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Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform

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This article examines the recent pattern and progress of health care reform in affluent democracies, focusing in particular on Britain, Canada, Germany, the Netherlands and the United States. Its main contention is that efforts to reform health care in advanced industrial states have been marked by a paradoxical pattern of 'reform without change and change without reform', in which large-scale structural reforms have had surprisingly modest effects yet major ground-level shifts have, nonetheless, frequently occurred as a result of decentralized adjustments to cost control. The main task of the article is to investigate the reasons for and effects of this puzzling pattern by plumbing the largely unexplored theoretical territory between comparative health policy analysis and cross-national research on the welfare state. Along the way, the article develops a simple model of the politics of reform that helps explain cross-national variation in legislative and policy outcomes – particularly outcomes that occur through decentralized processes of internal policy 'conversion' and policy 'drift', rather than through formal legislative reform. It also takes up a number of other intriguing issues raised by recent trends: why, for example, market reforms are clustered in centralized political and medical frameworks; why these reforms have generally enhanced state authority rather than market autonomy; why, despite fragmentation, decentralized political and medical systems shifted towards an expanded government role; and why significant retrenchment of the public–private structure of health benefits occurred in the United States.

Over the past two decades, structural reform of national health policies has dominated the political agendas of advanced industrial states as never before. Yet students of the welfare state – who have intensively examined the post-1970s development of other prominent realms of social policy – have devoted surprisingly little attention to these crucial disputes, leaving the field almost entirely to health policy specialists. This is unfortunate, for the recent progress of health care reform raises important puzzles not just about health policy, but about the politics and future of the welfare state more generally.

The puzzle at the heart of this article is a paradoxical pattern of policy development that I describe as 'reform without change and change without reform'. Government-initiated structural health reforms, I argue, have not produced much in the way of dramatic upheavals, much less movement towards a common market-based model. And yet major health policy shifts do in fact seem to be taking place within mature medical complexes – and, in some important cases, exposing citizens to significant new costs and risks.

This paradoxical pattern, I suggest, is rooted in the interplay of political decision procedures and the structure of the medical sector in a climate of budgetary austerity. Governments that enjoy consolidated authority have sometimes found it possible to enact major reforms. Yet they have had surprisingly little success in refashioning the highly hierarchical and embedded medical structures that centralized governance tends to foster.

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Conversely, in more decentralized political structures, rapid or decisive structural policy change has proved far more elusive. Yet even when political processes foster stalemate, consequential ground-level shifts may still take place through decentralized processes of adjustment *within* existing policy arrangements. As a result, many of the most notable policy changes of recent years have resulted not from formal reforms, but from the long-term working out of cost pressures in medical complexes that provide very different leeway for decentralized adaptations – a process that has created privatization at the margins in universal public systems but significant regress in the United States. The character and effect of these adaptations, however, vary markedly across different systems, both in their aggregate terms and in their implications for the distribution of the burdens of cost control among citizens.

To buttress this claim, I rely on two sorts of evidence. The first is basic cross-national statistics on health spending and the characteristics of medical financing. The second is a more detailed investigation of recent policy developments in five nations: Britain, Canada, Germany, the Netherlands and the United States. These nations all devote a large share of gross domestic product (GDP) to health care. They represent a wide range of medical financing arrangements. And they have all faced considerable cost pressures in the past two decades. Perhaps most importantly, they have had varying success in enacting comprehensive reforms, and the changes that have taken place in their medical financing structures have differed markedly. Finally, these cases each represent one of the four mixes of political authority and medical financing that form the backbone of my examination of the varied dynamics of structural reform: (1) centralized political decision making coupled with centralized medical financing (Britain), (2) centralized decision making coupled with decentralized financing (the Netherlands), (3) decentralized decision making coupled with decentralized financing (Germany and the United States), and (4) decentralized decision making coupled with centralized financing (Canada).

The article begins by exploring the roots and character of the fundamental differences in these nations' policies. It then examines the common pressures to control costs that all these countries have faced. Next, the article considers the politics of structural reform, outlining a simple framework for explaining the varied course of policy developments across nations that emphasizes the interaction between structures of governing authority, on the one hand, and structures of medical financing, on the other. This framework in turn provides an analytic lens through which I consider when, why and how political and market actors alter the major institutions of the modern health care state.

UNDERSTANDING AND EXPLAINING HEALTH POLICY VARIATION

Discussions of health policy usually bog down quickly in the sheer complexity of the field. A recent text, for example, identifies '11 structural "parameters" or "dimensions" along which the systems of various countries differ'.[1] The Organization for Economic Cooperation and Development (OECD) adopts a comparatively parsimonious scheme, which involves just two key dimensions and eight distinct types, although these types are then divided across three more continua.[2] As Joseph White argues, however, this baffling

[1] Francis D. Powell and Albert F. Wessen, eds, *Health Care Systems in Transition: An International Perspective* (Thousand Oaks, Calif.: Sage Publications, 1999), p. 12.

[2] Organization for Economic Cooperation and Development, *The Reform of Health Systems: A Review of Seventeen OECD Countries* (Paris: OECD, 1994).

diversity masks substantial similarity across rich democracies' health programmes, virtually all of which share two bedrock characteristics: they cover all citizens, and they employ measures to contain costs at a high level of aggregation.[3] Against this 'international standard', only the United States looks like a conspicuous outlier, its public programmes covering less than half the population, its overall spending largely unconstrained.

Among nations that uphold the international standard, the usual distinction is between a 'national health service' and 'national health insurance'. But this division is much less pure than supposed. The British National Health Service (NHS) and Canadian national health insurance are in key ways more alike than different, and both are quite distinct from Germany's system of non-profit sickness funds, which is also classified as national health insurance. To capture the similarities, it is helpful to note that both are *single-payer* systems, in which the government (in the Canadian case, the provincial governments) pays for services directly. Germany and most other Continental European nations, by contrast, have *multi-payer* systems based on insurance funds that pay for care within a public regulatory framework. What distinguishes the British and Canadian systems is not so much financing arrangements as the ownership of medical facilities, which are mostly public in Britain and mostly private in Canada.

As Figure 1 shows, then, national health programmes divide fairly neatly across two axes: the number of payers and ownership of facilities. Three of the four resulting combinations capture the most common system types: a prototypical *national health service* (single payer/public ownership), Canadian-style *national health insurance* (single payer/mixed ownership), and German-style *corporatist health insurance* (multiple payer/mixed ownership).[4] Several other distinctions are closely associated with these two axes. Single-payer systems tend to rely heavily on general tax revenues, whereas multi-payer systems generally employ payroll-tax financing. Systems with public ownership of medical facilities usually pay doctors at least partly on a salaried or per-patient basis, whereas fee-for-service payment is the norm when ownership is mixed. In public-ownership systems, too, a significantly larger share of spending is usually governmental than in mixed-ownership systems. Finally, multi-payer systems generally create the greatest diversity of coverage across citizens and, in some cases, even exclude from statutory protection wealthier citizens, who are expected to buy into the public system or insure themselves.

Why do the structures, if not the goals, of national health policies differ so starkly? One obvious reason is that political parties have differed historically on the proper role of government in medical care. In cross-national research, a well-supported finding is that rule by parties of the left, particularly during the formative years of welfare state development, is associated with more expansive and generous social programmes.[5] Leftist rule is certainly not a necessary condition for universal health care, as it has been adopted under governments of varying partisan stripes. But it does appear strongly associated with the establishment of national health services and, more generally, with a diminished role

[3] Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* (Washington, D.C.: The Brookings Institution, 1995).

[4] The fourth logical combination – multiple payer/public ownership – has no clear exemplars, though some corporatist systems rely more heavily on public ownership than others.

[5] See Evelyne Huber and John Stephens, *Development and Crisis of the Welfare State: Parties and Politics in Global Markets* (Chicago: University of Chicago Press, 2001). Using Huber and Stephens's dataset (http://www.lisproject.org/publications/welfaredata) and OECD expenditure data, the correlation between 1945–75 cumulative left-party governance and the 1975 private share of health spending is -0.58.

