HEALTH CARE REFORM OR HEALTH CARE RATIONING? A COMPARATIVE STUDY

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While the impact of the neo-conservative drift in Western states in the final decades of the twentieth century has been varied, yet everywhere it has provoked examination of the 'allocation of scarce resources' in social policy fields. Health care policy is one of the most important of these areas, and the 1990s has been marked by reforms in this area of public policy. Changes have been driven by two broadly shared concerns: the total cost of care in relation to national economies, and whether the existing systems can be managed more efficiently (Jerome-Forget, *et al.* 1995). Hence the language of reform has many cross-national similarities, although specific outcomes are quite dissimilar. This paper examines reform efforts in the United States, the United Kingdom and Canada, focusing particularly on state-specific proposals and outcomes. The three countries provide an interesting comparative

*A list of acronyms used in this article is provided on page 35.

study: although they have much shared historical experience and considerable evidence of exchanges of ideas concerning health policy, their approaches to the provision of health care and to health policy reform are quite distinct. It is of interest also to note that while each is focusing on the need for extensive reform, the percentage of gross domestic policy (GDP) devoted to health care is markedly different in the three nations (See Table 1). Already the United Kingdom has contained costs more successfully than almost any other Western nation, and the United States has had the least success. Canadian spending falls between the two.

The paper first examines different theoretical approaches to the allocation of limited health care resources (rationing) and then discusses the importance of particular political and societal institutions that affect policy determination. A third section then traces health policy in the three countries and relates it to the rationing/institutional discussion. It will be argued in the conclusion that policy choice and policy result are constrained by state-specific historical experience.

I. APPROACHES TO RATIONING

Health insurance programs are a symbol of the great divide between liberalism and socialism (Immergut, 1992), and as redistributive social programs they are inescapably linked to class divisions in society (Lowi, 1964); hence they are subjected to endless political and societal discord. As Section III will show, the United Kingdom, the United States and Canada have faced similar conflicts and pressures over the direction of health policy, yet they have resolved their problems in different ways. Despite many commonalties, shared experiences and convergent tendencies, their approaches to the provision of health care to their citizens and the allocation of resources to their health care sectors have diverged (see Tables 1, 2, & 3). Health care costs are frequently described in apocalyptic terms,

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Table 1. Total expenditure on health care in GDP, 1960-1992
Percent of GDP

	1960	1970	1975	1980	1985	1990	1992
United States	5.3	7.4	8.4	9.2	10.5	12.4	14.0
Japan	3.0	4.6	5.6	6.6	6.5	6.6	6.9
Germany	4.8	5.9	8.1	8.4	8.7	8.3	8.7
France	4.2	5.8	7.0	7.6	8.5	8.9	9.4
Italy	3.6	5.2	6.1	6.9	7.0	8.1	8.5
United Kingdom	3.9	4.5	5.5	5.8	6.0	6.2	7.1
Canada	5.5	7.1	7.2	7.4	8.5	9.4	10.2
Average of above countries	4.3	5.8	6.8	7.4	8.0	8.5	9.3

Table 2. Public share in total spending on health, 1960-1992
Percent

	1960	1970	1975	1980	1985	1990	1992
United States	24.5	37.2	41.5	42.0	41.4	42.2	45.7
Japan	60.4	69.8	72.0	70.8	72.7	70.8	71.2
Germany	66.1	69.6	77.2	75.0	73.6	71.8	71.5
France	57.8	74.7	77.2	78.8	76.9	74.5	74.7
Italy	83.1	86.4	86.1	81.1	77.1	77.8	75.2
United Kingdom	85.2	87.0	91.1	89.6	86.3	84.4	84.4
Canada	42.7	70.2	76.4	74.7	74.7	73.1	72.2

Table 3. Health-related administrative costs, 1970-1992

	Total expenditure on health administration as % of total expenditure on health				Public expenditure on health administration as % of public expenditure on health			
	1970	1980	1985	1992 or last year	1970	1980	1985	1992 or last year
United States	3.7	4.9	6.0	5.8	3.9	3.7	2.7	2.5
Japan	..	..	..	..	..	0.7	0.3	0.3
Germany	..	5.9	6.6	6.8	..	6.1	6.5	7.2
France	1.3	1.4	1.5	1.5	0.3	0.2	0.3	0.2
Italy	..	..	..	..	..	6.6	6.3	6.1
United Kingdom	..	..	..	..	..	3.0	2.4	2.5
Canada	1.6	1.4	1.4	1.3	1.7	1.2	0.9	0.9

Source: Organization for economic cooperation and development. Working papers No. 149, Paris, 1994.

and some form of rationing "has become and increasingly respectable response" (Mechanic, 1994:69).

It is an inescapable economic fact that health care resources are finite, and a discussion of the allocation of these resources is implicitly a discussion of rationing. Perhaps victims of their own successes (i.e., life-saving transplants, pharmaceutical wonders, intricate appliances and dramatic treatments), health care researchers have raised the public awareness of the possibilities of medical science, implanted the expectation of miracle cures, and perhaps have also instilled societal dependence on, and demands for, continuous treatment innovations. Pressures for increased availability of technological advances have forced governments to confront a cost/access ethical dilemma and the prospects of expanded health care rationing. While it is fair to assume that we cannot get all the care we want when we want it, on what basis will limits be decided? Recent book titles suggests the ethical dilemma: *Inescapable Decisions* (Mechanic, 1994), *Strong Medicine* (Rachlis and Kushner, 1994), *Limits to Care* (Blomquist and Brown, 1994), *Bitter Medicine* (Kassler, 1994). In *Mandated Health Care*, for example, Donald Westerfield states categorically: "good intentions aside, health care is a scarce commodity and must be rationed" (1991:172). Yet in the foreword to Westerfield's book, Thomas Curtis states just as categorically: "There are ample means (money) and resources to meet the needs of the 15 per cent [of Americans] who cannot afford any health care...there is no need to ration health care" (xii). But the literature does not reveal a consensus on the meaning of rationing, how it might be imposed, or by whom.

While rationing involves some restrictions on health care that might be of benefit, it is more problematical to determine in fact what limits on beneficial care constitute rationing (Baily, 1993). Rationing can result from market forces (ability to pay) and from less visible forces, such as a limited number of health care professionals, waiting times or the unavailability of a convenient hospital facility or a specific technology. Mary Ann Baily (1993) suggests that much of the ambiguity surrounding the issue of rationing in the United States stems from inconsistent values; Americans have not determined the precise meaning of the terms "medically necessary" or "beneficial care," and they object to any limits on their own access to care they perceive to be necessary or beneficial. Referring to the American case, David Mechanic (1994) suggests that there are three alternative approaches to the deliberate rationing of medical care: price ration-

ing, explicit rationing and implicit rationing. Price rationing, which increases the percentage of the cost borne by the patient, can be achieved in several ways, for example by implementing user fees, annual or per visit deductibles, or by implementing or raising insurance premiums. In this way the burden of payment for a third party payer (government or insurance company) is reduced, and it is expected that individuals will thus be deterred from seeking inappropriate or unnecessary care.[1] While this correlation is intuitively attractive, in fact several studies have shown that "copayers do not differentiate between appropriate and inappropriate care" (Mechanic, 1994:72), and the poor and elderly are more likely to be deterred from seeking care than the more affluent (Evans, *et al.* 1993, Stoddart *et al.* 1993). Furthermore, since price rationing affects only consumer-driven care and not provider-driven care, it cannot be relied upon to discourage the pursuit of inappropriate care.

Explicit rationing is also problematical since it involves a decision to precisely define, by legislation or regulation, limits on particular aspects of care. It has many manifestations from enrollment and reimbursement criteria to more controversial decisions regarding specific services that will be denied to identified groups of people. By employing specific budgetary restraints, explicit rationing can also involve limitations on the acquisition or use of technology or the expansion of facilities. This can result in the deliberate development of queues, an effective form of rationing non-urgent procedures, although queues inherently result in a first-come, first-served approach that may be inappropriate, and they are also subject to arbitrary adjustment. Explicit rationing, as an overt form, requires a high level of regulatory decision-making, broad societal consensus, and at least the appearance of equity. It also tends to be inflexible since the regulatory / consensus requirement can be time-consuming and cumbersome, thus increasing the difficulty of responding to a changing environment or to technological developments.

