

TO OUR READERS

At first glance readers familiar with CAPP will observe that this issue departs from the usual format. Rather than featuring a single essay, Number 51 contains several of varying lengths by five scholars, all focused on a single topic—health care policy—that is quite high on the public policy agenda nowadays in Canada, the United States, and several other nations. As a result of sagging economies, aging populations, escalating costs, coverage gaps, and service delays, some national health care systems seem badly strained or inadequately funded. Debate over what to do about the “crisis”, or even if there *is* one, has been echoing through the corridors of national, state and provincial capitols. Since the collapse of the World Trade towers health care policy has become a leading concern at the state level partly because of Washington’s single-minded focus on the terrorist issue. At the same time, two major investigations of the Canadian Medicare system (the Kirby and Romanow Reports) are offering somewhat different prescriptions for health care reform north of the 49th parallel.

Given Maine’s long boundary with Canada, it should not be surprising to CAPP readers that some of its citizens are looking across the border to Canada’s universal single-payer Medicare system with considerable envy. Well before the fall elections, groups of seniors had begun to charter buses carrying them to the nearest Canadian border-town pharmacy in order to purchase cheaper medicine, and rising drug costs became a hotly debated issue in Maine’s senatorial race. Two of the state’s three candidates for governor, one a Democrat (who won the contest) and the other representing the Green Party, strongly advocated different strategies to make affordable health insurance available to everyone in this state. With the growing prominence of these issues on the eve of the November vote, four groups in eastern Maine organized a special symposium to examine health care policy options from U.S., Canadian and Maine perspectives.* Two units of the University of Maine—the Center on Aging and the Canadian-American Center—joined with Eastern (ME) Agency on Aging and the Eastern Maine Medical

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Center to orchestrate and underwrite a special symposium held in late October and moderated by Dr. Peter Hoff, the University's president.

This was the context for Dr. Theodore Marmor of Yale, an internationally known expert on health care policy issues, to address an audience, mostly seniors, who had assembled in Orono to learn more about their society's health care policy options so that they might make informed decisions at the polls. In the papers appearing in this CAPP number, Dr. Marmor, his associates, and the commentators focus largely if not exclusively upon two basic issues that are fundamental to discussion of health care policy reform in both the U.S. and Canada; first, the gap between current media images about our health care systems and the actual realities, and secondly, the role of "national values" in shaping policy in this arena. Symposium participants found the presentations to be illuminating, and we offer them now to a larger audience in the conviction that many other residents of Canada and the United States will also find them to be salutary.

Robert H. Babcock, Editor

PART I
FACT OR FICTION?
THE CANADIAN
MEDICARE "CRISIS"
AS VIEWED FROM
THE U.S.

THEODORE R.
MARMOR

There are at present two conflicting images of Canada's Medicare available to observant adults in the United States. One is the conventional media portrait of crisis— from both U.S. and Canadian sources—an image of a program in deep trouble, overcome by problems of access, cost, and quality. The other image is far more favorable: Canadian Medicare as a structurally sound program of universal health insurance that largely satisfies those who use it, but, like all programs, requires managerial adjustment and attention to the fearfulness of Medicare's future that has marked the last decade. This was the conclusion of the report of the Canadian Institute for Health Information (CIHI) in 2000. Both portraits cannot be accurate, just as being green and white all over is logically impossible. What is the American interpreter to make of this dispute?

*A list of acronyms used in this article is provided on page 39.

I. THE EMERGENCY ROOM STORY: A Similar Tale with Two Meanings

One place to begin is the crowded state of the North American emergency room (ER), a familiar story in both Canada and the United States over the past decade. When the winter's flu season of 2000 aggravated overcrowding in North American ERs, the U.S. (and Canadian) media took special notice. That winter *The Washington Post*, *The New York Times*, and ABC News did stories on the quality of emergency rooms in Canada. (This paralleled Canadian media treatment and in fact amplified those stories). During the same period, *USA Today* and *Time* published substantial reports on U.S. emergency rooms. But there was a distinct difference in the stories told. The three reports on Canada used the overcrowding problem to suggest Medicare is critically flawed. The two extended reports on American overcrowding did not, by contrast, indict America's over-all health insurance arrangements.

The similarity of the North American stories was, however, quite striking. *USA Today* reported that "for nearly 10 days in December of 1999, "60 of 81 [Los Angeles] hospitals were so full that hospital administrators asked to send ambulances elsewhere." The same newspaper cited a California woman who died in an ambu-

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lance awaiting hospital admission. The journalistic portrait of Canadian ERs cited similar experiences. In Toronto, overcrowding was so serious that the *New York Times* reported “23 of the city’s hospitals [had] to turn away ambulances.” ABC News cited an asthma patient who died in an ambulance that had been diverted from the nearest hospital.

The important point is not the parallel reports but the different interpretations placed on them. The stories about U.S. conditions attributed the problem in part to the flu, while the reports about Canadian ERs either ignored the flu or dismissed it as an attempt by Canadian public officials to put a happy face on a Medicare in crisis.

Steven Pearlstein of *The Washington Post* asserted that “most experts” agree that Canada’s Medicare is doomed, that “while money might alleviate the shortage of advanced machinery, hospital beds, and medical school slots, it will only be a matter of time before the demand for medical services once again overtakes the willingness of voters to pay for it.” (Reader’s alert: most experts actually know that the demand for medical care is practically limitless and distinguish demand from serious needs. The claim of critical shortages appears universally in systems of “single-pipe financing” of health insurance. This phenomenon, called ‘orchestrated outrage’, is a familiar bargaining ploy which may, or may not, indicate worrisome medical circumstances. To conclude circumstances are dire requires evidence other than claims of shortage, as every national health insurance official in the Western world knows.)

What the U.S. media portrayed as programmatic failure was both a reflection and an amplification of the Canadian emergency room stories. Indeed most Canadian papers got at least a month’s solid copy out of hospital overcrowding, the turning away of patients from emergency rooms, and the deaths of individual patients unable to get emergency treatment. The shortage of 24-hour health care services outside the hospital is obviously the flip side of the emergency room story. So, why the near universal North American press assumption that these strains show a Medicare program in serious trouble, not as good as it once was, and likely to get worse?

II. THE PRESS AND THE PROBLEMS: Or, why the story of Medicare in Crisis?

The image of a critically flawed Medicare program is one predictably put forward by interest groups, regularly employed by

political leaders in their battles, widely amplified in the Canadian media and intermittently so in the U.S. Given that, it is no wonder Canadians worry about Medicare's viability. (Between 1988 and 1998, the proportion of Canadians reporting only minor problems with Medicare fell from 56 percent to 20 percent.) And, yet, the fearful portrait of Medicare is strikingly at variance with the recent and balanced CIHI report. How can one explain the differences?

The differences are obvious and rather easy to explain. The CIHI report represents a synthesis of research on Canadian Medicare. It presents itself as the enemy of anecdote and in that sense is explicitly critical of the press, both print and television. Canadians are indeed more concerned about Medicare's future than they were in the 1970s and 1980s. But there is a sharp distinction, according to the report, between the satisfaction of Canadian users of Medicare and the fears of the general public. Indeed, 54 percent of Canadian users regarded the care their family received in the previous twelve months as excellent or very good. This discrepancy between use satisfaction and system trouble is important, one which helps to explain the conflicting images of Medicare. The stories of emergency room crises awaken concern among everyone; all of us fear not having care when urgently needed.

The CIHI portrays Canadian medical care as institutionally stable, financially pressured, and with pockets of trouble. It reports sharp increases in hospital workload and constrained budgets. Tight budgets necessarily mean limits on the incomes of doctors, nurses, and others in the medical field. To understand why the selected problems identified by research can turn into a Medicare crisis requires attention to the habits and stakes of the press, pressure groups, and political elites.