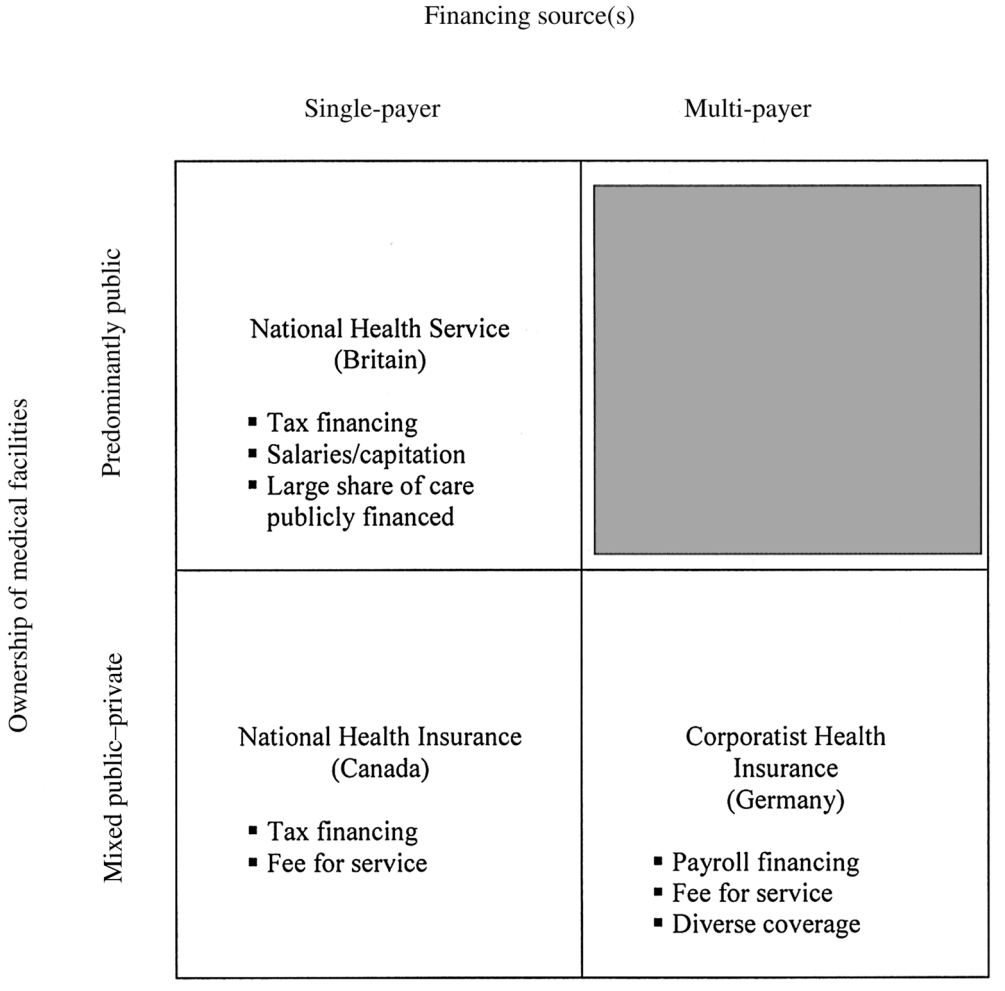

Fig. 1. Major types of medical systems

for private insurance and direct consumer payments, which the left has long viewed as inegalitarian.[6]

The scope for political leaders to achieve their favoured goals is heavily constrained, however, by the structure of political institutions, particularly the opportunities for blocking activity that institutions create for powerful opponents of national health programmes like the medical profession. As Ellen Immergut has convincingly argued, opponents of large-scale government entry into the health field have generally been advantaged when a polity has a large number of 'veto points', such as federalism and a separation of powers between the executive and legislature.[7] This no doubt helps explain why no federal state has adopted a national health service; why across nations the share

[6] In the OECD, only Italy's national health service was not enacted under social-democratic rule.

[7] Ellen Immergut, *Health Politics: Interests and Institutions in Western Europe* (New York: Cambridge University Press, 1992).

of medical spending financed by government is strongly correlated with the number of institutional veto points; and why Switzerland, with its strong federalism and tradition of the use of popular referendums by organized groups, has long been characterized by the most anemic government role in health policy of all European nations. It is also consistent with the fact that the United States, which has the most veto-point-ridden polity of any rich democracy, remains the only advanced industrial state that does not have a broad framework of public coverage or cost containment and the only one that relies principally on voluntary employment-based coverage.

Still, with the exception of the United States, all advanced industrial democracies have adopted some version of the international standard. This suggests that institutional barriers are better at slowing than halting government's entry into the medical field. The timing and sequence of policy interventions, however, may be highly consequential for the *form* that national health policies ultimately take. Most countries began to intrude into the doctor–patient relationship by subsidizing non-governmental insurers, rather than financing services. These policies created important vested interests in a pluralist financing structure and reinforced doctors' preferences for fee-for-service payment. How extensive and long-lived these arrangements were thus had crucial effects on the types of systems countries ended up with.[8] Countries in which authoritative government action to consolidate or supplant non-governmental insurance took longer to achieve generally ended up with more decentralized and costly health financing systems in which private insurance and finance played a more pivotal role – in part because delay allowed the formation and enrichment of a formidable collection of private stakeholders, and in part because sophisticated private care represents such a massive burden for government budgets to assume.

This is a paradigm example of *path dependence*, temporal processes in which early choices create self-reinforcing effects that are inherently difficult to reverse.[9] The United States, again, represents an extreme case: private insurance has, in effect, come to play the role that public programmes do elsewhere, and this role has proved as difficult to dislodge as the public foundations of mature welfare states.[10] Such path-dependent effects are an important reason why analysis of the contemporary politics of health reform must take seriously the constraints created by existing structures of medical finance. Even when facing similar strains, governments differ greatly in the particular challenges and demands that they confront and the particular policy tools they have at their disposal, quite apart from the institutional constraints that electoral and decision-making systems create.

STRAINS FACING MATURE MEDICAL COMPLEXES

Regardless of their structure, national health policies all came under severe pressure in the 1980s.[11] The reasons for this shift were both economic and political. In the economic realm,

[8] Jacob S. Hacker, 'The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy', *Studies in American Political Development*, 12 (1998), 57–130.

[9] Paul Pierson, 'Increasing Returns, Path Dependence, and the Study of Politics', *American Political Science Review*, 94 (2000), 251–67.

[10] Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2002).

[11] Paul Pierson, 'Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies', in Paul Pierson, ed., *The New Politics of the Welfare State* (New York: Oxford University Press, 2001), pp. 410–56.

the 1970s ushered in a marked decline in rates of economic growth. In the political realm, the period saw the emergence of anti-welfare state political movements, symbolized by the ascendance of Margaret Thatcher in Britain and Ronald Reagan in the United States. The effect of these linked developments was exacerbated by strains emerging out of welfare states themselves: in many nations, core programmes had grown to the point where avenues for further expansion were limited and the opportunity cost of pursuing them high. Caught between enduring support for the welfare state and the fiscal demands posed by these new realities, politicians everywhere faced hard choices, and many countries ran large deficits to elide tough trade-offs.

As the second most expensive area of the welfare state behind public pension programmes, health care was scarcely immune from these pressures. Indeed, while public pensions often presented the greater long-term fiscal threat, the rapid inflation of health spending was usually the largest and most immediate source of budgetary strain for countries facing up to the new fiscal order. In one sense, this was nothing new – and had more to do with the distinctive economics of medical care than with the particularities of welfare states. For as long as health spending has been recorded, it has tended to grow at a faster rate than general prices.[12] But the persistent problem of 'excess' medical inflation caused by technological change and weakly checked demand suddenly took on new and pressing urgency in the straitened fiscal circumstances of the period.