Mechanic argues that the third alternative, implicit rationing, offers the best opportunity to allocate finite health care resources effectively and fairly (74-75). This type of rationing, which occurs at the micro level or the confidential physician-patient meeting, relies on an exceptional level of trust since it necessarily involves the discretionary, case-by-case decisions of professionals (usually physicians). It means that society as a whole must be prepared to place the responsibility for making crucial judgements that the public itself

does not have the knowledge to make, or indeed even enough knowledge to judge the judgements, on individual members of the medical profession. Nevertheless, Mechanic makes a persuasive case for relying on the flexibility of implicit rationing as perhaps the least of three evils that must be applied in rationing a limited resource.

In a discussion of rationing under the centralized United Kingdom system (appropriate to a certain degree to individual Canadian provinces as well), Chris Ham (1992:251-255) finds that allocation can take place at three levels within the system. At the macro level, decisions must be made on the over-all share of public expenditure that will be allocated to the health care sector. At the meso, or regional level, the allocation of a limited share of resources occurs. This would include such policy priorities as global budgeting for hospitals, controls on the acquisition of expensive technology and caps on total physician remuneration. In a broad sense, these macro and meso-level decisions are examples of explicit rationing. At the micro level, implicit rationing is evident. For example, doctors and nurses set priorities for whom to treat and how and when they will be treated. As Ham also suggests, growing technological complexity and expense will increasingly affect rationing decisions at all levels of health care delivery. The lines between types of rationing are not always clear and there are many overlaps, but state-specific emphases are evident.

It is fair to assume that the purpose of planning a health care system is to achieve a more equitable consumption of health care resources. Even a predominantly private system such as in the United States has this purpose in its Medicare and Medicaid programs. A problem arises when policy makers and citizens are equivocal about the level of equitable service that they are willing to support; the equivocation is exacerbated in times of fiscal restraint. Section II below briefly discusses the institutional and cultural differences in the three nations that have led to the divergent approaches to structure and reform evident in Section III. It will be shown that some form of rationing exists in each system, albeit with different manifestations. Although there is a shared focus on containing the percentage of the GDP absorbed by health care and on improving the efficiency of their systems, the direction of reform has been determined by different, state-specific characteristics and learned experience.

II. INSTITUTIONAL INFLUENCES ON POLICY CHOICES

A common theme in much of the literature on institutions is the significance of the constraining effects of enduring political institutions on policy choices; the relative stability of these institutions provides important elements of order and continuity to politics. By conditioning the perceptions and preferences of political actors, institutional structure limits the number of available options and inhibits sharp changes in policy direction (see, for example, Atkinson, 1993; March and Olsen, 1989; Caporaso, 1988; Krasner, 1988; Steinmo and Watts, 1995). In this sense political institutions are 'path dependent', as decisions are made in a context that has been determined by previous (and perhaps very different) environmental circumstances (Krasner, 1988; Tuohy, 1995). Fundamental or structural change is inhibited by the constraining effects of societal institutions as well. That is, while participants in both state and societal policy process continuously engage in a sort of reciprocal 'social learning' (Peterson,1993a; Hall,1993), earlier choices determine the expectations of societal actors and set parameters on the possible. *Stasis* is clearly not the necessary result, but the inherent difficulty in overcoming political system inertia explains the pervasiveness of directed incrementalism in policy development.[2]

The three countries under discussion exhibit varying degrees of both institutional inertia and dramatic policy change. They have followed divergent paths in the historical development of health policy, and this has led to the state-specific paths that are apparent in their approaches to the rationing of scarce resources in the late twentieth century. An explanation of the divergent paths requires an examination of state and societal structures and their tendency to facilitate or inhibit policy change. A state that has a strong potential for independent, top-down policy determination can be expected to be more successful in the realization of even controversial and dramatic changes in policy direction. Conversely, states that lack this potential can at best move only in incremental ways. Societal structures that are encouraged to develop along the way tend to reinforce the independence potential.

Several factors that are considered to affect the potential of a state for top-down policy determination have been identified (see for example, van Waarden, 1992, 1992a; Atkinson and Coleman, 1989; Katzenstein, 1985; Skocpol, 1985; Rueschemeyer and Evans, 1985). Overall constitutional, political and administrative structure in a

particular polity will indicate the potential for political action and will influence the pattern of state-societal relationships that develop. It is clear that the United Kingdom as a unitary state with a parliamentary system of government, a propensity for party discipline, a permanent, low-profile, independent and experienced public service, and a long history of interventionist social policy is a potentially pro-active state in the social policy sector. Furthermore, it has developed a highly centralized and powerful bureaucracy in the National Health Service (NHS), and its health care groups (and British society) have been conditioned to expect centralized direction.

The United States, on the other hand, conforms to van Waarden's definition of a fragmented or weak state: it has a constitutional separation of power as well as a federal division of powers, a weak tradition of party discipline and interventionism, and an impermanent and diffused bureaucratic structure. Although it has an extensive bureaucracy to manage the Medicare and Medicaid systems, administration has not been unified (Marmor, 1994:22) and there is a potential for competition between them (Steinmo and Watts, 1995). The fragmented, strongly pluralist and competitive nature of both state and society often leads to the reactive resolution of controversial public policy.

The Canadian political system exhibits characteristics of both these systems. It shares with the United Kingdom the potential for executive dominance of a parliamentary system and with the United States the federal division of powers. It also has a strong tradition of party discipline, a public service more permanent than the United States, and a history of social intervention. The bureaucratic apparatus devoted to medical care in each of the provinces is also highly centralized and specialized; thus, there is a potential for pro-active policy in this sector. The fragmenting effect of federalism can be offset by the executive dominance inherent in the British parliamentary system, and while sharp changes in policy such as national health insurance require time-consuming federal-provincial negotiation, the federal government has shown an aptitude for achieving its policy priorities through the exploitation of its superior spending power.

One consequence of these institutional characteristics for health care policy has been the interesting differences in the public/private mix of the three systems. The United Kingdom has a basically

socialized medical system with some provision for private care, the United States has a fundamentally private system (albeit with government involvement in Medicare and Medicaid), and Canada's system is a mix. It can best be described as socialized insurance with private delivery of care, and no provision for a parallel system for basic medical care. Another significant consequence of the institutional factors is the different state-societal relationships that are encouraged to develop and become entrenched. That is, the patterns of interaction that evolve between government representatives and the broader policy community are dependent on the political environment within which they function, and these patterns tend to become entrenched, condition expectations and affect the evolution of political culture.

Thus, the top-down action of which governments are capable is further influenced by widely held state-specific attitudes, norms, beliefs and values, or the amorphous and fluid concept of political culture that answers the question: what should be the role of the state? Political culture and political action are interdependent and mutually reinforcing, for "politics must be invoked not merely as the outcome of political socialization but a cause thereof, as well" (Cook, quoted by Wildavsky:40). In a discussion of the close connection between social relations (culture) and the formation of preferences, Aaron Wildavsky makes the institutional linkage when he suggests that the way "people organize their institutions has a more powerful effect on their preferences than any rival explanation" (41). Since the three countries under examination here have organized their political institutions in very different ways, their broader political cultures will reflect and reinforce these differences.

Politics in the United Kingdom has often been referred to as 'elitist' or the 'politics of class' (McLennan, 1980:185; Crick,1964:242) and the British have been described as politically socialized to accept the upper-class monopoly on government. They have also developed a deferential attitude towards the 'gentry' and those perceived to be of superior class standing. Although these attitudes are changing, British political culture has clearly been affected by the organization of political institutions such as the monarchy and the dominance of the cabinet (Crick:229).

S.M. Lipset argues that there is a degree of continuity between the communitarian and elitist aspects of monarchical Britain and the character of the value orientation held by Canadians that have

historically contained a degree of deference to political leaders (1990:10). Furthermore, collectivist tendencies in Canada are evident in the British North America Act of 1867 that protected linguistic minority groups and in the acceptance of a traditionally interventionist state. The evolution of American political culture, on the other hand, was based on revolution, individualism, anti-statism (Lipset, chapter one) and an adversarial political and administrative culture (van Waarden, 1992).