Canadian newspapers, television programs, and politicians regularly treat Medicare as front-page news. For most of its history, it has been the jewel of the postwar Canadian crown. Polls from the 1970s through to 1990 regularly reported overwhelming Canadian approval of Medicare, dismay at U.S. experience, and no interest whatsoever in following America's health insurance lead. With disinterest southward and persistent scrutiny domestically, the Canadian press reported most any incident of apparent medical deprivation.

With the coming of serious recession in the early 1990s, Canadian journalism turned its attention to the real belt-tightening that

took place. Frozen budgets meant real strain, disappointed nurses and doctors, and in the hospital world, downsizing, closure, and merging. There was, in short, much to be concerned about and Canadian reporters followed the complaints that straightened economic circumstances understandably generate. In doing so, they amplified the demands of stakeholders much more than they systematically portrayed the circumstances of Canadian Medicare. The truth about a medical care system is complicated, the pressure groups have no or little interest in truth-telling as such, and journalists have a very difficult time evaluating complex, major programs through particular stories. That is why the high quality of the CIHI report is so important. It is both a voice to counterbalance vocal pressure groups with a stake in crisis talk and a reliable source that every journalist covering Medicare needs to master.

From the United States, journalistic interest in Canadian Medicare reflects the place of health insurance issues on the national agenda. The attention is intermittent, not very well informed, and mostly reflecting the preoccupations of American interest groups. So, for example, in early 2000 was a recent flurry of articles (and advertisements) in the U.S. about the dangers of Canadian “price controls” on pharmaceuticals. This story emerged in March just as the Congress debated adding outpatient drug coverage to the (U.S.) Medicare program. At the end of March, a group called “Citizens for Better Medicare” launched a multi-media campaign “urging American seniors to reject the Canadian model of health insurance and coverage of prescription drugs.” These “Citizens” include the U.S. Chamber of Commerce, The National Association of Manufacturers, and the pharmaceutical trade association, all saying that Canadians suffer from a “big government-run system that rations health care, delays access to treatments including new technology and medicines, and harms too many patients.” Since few American reporters know enough about Canada to question any of these caricatures, the claims get amplified rather than analyzed. And, given the North American media market, the claims are transmitted northward asymmetrically. For example, one can predict confidently that no *New York Times* story will analyze the CIHI report, whereas no doubt many Canadians witnessed the media campaign by the (U.S.) Citizens for a Better Medicare. That prediction was confirmed. Indeed no report of CIHI has been analyzed in any major American newspaper.

III. WHY SUCH DISMAY AND DISTORTION?

The incompatible portraits of Canadian Medicare are not accidental. The conventions of the press help to explain what image of Medicare is available to the average North American. In Canada, Medicare is a major story and ordinary Canadians not only care about the program but pay attention to reports about it. As a result, they hear from the media more about distress than anything else. Mainstream journalists in both countries treat dramatic problems as more interesting than explanations of complicated programs. American interest groups provide a spur to critical stories, and the richest of such groups overwhelmingly want to attack the Canadian model. It is precisely because Canada has achieved comparatively good value for money through Medicare that it represents an ideological threat to these American interest groups and their Canadian counterparts. To the extent these North American interest groups bring stories and documentation to the press, the media's commitment to even-handedness actually undermines a balanced view of Canadian Medicare.

That is once again why systematic evidence of the kind presented in CIHI reports is so vital. The portrait of Canadian Medicare will never be painted properly by episodic, dramatic representations of particular trouble spots. What those trouble spots mean—that is, how generally they apply—is what systematic evidence only can reveal. Moreover, the very structure of Canadian Medicare brings with it necessary and open conflict. Paying for medical care from a single provincial budget—where other competitors for public funds help restrain medical demands—means necessary and predictable controversy. That controversy is about how much to spend, on what, for whom, and under what conception of fairness. This brings accountability, but the other side of that program accountability is constant media attention, constant claims of need, and considerable exaggeration of the state of Canadian Medicare. As long as stories are the mechanism for understanding it, distortion of the program's strengths and weaknesses will continue. Evaluating a system requires systematic evidence and that is what the CIHI provides. From the perspective of an American analyst of Canadian Medicare, CIHI presents a program not critically flawed, but simply in need of targeted adjustments. But you would never know that from the tales political adversaries tell or the portraits painted by the North American media. One hopes the availability of systematic evidence will

condition the future behavior of the press and the politicians. Only a naïve observer would expect pressure groups to forego their rush to hyperbole in advancing what are their perfectly understandable stakes.

PART II: TWO COMMENTARIES ON “FACT OR FICTION?”

Trish Riley

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In [another essay] laying out options for health care reform in the United States, Ted Marmor has proposed as one alternative a possible Federalist approach. I would like to build on this point and discuss a state-based strategy for health care reform. In fact, as Dr. Marmor points out, Canada began its health reform in one province— Saskatchewan— and did so incrementally. The plan first covered hospitals for everyone and grew to broader coverage. As Dr. Marmor points out, we have taken a different approach in this country. Today only the elderly have universal access to coverage through Medicare, so I want to discuss the broader population of Americans without any health insurance. Indeed, there are more uninsured in the United States than Canada has citizens. About 140,000 of us in Maine below the age of 65 lack coverage. The biggest groups of uninsured are those between 18 and 24, often identified as the invincible— individuals who think health coverage is not essential because they won't get sick— and those between 60 and 64. This latter group often includes older Americans who were forced by illness or disability to leave the work force, have exhausted their COBRA extensions, and are left uninsured until Medicare becomes available.

While the notion of a national response and a national solution to this growing absence of health insurance is appealing, Americans tend to be raging incrementalists. In fact, states can and must lead, particularly now that the U.S. Medicaid program is, in fact, larger than the American Medicare program in both dollars spent and numbers served. Indeed, states have a proud tradition of leadership and Congress has only acted in health reform *after* the states have served as laboratories for innovation. The Health Insurance Portability and Accountability Act (HIPAA) provided protection, assuring that those who once had insurance will never lose that coverage even if changing jobs or becoming unemployed. While HIPAA does not deal with affordability, it was a major step forward in assuring the availability of health coverage for those who were once covered. HIPAA was enacted by the Congress only after the majority of states had passed similar health insurance reform initiatives. The Congress only enacted the State Children's Health Insurance Program (CHIP), covering all children up to 200 percent of the federal poverty level, after 26 states had experimented with similar programs of their own. Likewise, states have enacted patients' bills of rights, prescription drug reform, and initiatives to cover the uninsured—all of which the Congress is now negotiating and discussing. There is a clear track record for states taking the lead that Congress can follow. Regrettably, the issue of coverage for the uninsured is a costly endeavor and states will need federal dollars. But the State Children's Health Insurance Program (CHIP) is a model. Congress nationalized an effective state-based initiative by providing matching funds to states.

A reform for states will need to take a systems approach dealing with cost, quality, and accountability, and Norm Ledwin [CEO of Eastern Maine Healthcare] identified those serious tripartite issues in his opening remarks. America's resistance to health reform is difficult to comprehend. Certainly, part of the problem is the enormity of change in the deeply-rooted, complex system that cuts across multiple payers today. But, arguably, an equally compelling reason Americans have failed to advance reform is because they are always presented in a "we *vs.* they" scenario. I suggest that to advance reform we need to avoid looking for villains.

When President Truman advanced health policy reform he was fought by organized medicine; when President Clinton advanced health policy reform the insurance companies made government the villain. Today, the health policy reform debate has vilified the

prescription drug industry even though that group accounts for only 10 percent of total health care costs. The precipitous rise in costs and prices has been evident to consumers and, therefore, makes the drug industry an easy target. Tomorrow, villains will likely change as we begin to realize that the single biggest driver of health care costs is hospitals, and their expenses are increasing faster than drug costs and insurance companies as they pass more expenses onto consumers in response to the failure of managed care and the need to continue some kind of cost containment.