Moreover, nearly all nations (again, with the conspicuous exception of the United States) entered this harsh new era with public programmes in place covering all or most citizens. Not only, then, was access no longer the central rallying cry, but the cost of medicine had in most nations been effectively socialized. This is evident in the remarkably high average share of total medical spending borne by OECD governments in 1980 – some 80 per cent, excluding the United States. Although health costs are ultimately borne by society regardless of the source of financing, it makes a profound *political* difference whether they are financed by government or the private sector. An old adage of health policy is that every dollar spent on medical care is a dollar of somebody's income. In the 1980s, leaders came to face another unpleasant truth: every dollar spent by government on medical care is a dollar that cannot be spent on other ends (or, in systems financed by mandatory workplace contributions, a dollar that crowds out other possible uses of payroll taxes and risks distorting labour markets).

Many commentators have argued that 'globalization' created an additional heavy burden on welfare states in the 1980s and 1990s. As a wave of studies has demonstrated, however, the effects of increasing economic integration pale in comparison to the internal strains that welfare states have faced, and even these real but surprisingly modest effects have themselves been highly mediated by domestic political and economic institutions.[13]

[12] This is so for least three reasons. First, in some highly labour-intensive and low-technology areas (such as nursing), medical care presents a classic example of William Baumol's 'cost disease of personal services', wherein low productivity growth leads to rapidly rising costs relative to high-productivity sectors of the economy. In many areas of health care, however, a second cause of high inflation dominates: increasing technological sophistication. Thirdly, and finally, key features of the medical market – particularly uncertainty and risk aversion – empower agents with an interest in higher spending (that is, doctors) and encourage reliance on third-party insurance, which blunts the price signals that, in other sectors, help restrain inflation.

[13] See, for example, Geoffrey Garret, *Partisan Politics in the Global Economy* (New York: Cambridge University Press, 1998); Duane Swank, *Global Capital, Political Institutions, and Policy Change in Developed Welfare States* (New York: Cambridge University Press, 2002); and Pierson, ed., *The New Politics of the Welfare State*.

All this seems particularly true in the health care sector, where fiscal strains are largely caused by persistently high medical inflation. Global competition may well have provided a rationale for assaults on national health programmes. But the distinctive sources of cost pressure in health care and the internally generated fiscal strains that all social programmes faced are sufficient to explain why control of health spending became a paramount issue in the 1980s.

By the early 1980s, then, health care cost containment was a leading item on the political agenda of all advanced industrial democracies and old political deals came under newly intense strain. In the past, rapid growth had facilitated a generous framework of accommodation with medical providers, in which tight control over fees was traded off against decreased professional resistance to the socialization of finance. In the 1970s and 1980s, this bargain was called into doubt. Rather than 'states and interests' in uneasy co-operation, the pattern became 'states versus interests' in the struggle to control costs.[14]

As Table 1 suggests, the result was a remarkable reversal of past spending trends – one that carries surprisingly few simple messages about the effectiveness of different types of medical systems in controlling costs. Indeed, the most striking feature of the comparison between 1960–80 spending growth and 1980–2000 growth is the universality of decline. Only Canada comes close to bucking the trend. Among OECD nations as a whole, the percentage increase in health spending as a share of GDP in the second period is roughly a quarter of what it was in the first. Two OECD nations, Sweden and Denmark, actually experienced a decline in health spending as a share of GDP, and a number of countries saw negligible increases. In the light of past trends, as well as the general impression that health costs are inherently 'uncontrollable', this unambiguous and sustained response bears emphasis.

How it is that countries once deemed incapable of overcoming perennial institutional blockages suddenly found vast new reservoirs of power to rein in costs? The statistical literature on health spending does not provide much guidance on this question. After controlling for per capita GDP, long known to be the most powerful predictor of national spending, most studies find a limited role for government policy in explaining variations in expenditures across nations.[15] These studies do call into question some common assumptions – for example, that population ageing is a prime cause of higher spending (based on cross-national analyses, it is not) – but their main message is that the effect of per capita GDP washes out nearly all other influences. What these studies do not do, however, is explain the apparent structural shift in the spending–GDP relationship around 1980. Why did spending grow so much slower relative to the economy after 1980 than before?

The most easily identified reason is a major decline in professional power. If one were to cast the development of national health programmes as an epic drama, the key actors would be the medical profession and the state. In all industrialized nations, including the United States, doctors ultimately lost the war – government insurance of some sort came into being – but in all, professional self-regulation and generous payment were the price paid to ensure doctors' submission to state power. By the 1980s, however, political and business leaders had almost universally come to see the cost of this concordat as too high.

[14] David Wilsford, 'States Facing Interests: Struggles over Health Care Policy in Advanced Industrial Democracies', *Journal of Health Politics, Policy, and Law*, 20 (1995), 571–613.

[15] See the review of cross-national spending studies in Uwe Reinhardt, Peter S. Hussey and Gerard F. Anderson, 'Cross-National Comparisons of Health Systems Using OECD Data, 1999', *Health Affairs*, 21 (2002), 169–81.

TABLE 1 *Health Spending in Selected OECD Countries, 1960–2000*

	Total health spending as share of GDP, 2000 (%)	Percentage change in share of GDP devoted to health spending, 1960–80 (%)	Percentage change in share of GDP devoted to health spending, 1980–2000 (%)	Public medical spending as share of total health spending, 1980 (%)	Public medical spending as share of total health spending, 2000 (%)	Percentage-point change in public share, 1980–2000 (%)
Australia	8.9%	70.7%	27.1%	63.0%	68.9%	+ 5.9
Austria	7.7	76.7	1.3	68.8	69.4	+ 0.6
Belgium	8.6		34.4		72.1	
Canada	9.2	31.5	29.6	75.6	70.9	− 4.7
Denmark	8.3		− 8.8	87.8	82.5	− 5.3
Finland	6.7	68.4	4.7	79.0	75.1	− 3.9
France	9.3				75.8	
Germany	10.6		21.8	78.7	75.0	− 3.7
Iceland	9.3	106.7	50.0	88.2	83.7	− 4.5
Italy	8.2				73.4	
Japan	7.7	113.3	20.3	71.3	77.7	+ 6.4
Netherlands	8.6		14.7	69.4	63.4	− 6.0
New Zealand	8.0		35.6	88.0	78.0	− 10.0
Norway	7.6	137.9	10.1	85.1	85.2	+ 0.1
Spain	7.5	260.0	38.9	79.9	71.7	− 8.2
Sweden	8.4		− 4.5	92.5	85.0	− 7.5
Switzerland	10.7	55.1	40.8		55.6	
United Kingdom	7.3	43.6	30.4	89.4	80.9	− 8.5
United States	13.1	74.0	50.6	41.5	44.2	+ 2.7
OECD Mean*	8.7	94.4	23.3	77.2	73.1	− 4.1

* Excluding Turkey, Ireland, Portugal, Greece and Luxembourg, as well as the five most recent additions to the OECD: Poland, Hungary, Korea, Mexico and the Czech Republic.
Source: Organization for Economic Cooperation and Development, *OECD Health Data 2003* (Paris: OECD, 2003).

Stewards of public and private benefits increasingly conceived of themselves as 'payers', rather than guarantors; and, as payers, their goal was to control what was paid.

Although national embodiments of this shift were distinctive, its general direction was consistent and its cumulative results profound. In Britain, Thatcher waged a relentless assault on the British Medical Association's traditional consultative role. In Germany and the Netherlands, successive legislative changes strengthened the sickness funds against the providers and forced doctors to work within increasingly tight limits. In Canada, where the collegial model of professional self-regulation had reigned supreme, the provinces moved to cap total spending on physician services. Even amid the antigovernment 1980s, the US Medicare programme adopted new fee controls. And, of course, American physicians saw their power wane even further in the 1990s, as health plans contracted selectively with providers, micromanaged doctors' decisions and bargained-down fees.