State-specific political culture is very complex yet terribly important to the comparative study of politics, although its nebulous nature precludes dependable macro-level descriptions. Nevertheless, the political cultures of these three countries range over the spectrum from 'hierarchical collectivism' to `competitive individualism` (Wildavsky, quoted in Berger, 1989:49). British political culture, especially since World War II, conforms more clearly to hierarchical collectivism, the characteristics of which include: risk is taken for the gain of the group, not the individual; leadership is a function of hierarchical relations; scarce resources are allocated by bureaucratic means; uncertainty is reduced by intervention in the economy (Berger:49). The characteristics of competitive individualism as defined by Wildavsky are the opposite and are clearly applicable to contemporary American society. Its characteristics are: government protects people and property; a market culture predominates in which risks are taken for personal gain; equality of opportunity is basic; the definition of fairness is a level playing field for competition (Berger:99).

Traditional Canadian political culture, according to Lipset's analysis, would conform more closely to hierarchical collectivism moderated somewhat by the fragmenting effects of federalism, although it now contains more than a few traces of competitive individualism, perhaps partially as an early result of the Free Trade Agreement with the United States and Mexico. It is important to recognize that all political cultures contain contradictions, and the way in which these are resolved will either support the status quo or lead to cultural change (Berger:100). The following section will briefly trace the historical development of health policy in these three countries It will be evident in the discussion that both political institutions and political culture have constrained the direction of policy choice and have led to quite different national dialogues.

III. BACKGROUND SINCE WORLD WAR II[3]

This section will establish the path-directing legacy of earlier policy decisions in these three health care systems. Since future decisions must be made in the context created from past policies, historical development is a dependable indicator of how future choices will most likely be resolved. An historical approach indicates the traditional level of government involvement, the potential capacity of the state to overcome societal resistance (i.e., from the medical profession or insurance industry), public perceptions and expectations, and the established patterns of government-group interaction.

A. United Kingdom

The history of health policy in the United Kingdom, the United States and Canada since World War II has been one of increasing government involvement. Although governments showed varying degrees of concern for public health issues even in the 19th century, serious efforts to address the issue of health policy with sweeping changes did not begin until the decade of the 1940s. The most influential document that led to the establishment of the National Health Service (NHS) in Britain was the Beveridge Report submitted in 1942, the same year that the British Medical Association (BMA) recommended a national health insurance policy, and a year after the government announced it intended to develop a national hospital service following the war. The Report recommended that a comprehensive range of care be included in the plan, but when early proposals suggested partially nationalizing hospital ownership and putting general practitioners on salary, the medical profession, which favored an extension of the existing private insurance, was 'outraged'; it withdrew from discussions on the development of a comprehensive service.

Yet the British government persisted and published a White Paper containing proposals for a national health service in 1944. The following year a massive victory by the Labour party gave the state the institutional authority to proceed with its social policy agenda, a focus of which was health care. Despite an organized campaign by the BMA encouraging its members to boycott cooperation with the government, a draft NHS bill was released in March, 1946, which included a strategy to nationalize all hospitals. The bill was passed in November, 1946, and proclaimed in mid-1948. During the interim, prolonged negotiations between a chastened medical profession and

the government led to many important concessions that mostly favored the medical profession and established patterns of interaction which have persisted. (Balsam, 1987:86).

The compromises resulted from the need for a strong and committed government to reconcile its policy choices with the contradictory priorities and objectives of a crucial societal sector. To this task Health Minister Aneurin Bevan brought an ability to exploit and deepen existing divisions within the profession (Ham, 1992:15; Levitt and Wall, 1992:10), and while he addressed some of its major concerns, the concessions remained within the confines of his broader objectives for the NHS. Physicians were guaranteed that there would be no interference in their clinical judgement, they would be free to take private patients, and they were ensured a voice on all the statutory committees. With generous financial payments, Bevan was also able to obtain the support of hospital consultants and specialists. He appropriated both local authority and voluntary hospitals, placing them under a centralized system of administration. He ensured that the service would cover the entire population (many doctors had wanted it to cover only 90 per cent) and that it would be funded mainly from general taxation rather than insurance contributions, although the latter was the expressed preference of the BMA (Ham, 1992:14-15.) Thus an accommodation was reached between a strong government and a powerful, prestigious and self-interested societal group. Although it was an extra-parliamentary accommodation, it was dependent upon the executive dominance inherent in the British parliamentary system. The government was clearly the winner, but the medical profession was appeased by its central place in the planning of the system. Its involvement in the guiding of the system and its dominant position in the policy community, while weakened, was not greatly shaken.[4]

The NHS, a fundamentally redistributive social program theoretically based on equality of access and freedom of choice for both practitioners and patients, was thus established in a relatively short time and with a minimum of conflict. All health services were to be free at the point of use, and they were to be paid for mainly through taxation. The plan incorporated a three-point structure: hospital services (including consultants or specialists), family practitioner care, and maternity care. All came under the centralized control of the ministry of health, advised by central health services councils. A parallel private system was made available for those who wished to

seek care outside the NHS, or who wished to combine elements of the two systems (for example, private physician, public hospital bed).

The government's tenacity was soon rewarded by immediate popular as well as professional support. Although it was basically voluntary for both patients and providers, 97 per cent of the population was soon enrolled, and 98 per cent of general practitioners, 94 per cent of dentists and almost all the pharmacists had joined the plan by late 1948 (Leathard, 199 :31). The costs were difficult to predict, and the system expanded cautiously in the first few years. Its percentage of the Gross Domestic Product actually went down in the 1950s, but it then began to climb and NHS expenditures rose steadily after the 1950s (see chart, Leathard, 1990:33) As a result, the management practices of the service have been the subject of several reorganization attempts discussed below. The failure of these efforts can be attributed not only to entrenched medical and organizational resistance, but also to the many uncertainties inherent to health care planning.

As costs escalated during the early period, the rationing that occurred was both price rationing and implicit rationing; it took the form sometimes of lengthy queues at the doctor-patient meeting, so that rationing decisions were largely obscured. The doctors were left to themselves to resolve the problems that were difficult for managers and politicians, and the shape of the NHS became "the aggregate outcome of individual doctors' clinical decisions, rather that the result of decisions made by politicians, policy-makers, planners or managers" (Harrison and Pollitt, 1994:35). Commenting on the unofficial controls on care, Aaron and Schwartz put it somewhat more bluntly: "an internist confronted with a patient beyond the prevailing, unofficial age at which one's chances of receiving dialysis become slight is likely to tell the patient and family that nothing of medical benefit can be done and that he or she will simply make the patient as comfortable as possible" (1984:54) Price rationing was evident in the parallel private system which, although small, enabled some patients to jump the queues and pay for immediate care.

B. Canada

The struggle for a national health insurance program was somewhat more prolonged and difficult in Canada, reflecting both the differences and the similarities of the two political systems. As in the United Kingdom, a commitment to a national plan appeared

early in the federal Liberal party platform of 1919. Later the influential Marsh Report on post-World War II social reconstruction recommended a national plan (Marsh, 1943), and the federal government attempted to proceed in the mid-1940s as part of its postwar reconstruction proposals. Unlike the United Kingdom, however, the federal system in Canada requires intergovernmental negotiation and provincial as well as federal legislation for the development of national social policy. The majority of the provinces rejected the federal approaches in the immediate post-war period, and two decades passed before Canadians acquired a national medical care plan. This allowed time for some expansion of private insurance and for experimentation in individual provinces. The history of the development of the Canadian medical care system demonstrates at once the divisive nature of a political system based on a constitutional division of powers as well as the potential for autonomous state action at both levels of government that is inherent in a British parliamentary system.

Under a social democratic premier, one of the smaller provinces, Saskatchewan, developed the first publicly funded hospital plan in 1947, and later a pioneering publicly-funded medical care plan in North America in 1962. The implementation of the latter plan precipitated a bitter strike by the province's medical association supported by the Canadian Medical Association (CMA), the American Medical Association (AMA), and much of the Canadian media, and demonstrated the capacity of a committed government to overcome the strident resistance of a crucial societal group. The Saskatchewan government, like Labour in the U.K., was constrained to make important concessions with long-term implications for its relations with the medical profession. Doctors remained on a fee-for-service payment scheme (unlike Britain), they were permitted to balance bill their patients (these extra fees amounted to a type of rationing), and the government promised there would be no interference with clinical judgements. (see Taylor, 1987, ch.5). The medical profession retained its central position in the policy community and was consulted on all aspects of the system structure. A collaborative accommodation had been struck, and although the profession was apprehensive that the government might further restrict its freedoms, this did not occur until the 1980s, and even then it was not a major restriction.