Any reform will need to address costs and the reality of cost shifting. Today, those of us who pay for health care cover the cost of uninsured, and those costs tend to be high since the uninsured enter into the health care system too late, resulting in compromised health conditions that cost more to treat. Similarly, government programs pay providers less than private payers. The United States spends a trillion dollars in health care each year. In Maine we spend over five billion. Health care costs are growing three times faster than the cost of living. More worrisome, the United States spends about \$4,000 per capita on health care compared to an outlay of \$2,000 in other developed nations, yet we are at or near the bottom in health outcomes. While we enjoy a system providing some of the highest quality medicine in the world, we ought not to be sanguine about how good that quality is overall. Medical errors are the eighth leading cause of death and account for \$20 billion of wasted resources in the health care system. New research shows us that we are engaged in a technology "arms race" because health care has become a profitable business and health care providers seek to initiate services with the latest technologies where they are highly profitable. Research is showing us that supply drives demand, yet without improved outcomes. In short, in America we spend more and get less and we know that 20 percent of users of health care spend 80 percent of health care resources. Tough issues need to be addressed about utilization of our health care system and its quality.

Access continues to be a problem in the U.S. as well as in Maine where more than 140,000 lack coverage. A new access problem will likely emerge and that is the issue of under-insurance. As insurance companies pass on more costs to beneficiaries, it is likely that people and businesses will drop coverage or will provide bare bones or catastrophic plans which leave people uncovered for significant health care costs.

We at the National Academy for State Health Policy have been tracking the governors' [November 2002 electoral] races in 36 states where 80 candidates are seeking the office. We see in the states significant discussion and real debate about the issue of health care and health access. Here in Maine, a debate has unfolded in which all three candidates have significant health proposals and two, Jonathan Carter, the Green Party candidate, and John Baldacci, the Democrat, are committed to universal access. It is encouraging that health care policy is very much on the political radar screen, and Maine could become a national leader in developing solutions to some of these difficult problems.

Unlike many other states, Maine has only 1.2 million people, a number considered a good insurance pool for competitive marketing purposes, and its population is quite homogeneous, making product development and sales that much easier. Moreover, unlike other states, most of the state borders on the ocean or Canada; hence health care policy reforms would be less likely to attract "border creep"—that is, citizens coming here from nearby to qualify for health care.

But reform takes more than good ideas and money. Ted Marmor spoke of public values. In the end reform will take public will. Stunning as it may seem, during the economic boom of the 1990's we saw no concomitant increase in private sector investment in health care for employees. Clearly, something is missing in the public discourse, and a demand for health care reform does not yet resonate even when dollars are available. An active and engaged public calling for health access for all of us is the essential step to secure reform. That we *do* it is a more significant commitment than *how* we do it. Indeed, there are many, many ways to achieve universal access—one could require an individual mandate, seek provisions to require employers to provide insurance or pay a tax so the public program could, or we could expand U.S. Medicare or Medicaid. The options for reform are real, the demand for it is essential if dollars from this, the most wealthy country in the world, are to be committed to access for the uninsured. In the end though, states cannot do it alone. States like Maine can model reform but it will be essential for the federal government to provide critical resources to help fund it.

Gary Kenyon

Professor Kenyon is a gerontologist at St. Thomas University, Fredericton, New Brunswick Canada. He is a member of the McGill University Center for Studies on Aging, the Canadian Association on Gerontology, and the Gerontological Society of America.

Dr. Marmor presents an interesting and very informative argument concerning the historical development of both the Canadian and American health care systems. He also highlights the cultural and political factors that have resulted in the significant differences in these respective systems today. Finally, Dr. Marmor presents a cogent discussion of myths *vs.* facts in Canadian and American health care, and, in particular, the manner in which myths are promoted by the media in both countries.

I am in agreement with Dr. Marmor's observations concerning the media. There is an apocalyptic narrative that has received dominant circulation in the recent past. In contrast, as evidenced by the advance findings in the soon-to-be-released Romanow Report, Canadians feel that their health care system is in need of reform; however, they do not feel that it is "terminally ill." Further, they want their health care system to remain focused on the needs of all citizens rather than basing it upon their ability to pay. A recent report from the Canadian Senate [Kirby Report] reinforces these values in recommending that the federal government inject five billion dollars into the system to support such initiatives as funding more physicians and nurses, increased home care and palliative care support.

My final comment on this issue is based on a report entitled *Waiting for Romanow*, which was submitted to the Romanow Commission by the National Advisory Council on Aging, a group representing seniors nationally that advises the federal minister of health. "Though Canadians have voiced concerns in recent years related to specific aspects of the health care system (e.g., access to certain services, waiting lists)," the report states, "survey after survey demonstrates that Canadians who actually need to use the health care system, generally report a high level of satisfaction with the care they receive."

I would like to direct the balance of my remarks to the issue of the components of an effective health care system, whether Canadian

or American. As Dr. Marmor points out, we should be directing our energies to initiatives that are “doable.” I believe that many of the following suggestions are capable of implementation, that they can save money in the system, and that they can improve the quality of life for persons of all ages. In fact, in what follows, I am again guided by the *Waiting for Romanow* report, in which the following initiatives are being urged by Canadian seniors. This is an important indication of “doability”—namely, that users of the system are desirous of particular services or programs. I will briefly discuss three of these initiatives.

First, primary care reform is needed in the system. While this issue is very complex and intense, we need to move away from the exclusivity of fee-for-service remuneration for physicians and perhaps toward a mix of payment practices. Health care in an aging population should reflect principles of geriatric medicine that view the patient as a whole person with physical, psychological, social, and spiritual dimensions. Changing payment methods for physicians would encourage them to spend more time with a patient, and to broaden their work to include such practices as listening to a person’s story, counseling, and promoting health-promoting “prescriptions” that I will discuss a bit later. The province of New Brunswick has just opened its first four community health clinics. These facilities are staffed by health teams who are guided by some of the foregoing assumptions.

Second, home care provision needs to be expanded. A news report on the most recent Canadian census indicates that more and more people are living in their own homes, even in the 85+ age group. Conversely, a lower percentage of older persons is opting for nursing home placements. However, most home care is currently unpaid, and much of what is paid is delivered by under-trained staff. The desire of Canadians to stay home extends to the end of life as well. Recently, a national palliative care initiative has been established through the federal government. This initiative will provide encouragement for the further development of palliative care units and hospices, and also will give people the choice of dying at home through expanding programs such as the Extra-Mural Hospital in New Brunswick. In my view, it is a healthy development that we are gradually moving away from being a death-denying society. While it is obviously important to dying persons and their families, it is also vital to the health care system as we become more aware that

improving quality at the end of life requires a different set of assumptions from other periods in the life cycle. I refer here to the movement, at the appropriate time, from curing to caring.

The third issue I would like to stress is the link between health promotion and disease prevention. While it may be true that, as an existentialist writer would say, life is messy and habits are hard to change, future improvements in healthy life expectancy, and therefore, reduced costs to the health care system, will be largely due to changes in lifestyles. For instance, currently some 80 percent of visits to a doctor are stress-related. Studies have just been released indicating that obesity and diabetes II are rampant in Canada and the United States. Heart disease remains our number one cause of death. Osteoporosis and related fractures and falls are a major cause of morbidity and mortality, especially for women. While I do not wish to make a universal statement about the causes of all forms of the above conditions, the majority of these, and many others, are responsive to lifestyle interventions such as diet, physical activity, complementary medicine, and educational self-care programs (for example, the arthritis self-care program).

From an anecdotal perspective, I have been teaching *t'ai chi* for some ten years, and I regularly observe the significant health benefits that are derived from these kinds of activity. Practitioners report that they have reduced their blood pressure and require less medication, that they sleep better, and that they have cured or reduced the incidence of migraine headaches. This is aside from an increased ability to relax and feel at peace.