The decline of professional influence is, however, only one manifestation of a broader move by public authorities to slow the growth of medical spending via new regulatory and budgetary controls. Even a cursory review of the legislative changes listed in Table 2 conveys both the frequency and increasing stringency of these measures. Medical cost control has followed a ratchet-like pattern quite different from the zigzag of change and reversal seen in some other areas of health policy. New state capacities for cost control, once in place, tend to remain in place and, indeed, grow tighter and more comprehensive over time. Thus authorities in Canada, Germany and the Netherlands introduced or strengthened fee controls for physician services, set or tightened budget ceilings for hospitals, and attempted to put in place relatively fixed budgets for specific sectors or areas of health spending. The British National Health Service (NHS), financed as it is by general tax revenues, has long worked within an overall budget constraint, but the NHS budget was tightened in the early 1980s and new fiscal procedures established in the early 1990s heightened the visibility of trade-offs across policy priorities and between taxes and spending. In the United States, not only the two largest public health insurance programmes – Medicare and Medicaid – but also private health plans moved to rein in provider fees. For reasons to be discussed, however, US gravitation towards the 'international standard' in cost containment yielded decidedly mixed results. Still, the overarching movement across the five nations was towards increasingly stringent controls.

There is no need to postulate some independent 'reason of state' for this tendency, although the strong autonomy of states in the face of provider resistance is worth remarking on. Rather, cost-containment efforts followed an eminently political logic in their genesis and character. The underlying imperative was to restrain government health spending so as to minimize restrictions on other prized areas of public finance and avoid politically explosive tax increases. Notable here are the German and Dutch experiences, where rapidly rising payroll taxes became the key focal point of cost-control efforts. Given widespread cries by employers that payroll taxes stunted job growth, it was arguably as politically risky for leaders in these nations to avoid tackling medical inflation as it was for them to take on providers.

The specific character of cost-containment efforts also had roots in political incentives. It is striking when one reviews the catalogue of diverse cost-control measures employed within public programmes how few directly imposed new consumer costs or explicitly reduced the scope of benefits. This is not to say that consumer spending on private insurance and services has not increased, nor is it to deny that there are increasingly important areas of care that fall outside the scope of public protection. As the next section will emphasize, these forms of policy change are crucial. Yet these changes are for the most

TABLE 2 *Significant Legislative Changes in Health Policy in Five Nations, 1980–2000*

Britain
• Series of modest reorganizations accompany a tightened National Health Service budget (1980–89). • NHS and Community Care Act 1990 emerges from 1989 White Paper; it envisions the creation of new purchasing agents to contract with hospitals and the authorization of general practitioner (GP) 'fundholding' under which GPs would be given budgets to purchase secondary services. • 1997 White Paper of Labour government proposes the abolition of 'internal market' but the proposed changes retain purchaser–provider split and expand GP fundholding, key elements of 1990 reform. • Labour leadership commits itself to reaching spending parity with Continental Europe.
Canada
• Canada Health Act (1984) tightens federal standards for provincial programmes, limiting role of private finance. Reaffirmed through federal actions in mid-1990s. • Dramatic long-term decline of federal transfers to support provincial programmes under Progressive Conservatives (1983–93). • 1997 Report of National Forum on Health Care, a creation of federal Liberal government, endorses existing structure and calls for some expansions, to date largely unimplemented. • Ongoing provincial efforts at hospital restructuring yield change mainly at the margins. A few provinces consider but do not enact more ambitious reforms.
Germany
• Series of cost-containment acts expand co-payments and tighten budgeting and rate-setting. • Health Care Reform Act 1988 extends preventive check-ups and home care and increases co-payments, particularly for pharmaceuticals. Only increased co-payments survive implementation. • Health Care Structural Reform Act 1993 makes substantial change to hospital budgeting (further reformed in 1995 and 1996), creates scheme for equalizing contribution levels across sickness funds, and allows patients greater choice of funds while further expanding co-payments for pharmaceuticals. • Statutory Nursing Care Insurance 1995 expands long-term care coverage. • Health Care Reorganization Act 1997 lifts some budgetary restrictions imposed in 1992, maintains and expands patient choice of funds, places new cost-containment responsibilities on the sickness funds, and imposes greater cost-sharing, though not all cost-sharing provisions are fully implemented. • New Social Democratic leadership repeals some of the market-based elements of previous reforms and promises but postpones further structural reforms.
The Netherlands
• Series of cost-containment acts strengthen central budgeting, introduce prospective budgets for hospitals and other medical institutions, and create price control system for prescription drugs. • 1987 Dekker Report, supported by centre-right government, outlines a major reorganization to encourage competition among insurers and providers and to change the premium structure, separating basic from supplementary coverage and eroding firewall between sickness funds and private insurance. • Labour government elected in 1989 revises plan, stressing need for broader uniform social insurance. Series of subsequent revisions foster conflict, leaving many reforms unimplemented. • During the 1990s, policy makers, following a more cautious course, manage to increase scope for and freedom of private insurance while creating scheme to compensate insurers covering high risks.

United States

- Medicaid spending is significantly cut in first Reagan budget (1981).
- Passage of two cost-control measures for Medicare: prospective payment in the hospital sector (1982) and fee schedule for the physician sector (1989).
- Series of coverage expansions under Medicaid through federal mandates on states (1984–89).
- Medicare Catastrophic Coverage Act expanding Medicare is passed, then repealed (1988–89).
- Kassebaum–Kennedy (1996) regulations encouraging health insurance portability pass in wake of failure of Clinton health plan (1994) and aggressive Republican drive to cut social spending (1995).
- 1997 budget aims to foster Medicare contracts with private health plans while also cutting payments.
- 1997 budget funds new state plans for low-income children.
- New Republican administration enacts prescription drug benefit for elderly beneficiaries of Medicare in 2003; it includes measures designed to increase role of private health plans within the programme.

part *not* the result of explicit attempts at cost-shifting. To date, the use of cost-sharing has not increased dramatically in Britain, Canada, the Netherlands or Germany, or within the US Medicare programme, and the increases that have occurred have been unpopular, riddled with exceptions and vulnerable to reversal. 'Delisting' of benefits once covered by public programmes is quite rare, and the explicit exclusion of previously covered *populations* is essentially non-existent.[16] Between 1980 and 2000, only four of the countries in Table 1 – France, the Netherlands, Switzerland, and the United States – saw a change in public coverage, and in all four cases, the share of the population covered *increased* – on average by 2 percentage points.

Instead of cutting benefits or coverage, cost containment has focused overwhelmingly on controlling fees and overall spending. The motive is no secret: imposing limits on providers and then leaving them to cope has proved far more politically attractive than imposing costs or restrictions on patients. The medical maxim 'do no harm' has its counterpart in political life: 'Never be seen to impose highly visible costs on large numbers of voters.' The politics of cost control is not the happy politics of claiming credit for things done *for* constituents; it is the thorny politics of avoiding blame for things done *to* them.[17]

Despite the moderation of medical inflation in the mid-1990s, the United States continues to stand out as an outlier. Why has the American way of financing medical care proved so distinctly incapable of reining in medical costs? The strongest hypothesis is that the fragmentation and opacity of major financing sources and the limited scope of collective insurance pools have simultaneously muted concern about costs and prevented public and private authorities from exercising decisive control. For all the differences in their financing systems, Britain, Canada, Germany and the Netherlands all route a large

[16] I say 'essentially', because state Medicaid programmes in the United States have reduced coverage in the past, and are doing so currently, and because the Netherlands in the 1980s enacted legislation that removed a few relatively small population groups from the mandatory insurance scheme, although these groups were protected by elaborate new regulations ensuring their access to affordable private health insurance.

[17] R. Kent Weaver, 'The Politics of Blame-Avoidance', *Journal of Public Policy*, 6 (1986), 371–98.

share of health spending through highly visible and encompassing financing pipelines – principally, the general tax system (Britain and Canada) and the payroll tax system (Germany and the Netherlands). Of necessity, then, medical costs are highly transparent, and few obvious avenues exist for public or private payers to shift or obscure them.