The Saskatchewan plans quickly received enthusiastic popular support; the federal government then negotiated a national hospital plan with the provinces in 1957. Following a 1964 royal commission report, a full-fledged national medical care plan was established in 1966. The federal government agreed to provide approximately 50 per cent of the funding to the provinces that met enunciated federal standards: provincial plans had to be universally available, comprehensive, portable across provinces and administered by a public body. A fifth standard, accessibility, was added later. When the plan was passed, the federal government under Lester Pearson was in a minority position in the House of Commons and the balance of power was held by the NDP, a social democratic party. It was also an era of cooperative federalism, and a few dedicated Liberal ministers chose to exploit a 'window of opportunity' (see Taylor, Kingdon, Tuohy) to achieve fundamental change through the Medical Care Act. The Act was supported by all parties in the House of Commons and passed with only two dissenting votes, although the outcome obscures the extent of the resistance that still existed.[5]

Several of the provinces, as well as the medical profession and the insurance industry, expressed their dismay, and the Ontario government was dragged 'kicking and screaming' into the plan in 1968. Ontario was the heart of the private insurance industry, much of it medically sponsored, and its premier loudly proclaimed his opposition, referring to the national plan as 'coercive federalism'. The Canadian medical profession was able to present a united front to the federal and provincial governments (since it did not have the specialist/general practitioner split as in Britain), and it achieved the continuation of fee-for-service payment and extra-billing privileges in most provinces. Thus the greatest change for doctors during the buoyant economic times that accompanied the early years of medical care was that they no longer worried about bad debts.

Medicare in Canada quickly became a highly successful and popular social program. The system expanded rapidly, and while health care expenditures remained fairly stable during the 1970s (7.3 to 7.5 per cent of Gross National Product by 1980), they rose quickly during the recession of the early 1980s to 9 per cent in 1987 and actually dropped slightly in 1989 to 8.9 per cent before rising to 9.2 per cent in 1990 (Bennett and Adams, 1993, table p.125). During this period the federal government passed two major pieces of legislation that dramatically changed the financing of the system as well as the

government-profession relationship. First, in 1977, the Established Programs Financing Act shifted the federal portion of health care spending from 50 per cent of provincial spending to a block grant tied to increases in Gross National Product (plus 'tax points'). The second piece of legislation was the controversial Canada Health Act 1984 (CHA) that forced the provinces to ban extra billing charges by doctors and the proliferation of user fees for hospital treatment. The Act penalized provinces an amount equal to charges extra-billed or collected in user fees. This law was the federal response to a royal commission in the early 1980s which had concluded that extra billing by doctors and hospital user fees charged by some provinces, if allowed to continue, would produce an unacceptable two-tiered system and threaten the basic free access, egalitarian purpose of the plan. This form of price rationing was repugnant to the supporters of universal medical insurance. Against the opposition of several provincial ministers of health and the national and provincial medical associations, but supported by consumers groups, the NDP, the nurses and physiotherapy associations, the legislation was passed unanimously. Furthermore, the 'noblesse oblige' approach that allowed individual physicians to decide whom they would extra bill (discretionary price rationing) was considered an affront to the basic principles of Medicare. The provincial legislative moves following the CHA were extremely controversial. Ontario, for example, endured a three-week strike by its doctors, and New Brunswick only conformed to the legislation at the eleventh hour. An interesting aspect of the Ontario strike was that the physicians clearly failed to gain the public support that they expected; price-rationing in the form of user fees was perceived by most Canadians to be unacceptable.

The introduction of a national health insurance program in Canada produced and entrenched several relationships within the system that, in turn, shaped future developments. First, since the role of private insurance was restricted to ancillary care (private beds, pharmaceuticals and dental care, for example) the public/private split was quite different from that in Britain, where a small parallel private system for basic hospital and medical care has always existed. This ensured that the insurance industry played a minor role. For many, faith in the exclusion of the private sector solutions to financing problems reached symbolic proportions. Second, the federal/provincial role gradually evolved. Since policy decisions were made

at the provincial level (within the federal standards), the ten provincial and two territorial health ministries developed the administrative capacity to cope with their separate and highly centralized systems. Provincial governments exercised their individual policy capacities and pursued their own priorities, and the systems developed quite dissimilarly. The federal role was limited to major financial support that ensured compliance with its broad guidelines. Finally, the provincial state/professional accommodation encouraged the medical profession to expect its central role to endure, although in some provinces the relationship was often adversarial as well as collaborative.

C. United States

In discussing the fates of various public health insurance attempts in the United States, Marilyn Rosenthal (1994:1383) says that one must keep in mind two words: 'rampant diversity'. This statement is both simplistic and profound: simplistic because the response must be well, yes, that is what U.S. politics are about, and profound because it makes a statement not just about entrenched government attitudes in the United States, but about those in society as well. Not only is political authority in the United States dispersed and fragmented (King, 1990), but the corresponding fragmentation of society has meant that a consensus on health care reform has been elusive. As suggested earlier, fragmented and diffuse political power translates into a weak state, and in the United States it has provided fertile ground for strong and influential groups to influence public policy in a singularly pluralistic society. For example, Paul Starr says that the recurring failures to implement a national health insurance plan were due to "the structure of government and the demands of politics [that] were of overriding importance in shaping the strategy of the oppositions" (1982:257). The failures to bring legislation for universal health care into reality began in the 1930s when Roosevelt and his advisers dropped it from the New Deal agenda, convinced that it would threaten their whole social welfare package (Lauman and Knoke, 1987). Nevertheless, there is a long history of trying to pass such legislation.

In 1942, a *Fortune* poll found that 74.3 per cent of Americans favoured national health insurance, and President Truman voiced his support for it during the 1948 election campaign (Steinmo and Watts, 1995). The plan he tried to develop met strong congressional

opposition, and many members of his own party, recalcitrant southern Democrats who sat on key congressional committees, opposed all of his social policy legislative initiatives (Morone, 1990:259), Steinmo and Watts, 1995). When Truman's plan failed, no state-level experimentation occurred in the U.S. as had taken place at the provincial level in Canada. Tuohy says that this is "a puzzle" (1995:11). Perhaps a partial explanation can be found in the American Medical Association's (AMA) successful efforts to use excessive Cold War rhetoric when it labelled public health insurance as 'socialized medicine' linked to the Communist threat. Although similar rhetoric was heard in Canada, it was not as effective or as intimidating. State intervention was not anathema to Canadian political culture, events in Britain were being closely watched, and Canadians had long had an active social-democratic party at the federal and provincial levels.

During the Eisenhower years reformers chose an incrementalist strategy, and they attempted to achieve at least hospital care coverage for the elderly, a 'foot in the door' approach, in the hope that this would legitimate government involvement in health insurance and precipitate public support for expansion. They were unsuccessful, and throughout the Truman, Eisenhower and Kennedy years, either Congress or the president rejected all proposals (Morone, 1990). The massive Johnson victory in 1964 brought new hope for a priority commitment to medical care, and Johnson early in his mandate promised to pursue hospital insurance for the elderly. This was achieved through a Medicare plan (1965) and a companion Medicaid law providing means-tested care for the indigent. Morone laments that this success was tempered by the fact that "authority over the new programs was immediately ceded to the industry" (1990:263). The long-term effects of focusing on two specific societal groups reinforced the fragmenting traditions of American political and social life (Steinmo and Watts, 1995), and the plans were not extended to the general public as reformers had hoped. During the 1970s a national health insurance plan appeared again on the agenda, and, in retrospect, many believe that the closest they had yet come to achieving major reform was in 1974 under President Nixon. There appeared to be a broad consensus in Congress, but when various societal and congressional interests balked (see Steinmo and Watts, 1995, Morone, 1990 for details), the institutional labyrinth again proved to be non-navigable. Steinmo and Watts sadly comment that "in any other country at any other time, a meeting of the minds such

as occurred over National Health Insurance legislation would have led to passage and implementation of some sort of legislation" (1995:23). In the late 1970s more limited measures by President Carter (who had a two-to-one majority in the House) suffered the same fate. Reforms that had been recently implemented following Watergate made the passage of controversial legislation even more problematic (Peterson, 1990), and Carter's plan precipitated a negative response from every major lobbying group.

