tale of Two Provinces: a Case Study of Physicians Expenditure Caps as Financial Incentives." Working Paper No. 96-12, (Hamilton, Ontario: McMaster University, Centre for Health Economics and Policy Analysis, 1996).
- ⁴⁵ S.J. Katz, C. Charles, J. Lomas & H. Gilbert Welch, "Physician Relations in Canada: Shooting Inward as the Circle Closes" (1997) 22:6 *Journal of Health Politics, Policy and Law* 1413.
- ⁴⁶ K. Donelan, R.J. Blendon, C. Schoen, K. Davis & K. Binns, "The Cost of Health System Change: Public Discontent in Five Nations" (1999) 18:3 *Health Affairs* 209.
- ⁴⁷ The pollsters placed this question in the context of a consideration of taxation. Respondents were first asked:
 "Which of the following comes closest to your view of what your national government should do on the issue of taxes:
 Spend more on public services even if you have to pay more tax
 Spend less on public services to cut the amount you pay in tax
 Your government should keep their spending at current levels"
 Respondents were then asked:
 "Specifically, do you think your government should spend more money, less money or the same as now on each of the following"
 Angus Reid, "17 Country Poll on Taxes, Spending and Priorities" March 16, 2000, online: www.angusreid.com.
- ⁴⁸ It might be thought that this difference could be attributed to the already high levels of per capita public health spending in the US relative to the UK. But in another study, my colleagues and I showed that this measure of support for increased public spending was not correlated, across 11 OECD nations, with absolute levels of per capita public

spending. It was, however, related to changes in the public *share* of health care expenditure over time: where the public share had declined between 1987-1997, support for increased public spending in 1998 was likely to be higher. See C.H. Tuohy, C.M. Flood & M. Stabile, "How does private finance affect public health care systems?" (October 2000) Ontario Medical Review October.

⁴⁹ C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911 - 1966* (Montreal: McGill-Queen's University Press, 1986) at 122, 158, 236; M.G. Taylor, *Health Insurance and Canadian Public Policy: the Seven Decisions that Created the Canadian Health Insurance System* Montreal: McGill-Queen's University Press, 1979) at 367.

⁵⁰ R.J. Blendon & K. Donelan, "British Public Opinion on National Health Service Reform" (1989) 8:4 Health Affairs 52.

⁵¹ M. Brodie & R.J. Blendon, "The Public's Contribution to Congressional Gridlock on Health Care Reform" (1995) 20:2 Journal of Health Politics, Policy and Law 403; J. White, "The Horses and the Jumps: Comments on the Health Care Reform Steeplechase" (1995) 20:2 Journal of Health Politics, Policy and Law 373.

⁵² R. Klein, P. Day & S. Redmayne, *Managing Scarcity: Priority Setting and Rationing in the National Health Service* (Buckingham: Open University Press, 1996) at 118.

⁵³ L. Jacobs, T. Marmor & J. Oberlander, "The Oregon Health Plan and the Political Paradox of Rationing: What Advocates Have Claimed and What Oregon Did" (1999) 24:1 Journal of Health Politics, Policy and Law 161.

⁵⁴ N. Daniels, "Accountability for reasonableness in public and private health insurance," in A. Coulter & C. Ham, eds., *The Global Challenge of Health Care Rationing* (Buckingham: Open University Press, 2000), 89.