In the United States, by contrast, financing not only comes from a huge multiplicity of sources, but much of it is hidden in the form of tax breaks for private health benefits (which cost $188 billion in 2004) and reductions in take-home pay.[18] And even when payers undertake concerted attempts to clamp down, as did Medicare in the 1980s and employers in the 1990s, their universe of control is strictly circumscribed, and their effort likely to be dissipated by cost-shifting. Moreover, as the next section will discuss, private controls on spending have resulted in significant shifts of risk and costs from collective intermediaries on to workers. Such risk-shifting and cost-shifting is much more difficult when all or nearly all citizens have coverage guarantees that must be altered through democratic processes.

The barriers to cost containment posed by the fragmentation of American financing would seem to imply that fiscal concentration is a precondition for cost control, and indeed 'monopsonistic' financing in which governments pay for most care has proved quite effective at controlling spending. The German and Dutch experiences suggest, however, that more decentralized systems can nonetheless achieve similar levels of budgetary control through the creation of hard sectoral budgets within which insurers and providers negotiate. (The success, albeit temporary, of US managed care to control costs in the mid-1990s also rested largely on sharp reductions in fees paid to providers, although these efforts proved incapable of controlling the rate of increase of costs over the long run.) Furthermore, because monopsonistic financing makes it easier to hold politicians responsible for cost control's negative effects, governments face a trade-off between control and accountability, which may help explain why centralized systems do not demonstrate an even greater advantage.[19] Despite these caveats, levels of spending are typically lower in tax-financed national health services than in systems financed by payroll taxes. The 1990s Canadian clamp-down suggests that declining national contributions in fiscally decentralized systems can also be a powerful tool for spending control. (Although not one of the four cases, a similar process lies behind Sweden's impressive cost-restraint.) Here the mechanism would seem to be the capacity of central governments to minimize blame for subnational cost-containment precipitated by declining contributions from the centre.[20]

If blame-avoidance imperatives explain key features of cost-containment policies, a natural question is whether cost control creates political fallout. The answer is almost certainly yes, but the evidence is not wholly conclusive. Aggregate levels of public satisfaction with national health systems do appear to vary in accordance with public per capita health spending (and, importantly, also with *share* of total health spending paid for by the public sector).[21] But because public satisfaction is related to public expectations,

[18] The $188-plus billion figure comes from John Sheils and Paul Hogan, 'Cost of Tax-Exempt Health Benefits in 2004', *Health Affairs*, Web Exclusive (25 February 2004).

[19] Another notorious problem in estimating the effect of budgetary controls is the classic bugaboo of reverse causation: countries that adopt controls may do so precisely because they have more difficulty controlling spending.

[20] Or, in the case of Sweden, by central-government limits on local taxation.

[21] Carolyn Tuohy, Collen M. Flood and Mark Stabile, 'How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations' (unpublished paper, University of Toronto, n.d.).

which are likely to vary across nations, the more relevant indicator is changes in public satisfaction over time, which, due to the limited number of comparable over-time surveys, remains difficult to gauge.[22] On this more demanding measure, the striking feature of the scattered available evidence presented in Table 3 is the very sharp decline in satisfaction that occurred in Canada in the decade after 1988. A smaller but still notable decrease occurred in Germany between 1988 and 1994, while public views in the United Kingdom remained relatively stable during the 1990s – with discontent growing sharply, however, at the end of the decade. The United States presents a mixed picture that hints at increased opinion polarization: growing support for only minor changes alongside growing support for a complete overhaul.

Looking at events in individual countries, the conclusion that cost containment has prompted public backlash is considerably strengthened. In Britain in the late 1980s, for example, public dissatisfaction fuelled by media stories, provider appeals and mounting waiting lists forced the NHS to the top of Thatcher's political agenda. In the United States, increasing micromanagement of clinical decisions by private health plans prompted a wave of revulsion against 'managed care'. In Canada, the decline of federal funds set off an orgy of recrimination between doctors and provincial governments that fed Canadians' growing sense of unease. Public perceptions, however, are mediated by provider strategies and the dynamics of political competition. Cost control seems most likely to become a topic of public concern when competition between contending parties centres on the ruling government's health care stewardship, when payment disputes are frequent and visible, and when providers feel sufficiently aggrieved to adopt an 'outside' strategy of stoking public fears, rather than working through established mechanisms of state–professional bargaining.[23]

The most straightforward conclusion, however, is that the politics of blame avoidance cuts both ways. Leaders who fail to act as health care consumes ever larger shares of public and private budgets risk the wrath of employers and the clienteles of non-health programmes. But cost containment creates its own potent political risks, raising the spectre of waiting lists and outmoded facilities, and creating highly public conflict with providers. In this environment, politicians are understandably attracted to the idea of broader structural reform of health policies. The language of cost control connotes restraint and limitations. The watchwords of structural reform, by contrast, are 'efficiency' and 'responsiveness' – words that suggest the ability to rein in costs without reductions in the quality or quantity of medical services. Structural reform includes market-based reforms, but it also encompasses other major systemic shifts designed to control costs while improving quality and responsiveness. It is what Peter Hall, in the context of economic policy, terms *second-order* and *third-order* policy change: change in the instruments of policy or the hierarchy of goals that guide their use, rather than simply change in the stringency with which pre-existing instruments are used.[24]

In practice, as we shall see, the promise of structural reform has proved exceedingly difficult to realize. And unlike cost control, the emergence, character and effects of

[22] On the general problem of comparing survey results across nations (and other cultural groupings), see Gary King *et al.*, 'Enhancing the Validity and Cross-Cultural Comparability of Measurement in Survey Research', *American Political Science Review*, 98 (2004), 191–207.

[23] For this reason, the decline of professional influence over policy, which has encouraged popular appeals, may well be an indirect cause of the increased dissatisfaction voiced in many nations.

[24] Peter A. Hall, 'Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain', *Comparative Politics*, 25 (1993), 275–96.

TABLE 3 *Public Satisfaction and Health Spending in Four Nations, 1990–2001*

	Percentage saying minor changes needed (%)	Increase/ Decrease	Percentage saying fundamental changes needed (%)	Increase/ Decrease	Percentage favouring a complete rebuilding of the system (%)	Increase/ Decrease	Health spending as share of GDP (%)	Increase/ Decrease
Canada								
1990	56		38		5		9.0	
1994	29	−27	59	+21	12	+7	9.5	+0.5
1998	20	−9	56	−3	23	+11	9.1	−0.4
2001	21	+1	59	+3	18	−5	9.7	+0.6
Germany								
1990	41		35		13		8.5	
1994	30	−11	55	20	11	−2	9.9	1.5
United Kingdom								
1990	27		52		17		6.0	
1998	35	+8	58	+6	14	−3	6.9	−0.2
2001	21	−14	60	+2	18	+4	7.6	+0.7
United States								
1990	10		60		29		11.9	
1994	18	+8	53	−7	28	−1	13.2	+1.3
1998	17	−1	46	−7	33	5	13.0	−0.3
2001	18	+1	51	+5	28	−5	13.9	+0.9

Sources: Robert J. Blendon *et al.*, 'Satisfaction with Health Systems in Ten Nations', *Health Affairs*, 9 (1990), 185–92; 'Who has the Best Health Care System? A Second Look', 14 (1995), 220–30; and 'Inequities in Health Care: A Five-Country Survey', *Health Affairs* 21 (2002), 182–91. Spending from Organization for Economic Cooperation and Development, *OECD Health Data 2003* (Paris: OECD, 2003).

structural reform have varied greatly across nations To explain this variation requires exploring the interaction between political and medical systems in a climate of austerity, and the subtle but fundamental shifts that have occurred without legislative change, as the effects of cost control have played out within distinctive medical complexes.