Based on the foregoing discussion, my suggestion is that health promotion should become a central component of the Canadian health care system. We need to be very creative in meeting the challenge of designing and offering programs that will change many current unhealthy and expensive habits. More controversially, perhaps we should be held more responsible for our own health. For example, perhaps physicians should prescribe health promotion programs instead of, or along with, medications. Ideas such as these would need to be considered for their ethical implications as well as in other aspects. One such proposal has been offered in a western Canadian province, where it was suggested that a person's medical bills should not be covered [by Canadian Medicare] if that individual had failed to wear a seat belt at the time of an automobile accident. (Apparently, it can be determined with certainty whether or not the

passengers had been wearing seat belts in an accident.) Whether this type of intervention is appropriate is a matter for debate and reflection. Nevertheless, if it is the lifestyle factor that is crucial at this time in Canada's aging population, then interventions that encourage and facilitate this dimension of health care are necessary. Increasingly, Canadians—and I am sure it is the same for Americans—are seeking alternatives to expensive medications with possibly serious side effects, and also facing long waits for visits to the doctor. Ironically, these factors appear to create a fertile ground for expanding what we have considered up to now as mainline health care.

I would like to thank the sponsors of this symposium for asking me to participate in today's event. I have learned much from listening to the other speakers and to the comments from the audience. I wish you good luck in your pursuit of universal health care in the United States. Good things happen on the basis of individual efforts, and there are many dedicated people here today who should be lauded for their ongoing efforts to have their voices heard in Maine and in Washington.

PART III
NATIONAL VALUES, INSTITUTIONS, AND
HEALTH POLICIES:
WHAT DO THEY IMPLY FOR [CANADIAN]
MEDICARE REFORM?

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¹Discussion Paper No. 5, Romanow Commission. The views expressed herein are solely those of the authors and do not necessarily reflect those of the Commission.

I. INTRODUCTION

The Medicare program, it is quite often asserted, is special for Canadians because the program is taken to embody something distinctive and superior about Canadian social values. For some Canadians, it follows that any effort to alter Medicare substantially amounts to an attack on Canadian values and should be rejected. On the other hand, others have claimed that Canadian national values have undergone substantial changes, and that this shift in values may justify (or excuse) amendments and alterations to the Medicare program.

These are what we will term anti- and pro-amendment positions. Both assume a fairly tight connection between what are called "*Canadian national values*" and the particular structural features of Medicare. In light of this ongoing debate, we have been asked by the Romanow Commission to investigate the role of "*national values*" in the shaping (or re-shaping) of health insurance programs in Canada, and more generally in the world of developed democracies.

Section II is first a methodological commentary on what is and can sensibly be meant by appeals to "national values." It then addresses the general theoretical concerns about how such values might be embodied in the institutions of different Western democracies. Section III begins by taking note of the large number of reports that have recently called for reform of the Canadian health care system. After commenting briefly on the relevance of the value presumptions of these reports for this inquiry, we approach our central topic in Section IV. That part of the paper provides some comparative evidence that shows how loose the connections really are between anything coherently termed "national values" and the concrete forms of social institutions. Many variables besides "values" are at work in shaping and re-shaping particular institutions of social policy, we argue. And, conversely, we claim, many quite differently shaped social institutions may reasonably be said to embody the same set of values. In Section V, we return to the Canadian discussion of Medicare, and argue that a range of possible amendments would be perfectly consistent with – and therefore would be not greatly threaten – Canadian social values. Choosing among those options requires a degree of prudence – an attention to the political realities of conflicting interests, and to the practical realities of resource management and information – at least as important as the values that prudence aims to advance. That a social

welfare institution expresses the right values is a necessary, but is not a sufficient, basis for its adoption as a wise course of action. Section VI concludes.

II. WHAT ARE “NATIONAL VALUES”? THE PRESUMPTIONS OF THE INQUIRY

After all, values are held by persons, not by corporate entities that have neither minds nor desires. It is true that we may speak loosely of the “values of the common law,” or the “values of the Catholic church.” By such usage we mean to locate fundamental doctrines that emerge from the writings, or from the beliefs of the elite, within a certain tradition. But in general, “values” refers to subjective views of individuals about what is worthy or important. In politics, these are views about the ends that social institutions ought to advance, and the virtues they ought to embody.

One’s values are *general*; they do not dictate preferences for particular institutional structures at any level of detail (Rawls 1971). That one values privacy in health care need not lead one, for example, to endorse a particular set of detailed privacy rules (those contained in the new United States *Health Insurance Portability and Accountability Act of 1996* [HIPAA] regulations, say). It leads one only to prefer institutional arrangements that protect privacy over those that do not, and arrangements that protect privacy more over those that protect it less. One’s values also *compete with one another* (Berlin 1998). Efficiency, for example, may need to be sacrificed to favor participatory governance or *vice versa*. A strong commitment to equality may lead one to limit liberty to some extent. Multiple institutional arrangements may thus have equal claim to instantiating one’s values, by giving prominence to them differentially. Precision in statements about “national values” is thus doubly imperiled: such statements are necessarily a summation across a broad population of varied individuals’ – already general, and already potentially conflicting – values.

These cautionary observations should not, however, blind us to the important role that values may play in creating a political community and in guiding its actions. Statements of values may inspire, unite, even “constitute” a people: think of the Declaration of Independence and the Bill of Rights in the United States, or the Magna Carta in Britain. And public statements of shared values – even if the

values come to be shared only after they are publicly stated – may serve as important guides to action. The fact that values are general and may compete with one another does not, after all, render them meaningless. Values are no policy straitjacket, but there are certain choices they rule out.

In the context of the Medicare debate, Canada's core national values have been well expressed by Michael Ignatieff: "We [Canadians] think that public taxation should provide for health care and that it is wrong for decent medical care to depend on the size of our bank balances" (Ignatieff 2000). The five criteria mentioned in the *Canada Health Act* – public administration, comprehensiveness, universality, portability and accessibility – are themselves values, though perhaps narrower, more "instrumental" values, which give shape to the broad but fundamental public and egalitarian values expressed by Ignatieff. Since their articulation in the Hall Commission Report of 1964 and the *Canada Health Act* of 1984, the five criteria have gained widespread public support. (It is no coincidence that every contemporary report that calls for Medicare reform feels compelled to do so by alleging the consistency of their proposed reforms with the five criteria.) Our contention is that those five values, because they are general and may have to be traded off against one another, may be advanced by a number of different institutional arrangements. But we also claim that there are certain proposed reforms that they rule out.

Before attempting to substantiate this contention, however, we pause to distinguish values from a number of other important forces that shape public institutions. On the top of that list must be *interests*. Interests are states of affairs or courses of action that persons are motivated to pursue based on the powerful drive for self-aggrandizement (including self-aggrandizement's prerequisite, self-preservation) (Mansfield 1995, Hirschman 1992). Persons have multiple interests; these are calculable, predictable, objective, and – like values – can be traded off against one another (Mansfield 1995). Institutional arrangements that were created because they advanced shared values may survive because they further powerful interests. And institutions created from self-interested motives may well embody values, or serve to establish them in society over time (Immergut 1992).

Public opinion, too, can shape institutions.² Opinions are views,

²Equally, institutions can shape opinions (Immergut 1992).

prudential or ethical, about states of affairs or courses of action. These are notoriously more subject to short-term amendment than either values (which, because they are general, are less subject to amendment in light of short-term factual changes) or interests (which one can, in principle, objectively calculate). General opinions grounded in values ("Access to health care should be universal.") appear to be more "sticky" than opinions about particular states of affairs ("Medicare is working well.") (Maioni and Martin 2001).

Social institutions are also to some degree the products of the governmental and policymaking systems that create them, and those systems are, to use a difficult expression, value-informed. Thus centralist governments will more likely create centralized social welfare institutions; corporatist governments will more frequently create corporate entities whose bargains will determine the particular means of implementing social values. Here is a path by which societal values, by influencing styles of policymaking, may influence public policy. So, for example, Douglas and Wildavsky (1989) identify three distinguishable policymaking styles: *competitive individualism, hierarchical collectivism, and sectarianism*.