The United States story poses a sharp contrast to that of the United Kingdom and Canada. It is a story of repeated efforts and repeated failures that can be attributed to the uniquely pluralistic, fragmented and competitive nature of both political and societal institutions. Each failure affected the context within which the next would occur and reinforced existing relationships; in the absence of a national system, corporate entities and private insurance became increasingly dominant, and market principles prevailed (Tuohy, 1995). Outside the categorical and very limited Medicare and Medicaid plans, a complex web of mostly for-profit organizations such as health maintenance organizations (HMOs) and insurance plans continued to flourish and grow.

IV. RECENT REFORM EFFORTS

As suggested in the introduction, reform efforts in all Western states have been driven by concern for the total cost of health care relative to national economies and the desire to increase efficiencies (reduce the cost) in the delivery of services; it is evident that some form of rationing is the unavoidable result. But there is a curious paradox when relative reform efforts are compared to relative health care spending as a percentage of Gross Domestic Product (table 1). Although it is clear that costs in Britain were the lowest and the most stable in relation to GDP, it was here that structural change was first attempted; reform in Britain was constrained by ideology rather than by excessive cost. Margaret Thatcher's government, elected in 1979, was committed to allowing the self-regulatory power of a free market to operate to the greatest extent possible. Her government believed that Britain's welfare state had led to the nation's economic decline, and reform was essential (Le Grand, 1987:168; Jost *et al.* 1996). In the United States, where a perception of runaway costs could most convincingly be defended, serious reform efforts undertaken in the 1990s under President Bill Clinton at the federal level failed spectacu-

larly. In Canada, where the cost/GDP ratio was increasing more slowly, a rhetoric of crisis was widely employed during the 1980s. This occurred despite evidence that the rising ratio could be attributed more to weaknesses in the denominator (GDP) due to recession than to increases in the enumerator (health care costs) (Tuohy, 1995:20), and that the rate of expenditure increase was, in fact, holding steady (Evans, 1993). In other words, the momentum for reform depended as much on broad political factors as it did on internal expenditure problems. Although reform efforts reflected a growing emphasis on market forces in all three countries, their direction was firmly grounded in past experience.

A. United Kingdom

There were a number of attempts at reorganization of the NHS during the 1970s and early 1980s, but for the most part early reforms were fairly minor adjustments in professional arrangements and in particular services. Several important elements of continuity remained, such as central government control over financing, strong regional statutory bodies that acted as agents for the ministry, an accommodation with the medical profession that approached a corporatist arrangement, a doctrine of clinical freedom (Harrison *et al.* 1992), and a small but persistent parallel private system. These constant elements, which amounted to a strong state and a strong profession, provided the foundation for changes in the 1980s, and especially the post-1990 reforms. They prepared the way for the first rather tentative steps by the government to challenge the profession over the management of the NHS. These steps, begun after the Griffiths report in 1983, represented an attempt to empower managers and to install general management principles that were the antithesis of the pre-1983 system of team decision-making. But despite the initiatives and pronouncements, there was much evidence of an 'implementation gap', with little substantive change or shift in power and influence away from the medical profession (Harrison and Politt, 1994:48). The entrenched relationships within the system proved to be very resistant to structural change. Nevertheless, government faith in improved managerial 'inputs' (to make managers pro-active rather than reactive) did not diminish; increased management control was the accepted approach to reform.

The re-election of the Thatcher government in 1983 and her personal involvement led to renewed determination and an an-

nouncement in January, 1988, that there was to be a full review of the NHS. Yet another White Paper, Working For Patients (WfP), was released in 1989 and its proposed reforms were legislated in 1990. Although the expressed intention of the recommendations contained in WfP was to elicit cooperation from the medical profession and lessen confrontation, its implications were perceived somewhat differently. The essence of these reforms, as understood by Harrison and Pollitt, is caught in the title of their 1994 book, *Controlling the Health Professionals: The Future of Work and Organization in the NHS*. They suggest that the implications of the new vision are that "management authority will expand and professional autonomy will diminish" (13).

Tension in the management/profession dichotomy was evident at a conference held at the Royal College of Physicians in London on the first anniversary of the release of WfP. Both managers and doctors presented papers, and while the former emphasized the opportunities that WfP offered, all the latter spoke of their concerns and of the disruptions and problems that lay ahead. Rudolph Klein found that all the papers had suggested that increased managerial controls would favor movement towards explicit objectives and therefore explicit rationing (in Beck and Adams, 1990:138). He clearly regretted this implication for although he recognized that rationing had always existed in the NHS, it had never been explicit but was "dissipated, dissolved, and made invisible by largely being left to individual clinicians" (138-139). He lamented that managerial decisions, and explicit choices regarding priorities, could lead to a resolve not to do certain things. The medical audit created and could exacerbate the same problem. He predicted difficulty separating medical audit from resource management, and implied that WfP, if implemented, would provide the potential for the explicit rationing of medical care.

Medical audit was one of the controversial management tools emphasized by WfP. Under this proposal, hospital consultants and general practitioners were to be required to practice audit and to submit to audits of their practices. But after much negative response, a subsequent working paper deferred to the profession's insistence that the quality of medical work could only be evaluated by one's peers. The medical profession then produced guidelines that "created *a medical* model of medical audit, a version of audit which kept it as non-threatening activity carried out only by doctors and rigor-

ously protected from the public gaze" (Harrison and Pollit, 1994:101). In this way the medical profession reasserted control and assuaged the fears of doctors resistant to external audits; the result was that there is no effective external review in the NHS.

A second major thrust of reforms is the purchaser/provider split, which amounts to a new cultural paradigm within the NHS and attempts to alter the environment within which health professionals work. It has received mixed reviews. The structure that emerged is similar to (and, according to Harrison and Pollitt [114-116], even more radical than) that suggested by the American, Alain Enthoven, in his study of the NHS in the mid-1980s. It incorporates the concept of internal markets while also attempting to enhance the relative power of patients (see Harrison and Pollitt, 1994, chapter 5). The new organizational structure consists of two types of regional purchasers of provider care under the general authority of the regional health authorities (RHA), the district health authorities (DHA) and the fund-holding general practitioners (GPs). The DHA acts as a purchaser of services from the provider institutions, making the latter almost entirely dependent on the revenue received from these contracts, and the fund-holding GP is an arrangement very similar to the HMO concept popular in the United States. Funding is allocated directly to volunteer GPs from the RHA, and the GPs then contract with providers in the community, making their own contractual arrangements and thereby becoming a "second category of purchaser" of services, instilling a degree of competition into the system (Harrison and Pollitt, 1994:116).

It is feared that the effects of the purchaser/provider attempt to alter the professional environment will increase the pressure to define and cost services, making professional activity more transparent to the managers, and also will permit the judgements of managers to compete with, or even take precedence over, professional judgements (Harrison and Pollitt, 1994:117-134). In other words, the DHA managers or the fund-holding GPs may gradually gain more power over the clinical work of medical practitioners. Harrison and Pollitt argue that there is now a real potential for fundamental change in the institutional culture of the NHS and the government/management/professional relationship. They are less impressed with the success of efforts to empower patients through a patients' charter. Although there is some evidence that queues have been shortened, real empowerment which would curtail the autonomy of the medical profes-

sion has not occurred; there has been little intrusion on the freedom of the medical profession or the resource allocation of senior managers and the clinical work of consultants (132-133).

Chris Ham (1995) sees signs of another threat to the NHS in the form of a "private finance initiative" that he believes could profoundly affect the system in the longer term. This initiative was launched by the chancellor of the exchequer in 1992 to encourage private capital to fund capital expenditures in the health sector as well as several other. Ham suspects that the implication of this move is that increasingly, areas of the actual provision of services will gradually be privatized because private finance was being encouraged not just for buildings but also for the provision of associated services in 1994-95. For Ham this amounts to selling off the family silver as various financial institutions "scent the prospect of profits from the increasing commercialisation of health care" (416). These institutions, as he points out, cannot be expected to remain at a distance from managerial decisions about health care, and he concludes that privatization 'through the back door' could fundamentally and negatively alter the NHS.