THE POLITICS OF STRUCTURAL REFORM

In one form or another, structural reform has emerged on the decision-making agenda of the five nations under consideration in the past two decades, with Canada only recently moving towards discussion of the issue. The most ambitious of these proposals was President Bill Clinton's plan for universal health insurance via managed competition, but this initiative failed even to come up in Congress for a vote. The next most sweeping proposal was Thatcher's internal market reforms of 1989, which were enacted and in large part realized. On roughly the same plane of ambition were the so-called Dekker reforms (named after the head of the committee that formulated them) pursued in the Netherlands since the late 1980s, which have proved exceedingly difficult to implement. German leaders have charted a more cautious course, with significantly less comprehensive and radical structural reforms. The overall Canadian policy framework has remained extremely stable.

From the foregoing, it should already be clear that interest in reform is not confined to any single type of medical or political system. The conditions under which structural reform rises to prominence, however, do seem to differ between more and less centralized political structures. In the former, the commitment of the ruling government to action seems both necessary and sufficient to raise reform to the top of the agenda. The question thus becomes why parties in power seek the goal. In more fragmented settings, the conditions for the emergence of reform are less clear-cut. Economic downturns appear to promote interest. Serious momentum towards reform also seems to require cross-party agreement on the need for change, perhaps because oversized coalitions are required to achieve results. Thus while structural reforms seem favoured in centralized polities when ruling parties enjoy a strong position, close party divisions may actually facilitate the rise of the issue elsewhere.

To begin the analysis, therefore, we need a somewhat more systematic understanding of the major features of political and health financing institutions. At the risk of papering over subtle variations, the framework I outline here ruthlessly reduces the complexities of the terrain to two simple dimensions. In the case of political institutions, I emphasize the presence or absence of formal veto points, which shapes the incentives and opportunities of policy makers. In the case of medical financing, I emphasize the centrality of the state in financing and regulating medical care, which shapes the kinds of challenges policy makers confront and their ability to implement legislative aims. Figure 2 maps out the fourfold division that results. Political systems may be either *veto-free* or *veto-ridden*; medical systems may be either *hierarchical* or *decentralized*. I have placed the four cases at different points within the cells to indicate their relative location on these axes.[25]

Inevitably, some countries fit into this framework less well than others.[26] Treating the

[25] Canada is the only OECD example of a veto-ridden/hierarchical system, indicating a strong elective affinity between political centralization and hierarchical organization of the medical sector.

[26] Most problematic are Belgium (which has seen the development of federal institutions in the past thirty years but not in the area of social policy and is thus classified as centralized) and Australia (which has, since the creation

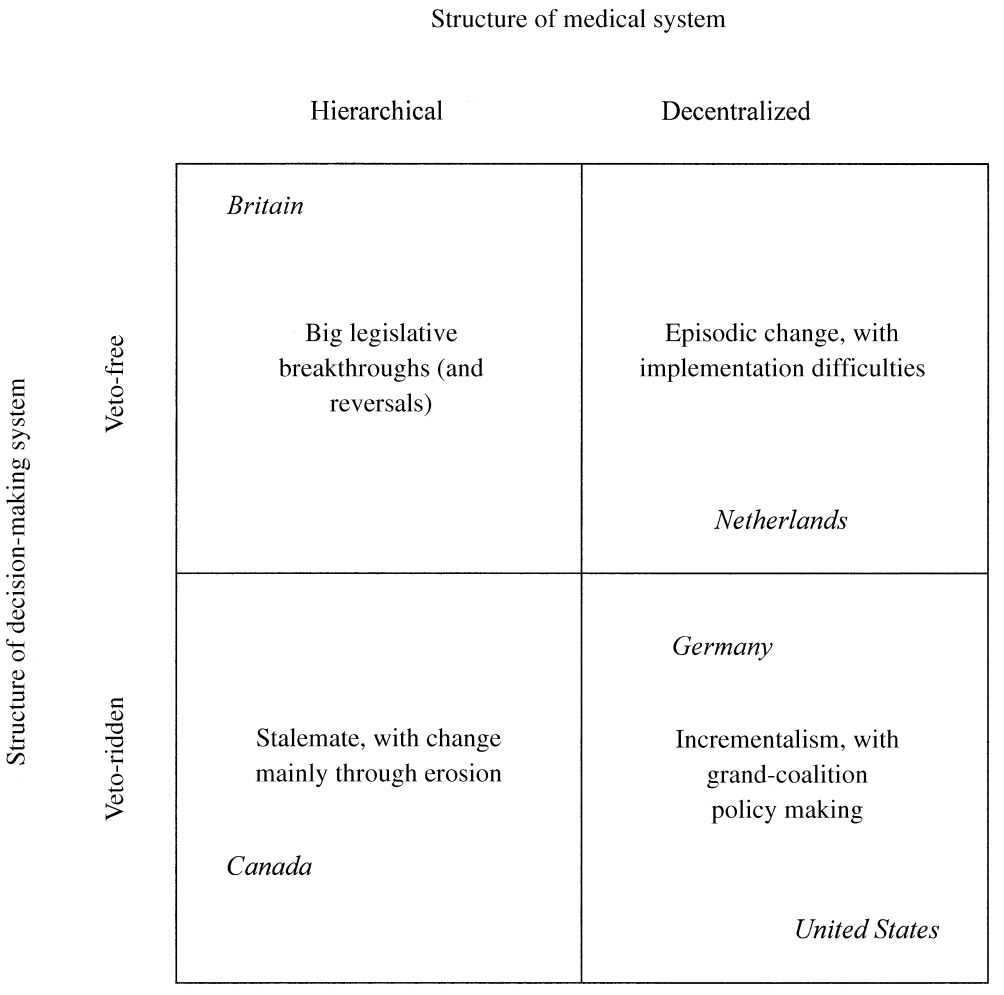

Fig. 2. Political and medical systems and the prospects for structural reform

Dutch political framework as veto-free, for instance, clearly slights the role of coalition governments and institutionalized corporatist arrangements in tempering what is, on paper, a highly centralized political structure. In the present framework, however, unitary states in which legislative and executive powers are fused are classified as veto-free, and the Netherlands fits this mould. That said, it is important to note that corporatism does enter into my assessment and explanation of Dutch policy dynamics via my characterization of medical financing. To have a decentralized medical system in my framework a nation must

(F'note continued)
of Medibank in 1984, had a hierarchical system of public medical finance but which, unlike Canada, allows private insurance to duplicate public coverage, has witnessed successive government efforts to encourage private health insurance, and is thus characterized as veto-ridden/decentralized). With regard to political structure, France might be seen as ambiguous, because it has an independently elected president. The president, however, shares power with the prime minister, who can be defeated by a no-confidence vote – the hallmarks of a parliamentary system.

rely significantly on multiple payers, such as sickness funds, commercial insurers and private employers. These interpenetrating policy institutions are, of course, a key hallmark of corporatism in the Netherlands and other institutionally similar nations, accounting for much of the distinctive character of health policy making within them.

It is also important to stress that in focusing on veto points and the centralization of financing, I am certainly not arguing that these are the *only* relevant influences on national paths. (The analysis to come suggests, for example, that electoral rules – and, in particular, the outsized majorities fostered by plurality elections in Britain and its former colonies, as opposed to the coalition governments fostered by proportional representation (PR) – also play an important role.) As we shall see, the countries within these categories do seem to hang together, but my overarching ambition in tracing these common patterns is limited to two broad goals: first, to show that the pattern of 'reform without change and change without reform' is robust and general; and secondly, to suggest that it is rooted in the interplay of financing structures and the rules of the political game.