The social democratic states of Northern Europe have, according to this line of argument, strong traditions of hierarchical collectivism, with moderate support of individualistic norms and weak embrace of sectarian modes of policy promotion (Okma 2002). The United States, by contrast, displays a weaker appeal to collectivism and an active streak of sectarian political mobilization. Market efficiency and individual liberty are, according to polling studies, leading American values. Yet, as Douglas and Wildavsky acknowledge, it is a mistake to assume a very close fit between value-informed modes of policymaking and actual policy. Even the United States, with its seemingly dominant competitive-individualist values in policymaking, managed to enact Medicare, Medicaid, the Veterans Administration health program, the Indian [ie., Native American] Health system, law mandating emergency medical care regardless of patients' ability to pay, tax incentives to encourage the purchase of private insurance, tax incentives for the provision of private charity care, and publicly funded hospitals that give free or discounted care. No one could reason her way to this set of health care institutions and programs from a premise of "competitive individualism" in policymaking. And this is so even if one concedes the accuracy of the characterization of U.S. values. The concrete details of health policy,

in short, are not tightly linked even to styles of policymaking that reflect dominant value orientations.

Finally, social and political institutions, once created, develop lives of their own (Tuohy 1999). For example, the historically contingent fact that Britain's National Health Service (NHS) was created just after the Second World War made its centralized organization likely, and that has shaped much of its subsequent development (Klein 1995). In the United States, the postwar development of private health insurance markets (driven, partly, by employer tax benefits) has made it very difficult for government to assume as central a role in the delivery and financing of health care as it has in other developed countries. The constitutional model for Canada's Medicare required bargaining between provinces and the federal government. From the beginning, also, there was regular bargaining with medical associations. Those features have conditioned Canadian policymaking and further developments of Medicare have emerged to a large extent out of these institutional processes and rules of the Canadian "game" (Tuohy 1999).

In the next section, we will briefly characterize the range of reform proposals that have marked the Canadian political scene in recent years. Our purpose is not to evaluate any of these reports here; we and others have done that elsewhere. Rather, the aim is to set the Canadian context for the more concrete discussion of national values and health policy. In Section IV, we will consider some concrete evidence regarding the question whether and to what extent different countries may, on the basis of similar distributions of values, establish quite different national institutions of social welfare. We hope to show there that many of the core structural differences in national health care arrangements are the product not of differences in fundamental social values but of differences in political superstructure, of differing accommodations of clashing interests, and of the historically contingent "accidental logics" of established social institutions. This will substantiate the first portion of our core contention, that is, that national values are not a policy straitjacket. In Section V, we will turn to the second feature of our core contention: namely, that contemporary Canadian values neither call for a major change in Medicare nor do most of the reforms proposed require a change in values to be justified.

III. CALLS FOR REFORM IN CANADIAN HEALTH CARE:

Context and Convictions

We begin by describing very briefly some of the recent history of the Canadian Medicare program so as to set the context of the current pressures for (and against) major reform. We then characterize the ideological and value spectrum on which one might locate current proposals for reform. Our purpose here is not to evaluate the validity of any of these reports. Rather, it is to substantiate the importance of being clear about when values are and are not at stake in discussions of the case for Medicare “reform.”

While we do not believe this is a “crisis moment” for Canadian health care, it is important to understand why the call for reform is so alarmist and why so many Canadians believe the values Medicare embodies are at stake. Canadian public expenditure on health care, as with most industrial democracies, has faced great pressures in recent years. Economic stagnation, high levels of unemployment and rapidly increasing fiscal deficits in the 1970s and 1980s fuelled debates about the sustainability of welfare states everywhere (OECD 1992, 1994). Throughout the Western industrial world, politicians and commentators raised questions about the proper role of the state and the private market in providing for and safeguarding the welfare of individual citizens. In Canada, efforts to rein in national government spending included a freeze of federal transfers that, over time, caused a considerable shift away from federal funding to the provincial and territorial level. In the last few years – with the coming, significantly, of improved economic times – participants at every level of the Medicare program have been vocal about the losses suffered during the long period of fiscal belt tightening. The Canadian press has been filled with fearful anecdotes and talk about a “crisis” in Medicare (Marmor 2002). For all the crisis language, few if any reform proposals explicitly demand a radical transformation of Medicare on the basis of a clear rejection of the values it embodies. Indeed, the Canadian debate has thus far included little explicit discussion of radical alternatives to Medicare’s basic funding model. This contrasts with debates in the United Kingdom and the Netherlands, for example, where fundamental funding options have been extensively investigated (but not chosen).

Canadian reform proposals have nonetheless received enormous attention. They range from the imposing of prospective budgets on providers of care to de-listing certain services from public

health insurance. Some provinces promote the introduction of private funding, and many have celebrated improved management (Okma 2002). The 2001 CIHI report aptly concludes that the reform debates in fact call for “overlapping generations of reform” (CIHI 2001). As in other OECD countries, many of these proposals have met with strong resistance from various constituencies. And reform ideas have prompted counter-ideas. There are, for example, proposals to devolve authority and to further decentralize the governance of medical institutions. At the same time, there are demands to centralize and assume stronger government control— for example, in the monitoring of outcomes or the provision of information about health care services to the general public. But, as in other OECD countries and in spite of much discussion, the basic public contracting model of public funding and private provision of health care has not, it appears, been challenged explicitly (Ranade 1998; Tuohy 1999).

Do any of these proposals amount to a threat to Canadian national values? Is the adoption of any of them contingent upon Canadians’ changing their core values? Do the different reform proposals reflect fundamentally different values regarding the social provision of health care to the sick or injured, or are they in fact simply the products of different views about management and governance in service of shared values? To these questions we now turn.

Our approach is not to summarize the reports. Rather, it is to locate them on a value spectrum in connection with the purposes of our inquiry. Our presumption is this: Reports can embrace the values Medicare expresses yet still propose reforms of at least three sorts. One category reaffirms those values in the course of recommending incremental improvements, as does the report of the Tommy Douglas Institute of February 2001 (Rachlis *et al.* 2001). At the other end of the spectrum, there are reports that propose changes in Medicare that, regardless of the report’s professed attachment to Medicare’s values, are in fact incompatible with the egalitarian values the program now embodies. An example of that category, in our view, is the Mazankowski report of December 2001 (Mazankowski Commission 2001).

Between these points on the spectrum are many reports whose reform proposals are compatible with Medicare’s fundamental values, but raise very different issues of practical value, political acceptability or managerial feasibility. These range from the 1997 report of the National Forum on Health to the 2000 commentary of the Institute

for Research on Public Policies (National Forum on Health 1997, Decter *et al.* 2000). The Clair Commission in Quebec, for example, recommended many policy and managerial changes, none of which depended on changes in Canadian or Quebec values (Clair Commission 2001). In Ontario, a restructuring commission struggled to implement substantial reforms in the structure of the province's hospitals and provision of medical services. But, as with Quebec, this commission embraced Medicare's value premises while promoting policy reforms (Ontario Health Services Restructuring Commission 2000).

The Saskatchewan Commission on Medicare proposed a major reorganization of provincial hospital and medical services (Fyke Commission 2001). But, like most of the reports we have reviewed, its recommendations did not rest on either the claim that Canadian values had changed substantially or that changes in values were needed to support reform.

The two federal commissions currently investigating Medicare are both broad in scope and the object of considerable media and public interest. In 2000, Senator Kirby's Commission began its own two-year review of health care. Its interim report, issued in September, 2001, was a virtual catalogue of the various reform proposals (Kirby Committee 2001). It did not call for comprehensive change in Medicare, but suggested that the "public administration" feature needed revisiting and piecemeal alteration.