Thus it remains unclear what the long-term effects of the reform efforts in Britain will be in the mid-1990s, and the discussion continues to reflect the great divide between liberalism and socialism. While the *Economist* (1995) argued that the reforms have been successful and the changes are both positive and here to stay, others suggest that the new financing system involving the purchaser/provider split may not, in fact, be working. (Ham, 1996, Coutts, 1995). One study suggests that although early reports showed that fundholding resulted in the curbing of prescribing costs, longer term analysis (three years) does not confirm this finding (Stewart Brown, *et al.* 1995). The threat of further rationing has also caused concern. During a debate in the House of Commons, Labour health critic Harriet Harman accused the government of encouraging the recent increases in rationing, saying that while only four districts were rationing care in 1993, forty districts now did. Rationing, she said, was the "new engine of privatisation being driven into the heart of the NHS" (*British Medical Journal*, 1995:7017). At the same time, members of the BMA voted overwhelmingly in support of a motion opposing compulsory privatization of health care (*IBID*:1095).

One serious result of reform which has been noted is the sharply increased cost of administration of the NHS as a result of the large

volumes of paperwork and increased staff necessary to monitor and negotiate contracts[7] (Ham, 1996). Another criticism is that patients in the small, rural practices of GP fundholders are disadvantaged because their GP does not have as great a purchasing power as other fundholders. There have been increasing suggestions that more money must be introduced into the system through an extension of user fees and co-payments (Nichol, 1995) or, as the Royal College of Physicians advocates, "health care will have increasingly to be rationed". (*The Times*, 1995). Yet, despite all the efforts to insert market principles and competition into the NHS, there is a tenacious and fundamental continuity with the previous system. The central government retains control over total financing, the regional statutory agencies continue to act for the government, and the entrenched accommodation with the medical profession and clinical freedom remain pillars of the system. In fact, Chris Ham suggests that already, in 1996, "quietly in the night, competition in British health care has slipped away, its passing unremarked and little noticed by those who brought it into the world" (1996:7023). He goes on to discuss the reasons why the attempt to bring markets to British health care has been a policy failure. The main reason, he suggests, is that the existence of monopoly providers has limited the scope for competition, and in recognition of this, DHA managers and fundholding doctors have increasingly established collaborative arrangements in which purchasers and providers work together on a long-term basis. Although there remains a degree of competition, since contracts need not always be renewed, what in fact exists is competition combined with planning, a result that he calls 'contestability', a middle path that he hopes will incorporate the more positive aspects of competition (improved efficiency and quality) and planning (cooperation and long-term strategy).

B. Canada

Any discussion of reform of the health care system in Canada is complicated by the shared federal-provincial nature of social policy. Unlike the federal government in the United States, the Canadian government does not have the power to issue mandates to its provinces, and although its British parliamentary system greatly facilitates the development of top-down initiatives, this potential exists at both levels of government. That is, the provinces have considerable freedom in the development of social policy, and the

decentralized nature of Canadian federalism ensures that, within the broad federal standards, ten discrete provincial health care systems have evolved. This greatly compounds the complexity of tracing reform attempts and presents a challenge to supporters of the principles of universality, comprehensiveness, portability, access and public administration. The challenge is driven by fiscal uncertainty and the apparent determination of the federal government to shift its fiscal responsibilities, and tough decisions, onto the provincial governments. The steady erosion of social welfare programs by the reduction of federal fiscal transfers has been called the "politics of stealth" (Banting, 1993). As a result, successive federal budgets have precipitated provincial reactions accusing the federal government of deliberately undermining provincial capacity to maintain program standards.

The Liberal government of Jean Chretien, elected in 1993, reiterated its long-time commitment to the principles of medical care. To emphasize the point it established a National Forum on Health Care quite separate from its more general review of social policy; the nominal chair was the prime minister himself. The government also exempted health care from the 1993/94 budget provisions that capped federal transfers for post-secondary education and social assistance. But in the 1995 budget it announced that federal transfers for these three programs would be combined into a single Canada Health and Social Transfer (CHST)[8] beginning in April, 1996. The expressed intention was to allow more provincial flexibility in decisions on how to spend cash transfers. Plans to progressively reduce the CHST in subsequent budgets meant that shortly after the turn of the century, the federal fiscal leverage would disappear altogether. But in reaction to widespread concern, the 1996 federal budget guaranteed that transfers would not be allowed to drop below a floor of $11 billion (from $18.5 in 1996), so that Ottawa could continue to "hold a club over provinces failing to conform to its interpretation of the CHA" (Greenspon, 1996). While federal support of the system has been strongly stated, Thomas Courchene (1995) believes that Ottawa is breaking the golden rule of federal-provincial relations: "If you want to make the rules, you have to supply the gold." Increasingly, disparate provincial governments are making their own rules to accommodate a diminishing supply of gold.

The decremental approach of successive federal finance ministers has prompted most provinces to announce reviews and reforms

of their own health care systems. While their strategies have differed, retrenchment has occurred in all provinces, leading to concerns about the future of health care. Several provincial governments have 'de-listed' certain procedures, medications and professions formerly covered by their plans. It is important to note here that this debate is taking place in the context of great gaps in knowledge about the original medical care plan. The 1966 and 1984 laws did not make specific provisions for services other than those of hospitals and physicians. The coverage was never as comprehensive as the United Kingdom plan, other professions (optometry, physiotherapy, dentistry, chiropractic) were admitted sporadically by some provinces and not others, and costs for these services were borne entirely by the provinces. To remove optometry, out-patient physiotherapy or medications from a provincial plan is not in fact an attack on the original principles, but the public has come to expect expansion, not retrenchment.

Discrete political priorities have driven efforts to reduce costs. For example, the contiguous western provinces of Alberta and Saskatchewan have very different political cultures and have reacted to federal cutbacks in dissimilar ways. Alberta, under the premiership of Conservative leader Ralph Klein, has gradually incorporated some market principles into its health care system. It has de-listed some services, and although it is one of the three richest provinces in Canada, it remains one of only two that impose health care premiums on individuals; these were raised in 1995 from thirty to thirty- six dollars a month. Klein (1993) has publicly mused about defying the CHA and imposing user fees for hospital and medical care, and his government has permitted-- even encouraged-- the foundations of a two-tier health care system.[9] Private clinics for cataract surgery and MRI imaging have appeared; the physicians who run them are reimbursed by the provincial plan and bill their patients a 'facility' fee (about $1,000) as well. The province appointed a deputy minister for health who is a well-known advocate of two-tiered health care, supports the notion of the wealthy receiving quicker and better care for a fee and incorporates the market euphemism of 'free consumer choice' into the discussion of service delivery. For many, what is occurring in Alberta has ominous long-term implications: as the province de-lists some services and allows clinic fees, private insurers rush in to fill the void. Not only has price rationing begun in Alberta for some procedures, but its insurance corporations are

gaining strength. (see Rachlis and Kushner, 1994, especially chapter 6).

Saskatchewan, where Medicare began, has taken a different approach under a social democratic government. While a representative of the medical association protested that the province is making "an assault on doctors' working conditions" (*Maclean's*, 1995:16-17), the provincial government proceeded with drastic restructuring. It closed 52 rural hospitals,[10] converting them to health centers, removed some services from coverage such as children's dental care, sterilization reversals, adult eye exams, and reduced others such as chiropractic services and out-of-country benefits. The government aggressively pursued regionalization by dividing Saskatchewan into 30 largely autonomous health districts so there would be more local responsibility for hospitals, nursing homes, ambulatory care, home care and public health services (although physicians continue to bill central health policy headquarters in Regina). This has tightened local control and permitted the districts to tailor services towards their own populations; it has been described as rationalizing and coordinating hospital, nursing home, and home care, and it has made possible bulk purchases of such things as hip and knee prostheses. Saskatchewan, as well as most other provinces, predicates its moves on the belief that there is enough money in the system; what it needs is strong public management and strong leadership to reform it. (Fyke, in *Maclean's*, 1995:11). Rationing of basic care is not an option that the Saskatchewan government or people want to pursue.

Regionalization as a description of reform of the governance of health services has caught on everywhere except in Ontario, although it has somewhat different meanings in different provinces (Reamy, 1995). There is a tendency to link regionalization to decentralization, but for the most part it occurs with continuing centralization, for centralized ministries still determine overall structure and financing. Although the regional boards often have broad powers over a wide range of services, no province has given funding for physician payment to a regional board. The Atlantic provinces have implemented extensive regionalization. While it is not a popular concept with the CMA (Reamy,1995), other health care professionals are more supportive because of its anticipated positive impact on alternative delivery systems.