Indeed, the principal benefit of the simple two-by-two framework just presented is that it allows for the formulation of straightforward and verifiable claims about how different configurations of political and medical authority should be expected to shape the politics of health reform. The basic expectations are mapped out in Figure 2. Veto-free/hierarchical regimes are the settings in which structural reforms, once proposed, are most likely to be enacted and implemented. In veto-free/decentralized regimes, by contrast, the political system allows legislative change, but the financing system is likely to become a serious barrier at the stage of implementation. In veto-ridden/decentralized regimes, it is highly difficult to consolidate authority for major policy change; yet the fragmentation of the health care system may actually facilitate smaller-scale reform by leaving room for shifting coalitions of interest. Finally, veto-ridden/hierarchical regimes – of which, admittedly, Canada is the only OECD example – may actually be more prone to policy stalemate than veto-ridden/decentralized regimes. This is not only because the political system makes change inherently difficult, but also because the hierarchical structure of medical authority leaves limited room for coalitional reshuffling among key stakeholders – and, in particular, limits the ability of business firms to become key agents of change.

The next two sections examine the dynamics and effects of structural reform within this framework of expectations, focusing on the five nations under consideration but occasionally drawing on the experience of other countries to amplify or test key claims. As will become clear, market-oriented reforms are, perhaps surprisingly, almost entirely clustered in the veto-free/hierarchical quadrant. Nearly all the nations in this category have also seen a decline in the government share of health spending – at times quite dramatic. Yet the specific effects of market-oriented reforms have been relatively modest and, on the whole, tended to enhance state authority rather than market forces. In the veto-ridden/decentralized regimes, by contrast, large-scale structural reforms have fared poorly. Yet these systems nonetheless saw an overall shift towards an expanded public share of spending in the 1980s and 1990s. Finally, and perhaps most importantly, in all four nations, the largest changes in ground-level outcomes were the result not of structural reforms, but of the long-term effects of cost-containment policies as they played out within distinctive health financing arrangements. These effects, however, varied greatly across different financing systems, imposing modest and widely shared costs in some and large and highly concentrated costs in others.

Structure of medical system

Structure of decision-making system

Veto free / Hierarchical

Public Share of Total Health Spending

	1980	2000	Pct. pt change	Total*
Denmark	87.7%	82.5%	–5.3	8.3%
Finland	79.0	75.1	–3.9	6.7
Iceland	88.2	83.7	–4.5	9.3
Italy	79.3†	73.4	–5.9	8.2
Norway	85.1	85.2	+0.1	7.6
NZ	88.0	78.0	–10.0	8.0
Sweden	92.5	85.0	–7.5	8.4
UK	89.4	80.9	–9.5	7.3
Mean	86.2	80.5	–5.4‡	8.0

*2000 Total expenditure on health as share of GDP
†1990
‡Weighted by years between observations.

Veto free / Decentralized

Public Share of Total Health Spending

	1980	2000	Pct. pt change	Total*
Austria	68.8%	69.4%	+0.6	8.9%
Belgium	70.5§	72.2	+1.7	8.6
France	76.6‡	75.8	–0.8	9.3
Japan	71.3	77.7	+6.4	7.7
Netherlands	69.4	63.4	–6.0	8.6
Mean	71.3¶	71.7¶	+0.2†¶	8.62¶

*2000 Total expenditure on health as share of GDP
†Weighted by years between observations.
‡1990
§1995
¶Different from veto-free/hierarchical mean at 95 per cent confidence level.

Veto-ridden / Hierarchical

Public Share of Total Health Spending

	1980	2000	Pct. pt change	Total*
Canada	75.6%†	70.9%†	–4.7†	8.9%†

*2000 Total expenditure on health as share of GDP
†Different from veto-free/hierarchical mean at 95 per cent confidence level.

Veto-ridden / Decentralized

Public Share of Total Health Spending

	1980	2000	Pct. pt change	Total*
Australia	63%	68.9%	+5.9	8.9%
Germany	78.7	75.0	–3.7	10.6
Switzerland	52.4‡	55.6	+3.2	10.7
United States	41.5	44.2	+2.7	13.1
Mean	58.9‡	60.9‡	1.6‡§	10.8‡

*2000 Total expenditure on health as share of GDP
†1990
‡Different from veto-free/hierarchical mean at 95 per cent confidence level.
§Weighted by years between observations.

Fig. 3. Political and medical systems and the public share of health spending

THE VETO-FREE CASES: BRITAIN AND THE NETHERLANDS

When health policy experts speak of a sweeping trend towards market reform, they typically cite Britain, the Netherlands and Sweden, with Denmark, Finland and New Zealand often mentioned, too.[27] Taking just these six agreed-upon exemplars, all but one is located in the veto-free/hierarchical quadrant, and all are characterized by relatively centralized polities. Indeed, given the extreme difficulties that Dutch policy makers have faced in transforming market reforms into actual policy change, it is arguable that the only unambiguous cases of realized market reform fall into the veto-free/hierarchical category. As Figure 3 shows, moreover, all but one of the nations in the veto-free/hierarchical quadrant display a notable decline in the government share of medical spending: On average, the public share dropped 5.4 percentage points between 1980 and 1998. By

[27] See, for example, Chris Ham and Mats Brommels, 'Health Care Reform in the Netherlands, Sweden, and the United Kingdom', *Health Affairs*, 13 (1994), 106–19. Germany is occasionally included, though the extremely limited move towards competition does not even begin to compare to the bolder aspirations elsewhere. See also Lawrence D. Brown and Volker E. Amelung, 'Manacled Competition: Market Reforms in German Health Care', *Health Affairs*, 18 (1999), 761–91.

contrast, the public share remained essentially stable, on average, in the veto-free/decentralized quadrant, and rose an average of 1.6 points in the veto-ridden/decentralized quadrant. Within the OECD, therefore, a significant convergence of the public share has occurred since 1980, much of it driven by the universal decline in the public fiscal role in the veto-free/hierarchical regimes.

At first glance, the concentration of market reforms in the veto-free/hierarchical regimes is at odds with expectations. These are nations, after all, that have demonstrated the greatest commitment to an expansive government role, and they have generally been the most successful in restraining health spending. The paradox evaporates, however, once we consider the capacities and aims that political leaders in these countries had, as well as the actual character and effect of the reforms that they pursued. First, and most obvious, the idea of introducing highly limited forms of market freedom simply made sense in nations where medical care had previously been governed through extremely hierarchical means. Whereas other nations came under acute fiscal strain at a point when their capacities for controlling spending were generally underdeveloped, the veto-free/hierarchical regimes already had in place financing systems and payment forms that embodied substantial capacities for restraint. To the extent that these nations faced a common challenge, it was less how to develop the means for control than how to exercise them without backlash or serious sectoral distortion.

Secondly, and more importantly, leaders in these nations worked within political institutions that gave them the *opportunity* to exercise decisive authority. To be sure, the more consensual policy style in the PR systems differs markedly from the see-saw pattern of majority-party dominance in Britain and New Zealand. In both settings, however, ruling governments did not have to cope with the veto points introduced by federalism, a powerful judiciary, the separation of powers or popular referendums – all features evident individually or in combination in the more veto-ridden systems. This proved crucial in Britain and New Zealand, where all evidence suggests that the reforms were initially quite unpopular. Leaders in veto-free systems did not always have the inclination or room to pursue structural reforms, but they had the means to do so more often than elsewhere.[28] In veto-ridden settings, by contrast, leaders instead generally followed a path of pre-emptive accommodation – 'tiptoeing in' rather than 'crashing through'. On this score, it is revealing that the most prominent attempt to use the strategy of one-shot reform within veto-ridden polities – the Clinton health plan – was distinguished mainly by the glaring gap between aspirations and accomplishments.

Thirdly, and perhaps least recognized, there was an important *policy* logic to reformers' strategies in the veto-free/hierarchical regimes. Health economists typically contrast regulation and competition.[29] Though few are naïve enough to think that competition requires *no* regulation, they usually see regulation as limited to policing and enabling market processes. The comparative record shows that this perspective grossly understates the extent of central power needed.[30] The ability of countries like Britain to pursue market reforms was not at odds with the hierarchical structure of their systems but deeply

[28] On these means, see Geoffrey Garrett, 'The Politics of Structural Change: Swedish Social Democracy and Thatcherism in Comparative Perspective', *Comparative Political Studies*, 25 (1993), 521–47.