In early 2001, the Romanow Commission began its effort "to examine the state of health care in Canada including the benefits and negatives of the current system." It has a substantial mandate, has conducted extensive research and consultation, and has prompted intense media interest. Its interim report of February, 2002, prompted considerable debate, an indication of just how much interest Medicare arouses in Canadian life (Romanow Commission 2002).

Despite the rhetoric of crisis and the appeal to needed reforms, very few of the Canadian reform proposals explicitly challenge the fundamental values. This, itself, is an interesting and important feature of Medicare's place in Canada. The program is more than a vehicle for financing hospital and medical insurance. It is best understood as an icon. For this reason there is understandable political reluctance to challenge directly the program's premises. On the other hand, the iconic status of Medicare makes it perfectly clear why the

media – and Medicare’s advocates – are on the hunt for threats to this widely “valued” program.

None of these claims mean, however, that *all* the proposals for reform are with Medicare’s values, which is a topic to which we will return. It is true, we contend, that most of the proposals – calling for increased integration and improved co-ordination of services, greater oversight of costs, and so on – are efforts to improve Medicare managerially and keep its outlays under reasonable control. Most do not amount to a threat to Canadian values nor would their adoption be contingent upon Canadians changing the values they hold regarding medical care. Most, in short, reflect different views about management and governance, not fundamentally different values concerning the social provision of health care to the sick or injured. Others have debated the merits of these reports at length. Here, our aim has been to note how little explicit debate about “values” has taken place in these reviews of Medicare and how difficult it is to identify unambiguously the value differences that some of the proposals for change actually reveal. We have elsewhere discussed some of these reports in detail, but that is not our purpose in this report (Okma 2002). On the other hand, we agree with the conclusions of Lewis and Maxwell (2002) that, among the most prominent reform reports, the Mazankowski Commission’s proposals constitute a real (if veiled) effort to transform the values on which Canadian Medicare operates.

Having used the reform reports as context, we now turn to exploring the core question of the relationship between national values and national health policy. We will do so by first discussing the evidence from other industrial democracies and then by addressing Canadian data more directly.

IV. EUROPEAN VALUES AND MEDICAL CARE: Similar Values, Divergent Arrangements

A. Public Attitudes Towards Government’s Role in Health Care

Public attitudes towards “government provision” (or financing) of medical care in the European Union show, according to both recent and older research, “surprisingly constant patterns of popularity” (Ardigo 1995 and Coughlin 1980, *cited in* Gevers *et al.* 2000). On the basis of data from seven European countries and the United States, Ardigo concluded that “citizens considered good medical

care 'very important' and its provision an 'essential responsibility' of the government." Coughlin's earlier research had come to the same conclusion. On the surface, then, there are grounds for believing that the "Western European welfare state [can] be regarded as an organized system of solidarity" in the sense of redistribution from the healthy to the sick, from the young to the old, and from the employed to the unemployed (Gevers *et al.* 2000, 302). This is the standard interpretation of polling data from Western Europe and forms the background to more sophisticated investigations of variation in views and values among the European citizens.

Gevers *et al.* have produced detailed data on contemporary sentiments³ in Western Europe towards the provision and financing of medical care. Table 1 shows evidence about the degree of agreement concerning the role of government in *assuring access* to medical care. It clearly reveals general disagreement with the idea that government should play only a minimal role.

³We use the terms "sentiments" and "attitudes" as synonyms in this section. Both can be based upon (the more fundamental) values, perhaps in combination with factual understanding and emotional commitment.

Question 1	The government should provide everyone with only essential services such as care for serious diseases and encourage people to provide for themselves in other respects (1 = agree strongly, to 5 = disagree strongly) (Gevers <i>et al.</i> 2000).
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Table 1				
Distribution Measures for Question 1				
Country	Percent disagree completely	Mean	Standard deviation	Skewness
Austria	18.60	3.10	1.27	-0.10
Denmark	41.90	3.71	1.41	-0.70
Finland	23.30	3.28	1.38	-0.22
France	26.60	3.44	1.35	-0.45
Great Britain	44.90	3.98	1.21	-1.03
Greece	29.20	3.60	1.30	-0.67
Ireland	25.00	3.40	1.30	-0.32
Italy	41.90	3.44	1.54	-0.29
Netherlands	39.00	3.54	1.46	-0.44
Portugal	21.30	3.48	1.20	0.44
Spain	35.20	3.82	1.20	-0.84
Sweden	36.80	3.98	1.08	-1.06
West Germany	25.60	3.50	1.26	-0.47

But the proportion of those who “disagree completely” varies among the samples and provides some basis for the study’s emphasis on a dispersion of values and beliefs among the nations of the European Union. In short, solidarity might generally describe the bedrock of Western European welfare state values, but understandably there are bases for making distinctions among them as well.

This is particularly evident in the findings summarized in Table 2. The variations in respondents’ answers to the three articulated views show just how much difference there is between the less extensive welfare states of southern Europe and the more extensive social policy regimes of the rest of the European Union. There is an unmistakable difference in the degree of egalitarian sentiment between the south and the north of Europe, especially between Sweden and Denmark on the one hand and Portugal, Spain, Greece and Italy on the other. (The means do not show this clearly, but Gevers *et al.* give that interpretation to the standard deviation and skewness measures.)

We could comment more fully on these interpretations, but, for present purposes, this establishes two points central to our paper. First, it does indicate a broad similarity in the central, solidaristic conception of the role of medical care in the Western European welfare state. This general value orientation, however, exists side by side with substantial differences in the detailed administration, policies, and rules of European medical care arrangements. Second, the variation across Europe suggests that more egalitarian (and homogeneous) societies like Sweden and Denmark reveal links between views about equal access to medical care and programmatic

Question 2	Here are three opinions. Please tell me which one comes closest to your own? 1) The government has to ensure that health care is provided to all people residing legally here, irrespective of their income; 2) The government has to ensure that health care is provided only to those people residing legally here, with low income; 3) The government does not have to ensure that health care is provided to people residing legally here, not even those with low income (Gevers <i>et al.</i> 2000).
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Table 2
Distribution Measures for Question 2

Country	Percent choosing alternative 1	Mean	Standard deviation	Skewness
Denmark	86.50	2.86	0.38	2.52
West Germany	71.80	2.67	0.57	1.52
Greece	87.20	2.83	0.47	2.85
Italy	71.70	2.68	0.53	1.44
Spain	90.10	2.88	0.40	3.39
France	76.20	2.70	0.58	1.79
Ireland	58.90	2.55	0.58	0.84
Netherlands	77.70	2.75	0.50	1.84
Portugal	72.00	2.66	0.59	1.53
Great Britain	85.90	2.84	0.41	2.60
Finland	79.60	2.79	0.43	1.70
Sweden	94.80	2.94	0.27	4.87
Austria	65.00	2.59	0.61	1.18

arrangements that minimize the role of income in access or financing. The irony, from the standpoint of Canadian discussion, is that in recent years both Sweden and Denmark have experienced greater incremental policy changes than in Canada and have done so without dramatic shifts in values and attitudes, as opposed to fiscal conditions.

All the OECD countries, we have suggested, publicly express basic commitments to universal access to care and relatively equal treatment of similarly ill citizens. Their citizens, as we have noted, embrace such attitudes at a very general level. There is expressed concern that any care given be of high quality, even though there is little basis for believing that paying for care can ensure that care is appropriate. Leaders of these countries also voice concern about patient satisfaction; they call for some degree of choice of provider and typically acknowledge the importance of preserving physician autonomy in professional decisions (OECD 1992, 1994). (The operational definition of what would count as appropriate autonomy, satisfaction, or quality is far from settled, one must add, but the appeals to these values are real.) With public funds the largest single source of funding, cost control is a generally acknowledged goal as well. And, finally, there is implicit or explicit sponsorship in most of the OECD for health promotion and consumer safety. These are presented as worthy – or at least appealing – national policy goals. To what extent do these strikingly similar sets of expressed values result in similar social institutions for the delivery of health care?