The provincial governments collectively and individually have taken action to address the funding changes. The Ministers Council on Social Policy Reform produced a document, *Report to Premiers*, as a guide for the provinces themselves to formulate standards for social policy issues (Valpy, 1995), and the ministers of health considered a report on physician reimbursement at their September, 1995, meeting. This latter report recommended a concept, Primary Care Organizations (PCO), similar to the HMOs in the United States; it would include a system of capitation for primary care physicians (Reamy, 1995). A similar health care experiment was underway in Ontario in the fall of 1995 as the government set up pilot projects in northern Ontario called Comprehensive Health Organizations (CHO) which has the population there worried about the development of two-tiered medicine. (Papp, 1995) Individual provinces have also closed hospitals: British Columbia was the first to close a downtown hospital, and Quebec has closed several hospitals while Ontario is experimenting with 'reconfiguration' of hospitals in Windsor. Despite all the activity, experimentation and recommendations, threads of continuity are evident. The federal government is adamant that it will insist on the maintenance of national standards, the provincial governments retain control over global budgets and physician reimbursement, thereby perpetuating existing relationships, and there is popular resistance to privatization of basic medical care.

C. United States

During the decade of the 1980s a profusion of innovative market-oriented health care plans appeared in the United States, supplementing those already in existence and encouraging the expansion of the medical-industrial complex. Reform advocates expressed alarm at the unrelenting rise in health care expenditures as a percentage of GDP, while no insurance was provided for about 35 million people and there was inadequate insurance for millions more. Towards the end of the decade health reform issues gained momentum, underscored by the unexpected election of Harris Wofford of Pennsylvania to the Senate after he had campaigned on the theme that 'Americans want health care reform, and they want it now.' Concern for future directions of health care and health care expenditures was expressed by business, labor, insurance companies, hospitals, doctors and other health professionals. They argued that the system was sick and that it was more expensive, although on

average it covered fewer people than that of virtually any other developed country (*Congressional Quarterly*, 1991:414).

The arrival of Democrat Bill Clinton in the White House, for whom health insurance reform had been a central campaign issue, and whose party held the majority in both houses of Congress, suggested to many that National Health Insurance (NHI) was an idea "whose time had come" (Skocpol, 1994, Peterson, 1994, Morone, 1994, Marmor, 1994). Public expectations were high as polls continued to show that popular support for NHI was between 70-82 percent (Steinmo and Watts, 1995: 32). It seemed that even provider groups and business had come to believe that health care reform was inevitable (Martin, 1994). Yet despite the fact that fulfillment of Clinton's campaign promise was judged to be a political imperative, and he presented his exceedingly complex plan in an eloquent speech to Congress in September, 1993, in less than a year it was dead-- a victim of the fragmented political system, the high level of Congressional consensus required, and the permeability of Congress to societal interests (see Steinmo and Watts, 1995, Boase, 1996). If a window of opportunity for national health insurance had indeed opened, it soon slammed shut.

While many reasons have been given for the demise of the plan, from the Clintons' personal unpopularity to poor public relations following an eight-month secretive White House consultation period (see Boase, 1996), the nature of the plan itself is instructive. Clinton's program was clearly a product of past political and policy experience, a reinforcement of the pluralist, market-oriented nature of government-society relationships in the United States. It was not an extension of government-sponsored Medicare, as many had advocated and hoped, but rather an exceedingly complex interpretation of Enthoven's 'managed competition' approach (1979) that embodied the American faith in private markets, competition and a plurality of interests. The plan ensured that the insurance industry would remain an integral partner with federal and state governments and the medical professionals, and it proposed a greatly expanded regulatory role for the state.

The spectacular failure of Clinton's highly publicized health insurance initiative has led many reformers to look to the individual states for policy innovation. Skocpol (1995) suggests that the path to reform may begin with the states (although it will eventually need Congressional action), and Colleen Grogan (1995) wonders if there

could be hope in the federal system. She examines the efforts of several states (such as reform of insurance laws, or employer-based mandates and restrictions on insurance underwriting) and finds that while many changes are important and needed, they do little to help the uninsured (481). Grogan concludes that meaningful reform is unlikely to originate in the states and finds the most optimistic scenario for state-based reform in an incremental, cautious approach that "unfortunately will not move us toward the goal of universal (or even state-wide) coverage" (1995:483). Although the states argue that they must have exemptions from the Employment Retirement Income Security Act (ERISA)[11] to overcome financing and regulatory obstacles, she believes the barriers are not as formidable as the states claim, and there are other innovative ways to raise the necessary capital such as a payroll tax on all companies. It is also worth noting that although Hawaii was granted an ERISA waiver, not all commentators are impressed by the substantive results of the Hawaiian employer mandate approach to extended coverage[12] (Dick, 1994; Grogan, 1995).

An alternative route to health care coverage that may be pursued by other states is Oregon's explicit, rule-based rationing approach which has attracted much attention in the United States and elsewhere, including heated debate over its practical and ethical issues. The Oregon plan is defended by Paige Sipes-Mitzler (1994) as a thoughtful and deliberate blending of public values with explicit decisions about what, rather than who, shall be covered. It is the overt nature of these decisions, reached through citizen participation and acted upon by the legislature, that attracts the attention of policy makers in other jurisdictions. Critics of the Oregon plan find that it is too rigidly rule-based and insensitive to the inevitable nuances inherent in the complexities of modern medical science (Hall, 1994, Hansson *et al.* 1994). Other states may experiment with equally innovative plans, but it is difficult to imagine a comprehensive and universal system emerging through the back door of state-by-state legislation (as originally happened in Canada), and it is more plausible to suggest that "reform of national health care financing will not happen in the United States until powerful interests and citizens decide that the federal government is necessary after all" (Skocpol,1995:489).

Evidence in the United States indicates that the move towards managed care so apparent in the early 1990s will continue into the

millennium. Indeed, the increased enrollment in HMOs even since Clinton's reform efforts failed has been impressive, and as we have seen, the philosophy of managed care has spread to the United Kingdom and to Canada to a lesser extent. The emphasis on 'managed competition' (which included HMO-type alliances) during the debate on the Clinton bill focused the attention of the entire nation on the HMO approach, despite growing evidence that "managed care in the '90s is seen more as a tool for controlling cost and utilization and less as an endeavor to ensure that patients get what they need" (Mechanic, 1994a:124). Thus far, experience with managed care and competing plans has not been encouraging and "limited international experience with 'internal markets' all involves strong external costs controls" (Goldberg, Marmor and White, 1995:744). The most probable result of profit-oriented HMOs in combination with Utilization Review Organizations (UROs) which second-guess professional judgements is an increase in bureaucracy and administrative costs, less freedom for both patients and providers, more profit for insurance companies, and especially, an increased potential for the rationing of medical care (see Jackson, 1994; Well, 1994; Woolhander and Himmelstein, 1994; Baily, 1993).

The proliferation[14] of managed care arrangements in their various manifestations is an indication of the continuing, dominant influence of market forces on health care delivery and financing. Where market forces and competition prevail, increased efforts to achieve cost-containment are a necessary corollary. In 1994, an American Managed Care and Review Association (AMCRA) survey revealed 277 UROs performing such review activities as certifying patients for admission to hospital and any extension of that stay, as well as approving the provision of other health care services for a plan member. Furthermore, the American Nurses Association (ANA) suggests that the emphasis on cost-containment under managed care is a driving force behind recent worrisome RN layoffs (Himali, June, 1995). The Association says that there has been a shift from understanding managed care as a system of organizing care, where nurses are essential, to a mechanism of financing which often makes nurses superfluous. Arthur Springer (1993) concurs: "managed care is one more form of health care rationing, increasingly substituting economic for medical judgements and issues of price for issues of value." Yet the Republican majority in Congress, in their efforts to overhaul and rein in Medicare, is encouraging Medicare recipients to join

pre-paid plans (HMOs) rather than remain in a fee-for-service practice (*British Medical Journal*, 311:7011). And Newt Gingrich, Speaker of the House, told a gathering of HMOs in June, 1995, that "managed care is going to be a major part of American health care for the future" *USA TODAY*, 28 June).