B. Funding and Provision of Health Care in the OECD: Institutional Arrangement

The OECD provides a useful way to portray variations in arrangements for funding and contracting health care. In most if not all OECD countries, *public funding* sources (i.e., general taxation, earmarked taxation, social health insurance) are dominant compared to *out-of-pocket* spending or *private health insurance*. As to contracting, the OECD distinguishes three basic models. One is an *integrated system* in which – as is the case in Britain – the government handles both the funding and the provision of health care. The second is a *contracting model*, in which third-party payers negotiate agreements with independent providers. The third is a *reimbursement model*, in which patients pay their health care providers and then seek financial indemnification from their public or private insurers. According to

the OECD, the *public contracting model* has been on the rise in recent decades, combining collective funding with independent providers of care.

In the mid-1990s, the OECD summarized the systems in the following way:

Funding and Provision of Health Care in OECD Countries		
Country	Funding sources of health care	Provision of health care
Germany	Mix of public and private insurance	Mix of public and private providers
The Netherlands	Mix of public and private insurance	Mostly private providers
Denmark, Finland Greece, Iceland, Ireland, Norway, Portugal, Spain and Sweden	Mainly financed out of taxation	Mostly public providers
Australia, New Zealand	Taxation and private health insurance (in Australia)	Mixed public and private providers
Canada	Mainly taxation (and supplemental voluntary private insurance)	Mainly private providers
Switzerland	Mainly voluntary private insurance	Mainly private providers
United States	Mix of private insurance and public schemes (Medicare, Medicaid, and Veteran's Administration, Indian Health)	Mainly private providers

Source: OECD 1994.

What these portraits reveal is that, despite broad support for social solidarity in distributing and financing medical care, the OECD countries differ markedly in organizational features. They reflect a wide variety of legal forms of ownership and management, ranging from private for-profit firms and religious and charitable not-for-profit institutions to local or regional authorities providing community-based care. And some public financing arrangements cater to specific population groups, while others finance access to the entire population. How this developed over time is the subject of many studies. In the following part, we review some of these historical developments in order to show how very similar baseline values have expressed themselves in very different social welfare institutions.

Germany was first to introduce compulsory health insurance for low-income industrial workers in 1883 (Okma 2002). Denmark followed within a decade. Over the course of many decades, other European countries followed these examples. They developed mandatory social insurance schemes covering the risks of disability, sickness, old age and death. Some, including France, Belgium, the Netherlands (as well as Japan and Korea), imported the "Bismarckian" model of employment-related health insurance from Germany. In this model, legally independent and semi-autonomous bodies ("sick funds") administer social health insurance and negotiate contracts with providers of care. Other countries expanded coverage beyond the working class and introduced population-wide schemes funded out of general taxation; this was the example set by the British National Health Service (NHS) in 1948. In a few countries – for example, the United States, Germany and the Netherlands – access to social insurance is limited to specific population groups. In Germany, upper income people can opt out, and a group comprising about 10 percent of the population has actually done so. In the Netherlands, the compulsorily insured constitute 60 percent of the population. The remaining 40 percent has to take out private health insurance. In practice, 99 percent of the Dutch population has health insurance (Okma 1997). The United States has separate schemes for the older and disabled under social insurance principles, categories of low-income Americans under Medicaid, programs for veterans and those on Native American reservations. In addition to universal Medicare, Canada has special arrangements for veterans and the armed forces, inmates, and First Nation populations. Belgium, France and Japan expanded the sickness fund model to include the entire population. By the late 1990s, the main funding sources for health care in Europe and North America were general (earmarked) taxation and health insurance premiums, both public and private (OECD 1992, 1994).

In the Scandinavian countries, local and regional authorities have primary responsibility for funding and providing health care and related social services to their populations. They bear the financial risk of acute medical and nursing care and have developed extensive social services, which include home care, support for adjusted housing for elderly or handicapped persons, and support for independent living. In the United Kingdom, there is a clear split between the administration of the NHS covering the costs of medical care and the social services provided by local authorities. The Neth-

erlands (in 1988), Germany (in 1992) and Japan (in 1995) introduced separate population-wide social insurance covering the costs of long-term care and home care for their aging populations. In those three countries, the long-term care insurance serves as a supplement to the existing schemes for acute medical care. The three countries accept a mix of public and private providers in this field, and all three are experimenting with cash benefits allowing consumers to directly contract providers of care instead of services in kind. Policy and institutional variation across the OECD world, then, is undisputable.

C. Styles of Policymaking

The variation extends to styles of policymaking as well. The centralist policy processes of the United Kingdom and France sharply contrast with the functionally decentralized models of Germany, Belgium and the Netherlands (Klein 1995). In the latter three countries, the label of *neo-corporatism* is broadly applicable, a decision-making model where governments and private actors (represented through their interest organizations) share responsibility for the shaping and outcome of social policies (Wilson 1990). This model implies that private actors are willing and able to take on public responsibilities in the form of active participation in the policy process as well as self-regulation. For example, the representative organizations or interest associations of the German and Dutch hospitals and physicians represent their members in regional or countrywide negotiations with the health insurance agencies over tariffs and volume of their services. Medical associations are empowered with public authority to regulate access to the medical profession, to set standards for medical education and for professional conduct, and to police the professional conduct of all medical professionals (members and non-members alike) with rules and sanctions. The main administrative bodies of social health insurance, the sickness funds, are legally independent actors, and their organizations have collective bargaining power to contract health services on behalf of their insured. In some Western European countries, a large share (and in the Netherlands, the largest share) of health facilities has always been under private, non-governmental ownership and management.

The German corporatist model limits the role of the state in social arenas like housing and health care. Moreover, its federal state has shifted much of administrative responsibilities for its social

policies to the provinces or *Länder*. In this policymaking model, most if not all organized interests meet with government in the annual round of consultation, the Concerted Action or *Konzertierte Aktion*, to decide on spending levels and the broad allocation of public funding for health care. After establishing this financial framework, regional representatives of health insurers and providers negotiate contracts with detailed and binding agreements on the volumes and prices of health services.

Germany's neighbor Holland has copied many of the features of this model. Until the 1980s, Netherlands social policy process provided "a striking model of corporatist arrangements," with private agencies empowered with public authority (Freddi 1989). These institutions were not only set up along functional lines, but also based on religious denominations. After mounting criticism of this model in the 1970s and 1980s, successive Dutch governments took steps to reduce, and in some cases, dismantle this model of "*consociational corporatism*" (Baakman, Van der Made and Mur-Veeman 1989; Okma 1997). While Germany and Belgium kept most of their corporatist structures intact, the Netherlands eliminated the direct representation of organized stakeholders in shaping social policies in an effort to streamline and speed up decision-making procedures. By the end of the 1990s, the main interest groups had lost their direct representation in the advisory and administrative bodies in social policies.

In contrast to such decentralized policy models, France and the United Kingdom largely maintained their tradition of central state dominance. Under the French *étatisme*, interest groups have not developed a strong role as participants in social policymaking. The medical associations are fragmented and show little inclination to collaborate with each other or with government. In contrast, the British Medical Association has had a significant (if now diminished) role in health policies. In the 1940s, it accepted the formation of the National Health Service (NHS), effectively nationalizing most hospitals, and in the 1990s, the creation of primary care groups (effectively terminating the self-employed status of general practitioners). Yet, British physicians have retained considerable professional autonomy and strong influence in the management of health care institutions (Klein 1995).

In habits of governance, then, developed democracies have established very different public institutions on the basis of quite similar national values. A tradition of statism will promote values

through institutions governed by a central authority. A tradition of neo-corporatism will promote similar values as the outcome of a more-or-less structured bargaining game played among organized stakeholders, of whom only one is the government. On the other hand, decisions about whether values are to be advanced by central authorities or by a contest among individuals or sectors – or primarily by the public or by the private purse – are obviously not neutral. The shape of social institutions – even when promoting very similar values – can nonetheless make particular values easier or harder to maintain or enhance.