V. CONCLUSION

In the early 1990s all Western nations experienced a deep recession and sharply escalating government deficits. In conjunction with a shift towards neo-conservative governments, there was a relentless espousal of market mechanisms and rhetoric: efficiency, competition, evaluation, contracts, privatization, public market systems. In the health care sector, this resulted in emphasis on the payer/provider dichotomy and the description of the users of the system as clients and consumers rather than as patients. As all states continue to face similar economic and societal pressures, the forces of convergence are strong. But, the evidence presented in this essay indicates that the UK, Canada, and U.S. will pursue divergent paths in the development of health policy. Why should this be so? The answer must rest in the state-specific political and societal institutions and the manner in which policy options and demands are filtered through these institutions, leading to unique historical experience.

The political institutions of the United Kingdom facilitate the development of top-down policy making, for when a polity combines unitary government with a parliamentary system, it provides a dominant executive that is potentially unassailable. Thus when the United Kingdom government was committed to pursuing its national health insurance initiative, legislative success was assured despite strong opposition from the BMA and hospital groups. Resistance rapidly dissipated when it was clearly ineffective and the NHS quickly became a popular national institution. While it is true that the government was forced to make concessions to the medical profession, the concessions were not incongruous with established British political culture. A cooperative, even corporatist relationship soon evolved.

Yet in the 1990s when an equally strong and committed government attempted to fundamentally alter the structure and culture of the NHS by introducing managerial control and market principles, it was only partially successful. The resistance to the new structures

was less obvious, resulting more from entrenched attitudes, routines and relationships than from conspicuous opposition. Although there were many who argued for an increase in private expenditures such as user fees and co-payments (see *The Times*, Sept. 19, 1995), there was clearly a widespread suspicion of entrusting managers with essential health care decisions. Despite an acceptance of a parallel private system, support for the British NHS is strong (no one under 50 has lived without it), and this is the context within which present day policy decisions must be made.

Governments in the provincial capitals of Canada enjoy the potential strength of unitary governments in a parliamentary system (with no second House to contend with). As participants in a federal system, however, they are greatly affected by policy development at the federal level; the necessary interaction in the pursuit of national social policy is a countervailing force to the executive dominance extant at both levels of government. Yet it is true that a committed provincial government can legally unravel its health care system if it is prepared to forfeit federal funds and can depend on the necessary popular support. A serious challenge to the Medicare system could be mounted from the provinces, and Premier Klein of Alberta has suggested that he might pursue a constitutional challenge to the restrictions on private health care under the CHA.

The mixture of public insurance and private provision of services mirrors the ambivalence towards government that is manifest in Canadian society. Canadian political culture has deferred to executive dominance, accepted government intervention, and supported the collectivist notion of a public good such as universal health insurance. While it is true that the negative reaction of the medical profession to the imposition of Medicare was more vociferous than in the United Kingdom, medical professionals in Canada soon learned to exploit a clientelistic relationship with government and to develop a more corporatist involvement as governments increased their control of the system. Sporadic and unpopular episodes of mild civic disobedience by the medical profession are evidence of the tenacity of the ideology of professional autonomy, and they mask an entrenched (although recently shaken) support of the system. Clearly, a widespread suspicion of new market mechanisms in the health care system exists (there are already some unhappy Albertans) and little tolerance for major reforms that would increase rationing or exclude categories of the population.

The perception of fragmented government in the United States has been greatly strengthened by the demise of a popularly-supported health financing initiative and an increasingly adversarial, even hostile, relationship between the White House and Congress. When a presidential initiative cannot gain the support of Congressional members of the president's own party, it is almost unimaginable that legislation as controversial as NHI could be successful unless there is an unexpected and dramatic change in the environment. American society adheres to a remarkable degree of pluralism, individualism and competition (all clearly reflected in the president's plan) and retains its suspicion of government activity that was the foundation of the system in the eighteenth century. Health care rationing in the form of price rationing, as well as the openness of the Oregon rationing system, conforms with the dominant political culture.

Despite similar pressures, these states are unlikely to develop similar policies as they wrestle with crucial resource allocation decisions. A shared emphasis on management to separate the purchaser/provider functions, illuminate professional activity and open the door for more explicit decisions about health care has been far more successful in the United States than it has in Britain. Profound differences between the two systems remain: any decisions about rationing in the United Kingdom and in Canada will be taken by public agencies or left to individual physician judgements. In the United States they increasingly will be taken by profit-oriented private corporations. The NHS remains a single statutory entity, as does the Canadian public insurance system in each of the provinces, but in the United States, there are multiple, private purchasers and providers. (Jost *et al*, 1995).

Canadians have repeatedly shown that price rationing does not conform to their idea of an egalitarian society, and explicit rationing of basic care, such as in Oregon, or even the British parallel private system is unlikely to be tolerated. If nascent managed care structures place restrictions on theirs and their physicians' freedom of choice, Canadians will find this an unwelcome alternative. In both the United Kingdom and Canada, faith in government, an often very secretive government that would be rejected in the United States, has conditioned citizens to favor implicit rationing that places individual physicians in a position of trust. Harrison and Pollitt (1994:3) accurately portray the probable British and Canadian approach when they suggest that although governments will continue to

tighten controls, they will leave enough clinical autonomy with the professionals so that they themselves can escape politically awkward decisions concerning the allocation of finite resources.

ACRONYMS

AMCRA	American Managed Care and Review Association
AMA	American Medical Association
ANA	American Nurses Association
BMA	British Medical Association
CHA	Canada Health Act (1984)
CHO	comprehensive health organizations (Cda)
CHST	Canada Health and Social Transfer
CMA	Canada Medical Association
DHA	district health authorities (UK)
ERISA	Employment Retirement Income Security Act (US)
GDP	gross domestic product
GNP	gross national product
GPs	general practitioners
HMOs	health maintenance organizations (US)
MRI	magnetic resonance imaging
NDP	New Democratic Party (Cda)
NHI	national health insurance
NHS	National Health Service (UK)
PCOs	primary care organizations (Cda)
RHA	regional health authorities (UK)
RN	registered nurse
UROs	utilization review organizations
WfP	Working for Patients (UK)

NOTES

[1]An important part of this debate is that recent studies have shown that social status is closely linked to health status (see, for example, Fierlbeck, 1995.

[2]Dramatic or structural change happens rarely, and only when a "coincidence of external forces is strong enough to overcome the resistance of interests within the arena to such change"; a window of opportunity then may open. See Tuohy, 1995, Kingdon, 1984.

[3]For further descriptions of the developments of these systems, see Ham, 1992 (U.K.), Marmor, 1993, Maioni, 1994 (U.S.), Taylor, 1987 (Canada).

[4]Balsam (1987:86) says that "compromises between Bevan and the doctors is a flaw that continues to dog the system".

[5]The federal finance minister, Mitchell Sharp, for example, was very resistant to implementing the plan at that time.

[6]There are 1500 private insurers in the U.S. (Marmor, 1994: 182).

[7]Although comparing cross-national administrative costs is difficult, the U.K., because of its centralized control has low administrative costs, as has Canada. U.S. administrative costs are about 4 times those of Canada, and the U.S. Congress Report (1994) says that "analyses of the administrative costs in countries other than Canada suggest that health care systems with more than a single payer, entailing a choice of insurance plans along with decentralized cost control measures and payment of providers, involve higher administrative expenditures than does a single payer system" (1-2).

[8]Originally announced as the Canada Social Transfer (CST), the government quickly responded to public alarm and added an 'H' for health.

[9]In Canada, a two-tier health care system is usually perceived to be one where there is a parallel private system (as in Britain and Australia), and where preferred and quicker treatment can be obtained by those willing and able to pay for it. That is, price rationing would undermine the egalitarian principles.

[10]Although this might seem apocalyptic, in fact Saskatchewan had a surfeit of hospitals. With only one million people (compared to Ontario's ten million), Saskatchewan had about the same number of hospitals as Ontario.

[11]This federal Act (1974) provides for uniform federal regulation and protection of pension and employee welfare plans.

[12]Massachusetts enacted a universal 'pay or play' health care law, but repealed it (Blendon *et al.* 1992).

[13]Ontario, for example, commissioned papers examining health care reform in the American states, to see if lessons could be learned. (Ontario Legislative Library).

[14]A representative of AMCRA (which represents managed care organizations) was understandably enthusiastic about the most recent statistics for enrollment in the various plans.

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