D. Interest Bargaining

In addition to the ways in which different habits of governance affect the embodiment of values in public institutions, the play of interests among parties has considerable impact as well. In social policies, governments confront a large number of interested *stakeholders* (Sabatier *et al.* 1993; Pross 1986; and Alford 1974). There are provincial, regional and local governments and semi-autonomous governmental agencies; labor unions and private business associations; consumer advocacy groups, public interest groups, and many others. In most industrialized countries, the funding and provision of public services like housing, education and health care are not a governmental matter alone. Governments depend on others to make public systems work. The health policy arena is crowded with many stakeholders and well-organized interests affecting the shaping and outcome of government policies (Okma 1997). Governments have to deal with such competing interests and stakeholders that often have strong veto powers. It is not easy to replace existing arrangements with new ones.

V. CANADIAN VALUES AND MEDICARE ARRANGEMENTS

In section III of this paper, we noted that nearly all of the recent reports on Canadian Medicare support the five basic principles of the *Canada Health Act* (*universality, accessibility, comprehensiveness, portability, and public administration*). Several polls conducted in the 1980s and 1990s also demonstrated strong public support of those principles, even as general confidence in government has declined. In the late 1980s, one poll reported a more general erosion of the public confidence in the state (Graves 1988). The Graves study concluded

that public institutions in the industrialized world were facing a legitimacy crisis. Interestingly, Canadians did not share a categorical, negative judgement of government. But they expressed the wish to strengthen the public institutions. In explaining those results, the survey found evidence that the media played a role in fueling cynicism about all major public institutions.

Polling data from the 1980s and 1990s showed that Canadian support for the CHA's principles remained quite high (HayGroup 1999; Maioni and Martin 2001; and *Hospital Quarterly* 2000). Though public support for "public administration" fell significantly during the 1990s, a commanding 59 percent continued to regard that principle as "very important," with additional respondents regarding it as "important." Higher percentages rated "universality" (89), "accessibility" (81), "portability" (79) and "comprehensiveness" (80) as "very important." Despite concerns about the future of Medicare, Canadians express high satisfaction with the services they actually received (Picard 2000). (This finding, incidentally, is consistent with that in other industrial democracies.) About one-third of those Canadians polled feel that Medicare needs major reform. But over 44 percent think that minor changes will do.

Some studies, however, emphasized problems, not principled support for Medicare. For example, the HayGroup study found widespread concern about waiting lists, lack of access to medical services and waste, and concluded that "Canadians are ready for reform" (Conference Board of Canada 2001). The Conference Board reported declining confidence in Medicare. It concluded that Canadians believe their health care system has deteriorated even while they still are committed to the principles of the *Canada Health Act* and the values they embody.

In short, there seems to be overwhelming, continuing support, both among policymakers and among Canadians at large, for the baseline values of the Medicare program. At the same time, concern about Medicare is widespread. And, beyond that, the reports we have reviewed draw quite different portraits of what needs to be done. Some, we noted, argue that because of the continuing popular support for Medicare's principles the program requires nothing but marginal adjustments. Others – like those of the Conference Board, the Mazankowski Commission, and the HayGroup – claim there is an urgent need for more fundamental changes in how Medicare operates.

Importantly, the appeal to general principles provides little guidance as to how to frame actual policy options or design concrete programs. For example, the above-mentioned HayGroup study reports widespread support for a national home care and pharmaceutical program but stops short of recommendations for the actual form of such programs. Nor do the reports pay much attention to the conditions that promote change or stability.

Yet even within Canada, as Carolyn Tuohy (1999) has shown, the play of historical contingency with political intrigue has yielded different social institutions and different approaches to health care reform. Quebec, with its French-influenced and comparatively “statist” political culture, is of course a special case. It came early to banning physician over-billing, and to placing global caps on medical billings. In Quebec also, negotiations between the medical profession and the province are more or less permanent and ongoing, marked by a concern for sharing and acting upon expert information. In British Columbia, in contrast, such negotiations are periodic and highly adversarial, marked by the use of confrontational tactics common in collective bargaining. Ontario physicians resisted the *Canada Health Act*’s ban on extra billing even to the point of engaging in a strike during the 1980s; no comparable resistance arose elsewhere at that time. In contrast to British Columbia, Ontario, Alberta and Manitoba, the working relationships between the medical societies and the Atlantic provinces and Saskatchewan have been less formal and substantially less confrontational. In short, cross-province and cross-time evidence from Canada supports the proposition that the link between operational policies and underlying programmatic values is relatively loose, but not without constraints. That latter lesson Canadians learned in the struggle over extra-billing in the prelude to the *Canada Health Act* of 1984. The values expressed by the five operating principles of Medicare – presented in the 1960s and reasserted in the *Canada Health Act* of 1984 – have in large measure arisen from Medicare’s performance, not its origins. None of the major studies of the origins of Medicare, whether the hospital insurance program of the late 1950s or the medical insurance program promoted by the Hall Commission, have concluded that the overwhelming support for the egalitarian values of the Medicare program preceded the passage of national health insurance legislation (Taylor 1987). Instead, the story is one of strengthened commitment to these values as Canadians discovered in disputes what was at

stake. And, most important for comparative purposes, Medicare is more restrictive than any other OECD country in restricting the role of private payment and private insurance in gaining differential access to care (Marmor, Mashaw and Harvey, 1990).

VI. CONCLUSION

Data from OECD countries, as well as evidence from Canadian debates about Medicare, support our major claim that national values and program structure and practices in medical care are loosely associated. A substantial variety of institutional forms and policy practices have developed that have appeared consistent with broadly shared social values. Values may serve as the foundation for social programs, we have argued in reviewing the experience of largely Western European democracies, but they do not supply those programs' architecture. Differences in social institutions are reflective not only of fundamentally different ideological positions, but of subtle historical (and contingent) differences in those programs' initial construction, and in the subsequent play of political and social interests.

It is not surprising that calls for Canadian Medicare reform arose in the 1990s, at a time of relative economic prosperity, when a long period of health care belt tightening seemed to be coming to an end. It is to the political advantage of every interest group to attempt to secure a larger share of public financial resources by stressing the sacrifices it has made and the fiscal challenges it faces. "Crisis talk" – allegations to the effect that these times are extraordinary, and extraordinarily dangerous – is in fact a quite ordinary tool of interest-group politics. Canadian policymakers have thus far resisted the temptation to allow an unwarranted fear of collapse, or an unwarranted allegation of "abandonment of Canadian values," to guide their deliberations. By every indication we reviewed, Canadian Medicare stands firm on its foundations of still-shared Canadian national values. The question for Medicare reformers, we suggest, is not whether to abandon or re-think those values. It is, instead, how best to embody those values in 21st century institutions. That question requires, for its answer, a prudent attention to the ground-level political and economic realities of Canada, and a prudent review of the health care managerial and financing arrangements that have been tried, for better or for worse, in other nations. That is not to claim, as we emphasized throughout the report, that Medicare's

values are consistent with just any prudential or managerial adjustment. The program's iconic status assures attention to the issue. And there is little doubt that some of the suggestions for "reforming" Medicare are actually threats to its continuation and do express values inconsistent with the values that Medicare's fundamental principles express. Most Canadians do not believe that access to medical care should depend on the size of their bank accounts. That, we say in conclusion, is a fundamental value, and there are some prominent Canadians who do not share it and yet will not explicitly say so. Clarity in this topic is, we suggest, hard to find and to maintain.

ACRONYMS

CHA	Canada Health Act
CHIP	U.S. Childrens Health Insurance Program
CIHI	Canadian Institute for Health Information
COBRA	U.S. Consolidated Omnibus Budget Reconciliation Act, 1986
ERs	hospital emergency rooms
HIPAA	U.S. Health Insurance Portability and Accountability Act. 1996
NHS	U.K. National Health Service
OECD	Organization for Economic Cooperation and Development

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