[29] For example, Sherry Glied, Michael Sparer and Lawrence Brown, 'Containing State Health Expenditures: The Competition vs. Regulation Debate', *American Journal of Public Health*, 85 (1995), 1347–9.

[30] See James A. Morone, 'The Ironic Flaw in Health Care Competition: The Politics of Markets', in Richard J. Arnould, Robert F. Rich and William D. White, eds, *Competitive Approaches to Health Care Reform* (Washington, D.C.: The Urban Institute, 1993), pp. 207–22.

dependent upon it, and the surest effect of market reforms was to strengthen the state's authority. Moreover, these reforms carried with them the seeds of further intervention. Introduced into hierarchical systems, market mechanisms entailed strong claims for system improvement, the deployment of visible levers of power and new performance measures. With these in place, it proved nearly impossible for governments to let go of the instruments they had deployed.

As the nation where market reforms went furthest, Britain presents the hardest test for the argument. Early expectations were certainly high. Chris Ham and Mats Brommels pronounced in 1994: 'Since Prime Minister Margaret Thatcher published her government's proposal for reforming the National Health Service (NHS), the United Kingdom has witnessed a near-revolution in health services delivery.'[31] On close inspection, however, Britain is a veritable showcase of the limited and contradictory effects of market reform. As discussed already, Thatcher turned to reform not as part of an ideological crusade, but as an attempt to head off a mounting crisis over NHS funding. Once reform had been promised, however, she was 'loathe' merely to spend more and instead presented a blueprint for structural change, the centerpiece of which was a new internal market in which regionally based public managers would be given the authority to contract selectively for services.[32] In a third term in power at the time of the campaign, Conservatives did not fully implement the changes, nor were more radical reforms considered feasible. Nonetheless, the reforms marked a dramatic break with previous NHS adjustments.

What they did not mark, however, was a dramatic shift towards markets. If anything, the reverse was true. Susan Giaimo concludes that 'the managerial reforms worked in the opposite direction of devolution to strengthen both the legal authority and institutional capacity of policymakers for centralized intervention in the NHS.'[33] Rudolf Klein observes: 'Far from leading to the devolution of decision making – the ultimate logic of a market system – the Conservative reforms led to increasing centralization.'[34] Although it is tempting to see the limits of competition as a result of implementation gone awry, in fact the cornerstone of the internal market – new regional purchasers – was inherently centralizing in its emphasis on greater managerial power and accountability to the central government. Conservatives saw this as the most effective means of distributing initial resources and crippling the only other real centre of influence, namely, doctors. But it had the effect of augmenting central authority. In turn, by selling reform on the basis of improved outcomes, politicians set themselves up to be judged on the results. Each new indicator was an invitation to intervention – the 'bedpan … dropped on a hospital floor' that the NHS's creator, Aneurin Bevan, once predicted would henceforth 'resound in the Palace of Westminster.'[35]

As might be expected from the foregoing, moreover, the ground-level changes introduced by the reform were underwhelming, especially if judged against the rhetoric.

[31] Ham and Brommels, 'Health Care Reform in the Netherlands, Sweden, and the United Kingdom', p. 108.

[32] Alan Jacobs, 'Seeing Difference: Market Health Reform in Europe', *Journal of Health Politics, Policy, and Law*, 23 (1998), 1–34, p. 19. A second key element was primary care physician 'fundholding', under which doctors would be given new latitude to purchase services.

[33] Susan Giaimo, *Markets and Medicine: The Politics of Health Care Reform in Britain, Germany, and the United States* (Ann Arbor: University of Michigan Press, 2002).

[34] Rudolf Klein, 'Why Britain is Reorganizing its National Health Service – Yet Again', *Health Affairs*, 17 (1998), 111–25, p. 117.

[35] Klein, 'Why Britain is Reorganizing its National Health Service', p. 117.

Giaimo writes that the fears of critics of the internal market have not been borne out 'precisely because competition has been so limited'.[36] Carolyn Tuohy notes that 'arguably little change occurred in the broad balance among state actors, the medical profession, and private finance.'[37] In a comprehensive survey of the relevant micro-level evidence, Julian Le Grand concludes that '[p]erhaps the most striking conclusion to arise from the evidence is how little overall measurable change there seems to have been.'[38]

The story of the Dekker reforms in the Netherlands, though in many respects quite different, bears important similarities to the British saga. There the reform ideal was also dressed in market garb. Yet in keeping with the Netherlands' highly decentralized financing structure, it envisioned not markets *within* public programmes, but greater competition between sickness funds and commercial insurers within a framework of expanded basic risk protection. And more so than in Britain, the Dutch proposals had to adopt pre-emptive concessions, both to accommodate the coalition partners in power at the time and to head off the plethora of potential opponents, from insurers and sickness funds to employers and providers. All the same, the reforms eventually passed were extremely ambitious, and many experts writing in the early 1990s saw them as the surest sign of a global trend towards market innovation.

That judgement, however, proved wildly premature, as the reform train ground to a halt in the implementation stage, blocked by the decentralized medical system that it aimed to remodel. As Alan Jacobs observed in 1998, 'Dutch governments have been unable to bring the Dekker vision to life, leaving the old system largely intact.'[39] Two Dutch policy insiders concluded in 1997: '[T]he restructuring process generated growing opposition and, despite a seemingly realistic time-table of five years for implementation, it was subsequently abandoned. In many ways, decision-making … lies in limbo.'[40] Instead of decentralizing power to consumers, another insider noted in the mid-1990s, the Dutch reform process 'provoked a largely unplanned process of creeping estatization'.[41] Although one clear effect of the reforms has been to increase the autonomy of insurers in negotiating fees with providers, other key elements of the enacted reforms – notably, efforts to level the playing field between funds and private insurers and the shift of some fund-provided benefits to a state-run catastrophic insurance programme – were in the direction of enhanced state power.

What, then, are we to make of the notable decline in the public share of spending seen in the Netherlands and Britain and, indeed, in all but one of the veto-free/hierarchical regimes? The fall in the public share of spending suggests that the role of the welfare state is changing, but this change is almost certainly not caused by market reforms. The British experience is instructive. The level of private spending and reliance on private insurance rose most precipitously in the 1980s, *before* the Thatcher reforms, and they have been

[36] Giaimo, *Markets and Medicine*, p. 221.

[37] Carolyn Tuohy, *Accidental Logics: The Dynamics of the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999), p. 198.

[38] Julian Le Grand, 'Competition, Cooperation, or Control? Tales from the British National Health Service', *Health Affairs*, 18 (1999), 27–39, p. 31.

[39] Jacobs, 'Seeing Difference', p. 15.

[40] James Warner Björkman and Kieke G. H. Okma, 'Restructuring Health Care Systems in the Netherlands: The Institutional Heritage of Dutch Health Policy Reforms', in Christa Altenstetter and James Warner Björkman, eds, *Health Policy Reform, National Variations and Globalization* (London: Macmillan, 1997), pp. 79–108, at p. 106.

[41] Frederick T. Schut, 'Health Care Reform in the Netherlands: Balancing Corporatism, Etatism, and Market Mechanisms', *Journal of Health Politics, Policy, and Law*, 20 (1995), 615–52, p. 649.

relatively stable since. Despite dire stories about the flight of the rich, popular support for the NHS remains overwhelming, and the reach of private coverage still minimal. All signs are that the rise of the private spending share in Britain, as in other veto-free/hierarchical cases, has principally been a by-product of public-sector austerity and only secondarily a result of formal policy changes. The British experience thus strongly suggests that what I have termed elsewhere 'conversion' and 'drift' – that is, changes in levels of protection *within* established policy parameters, either through decentralized adaptation (*conversion*) or failure to adjust policies to changing circumstances (*drift*) – has been more consequential than formal reforms.[42]

This conclusion is further reinforced by the recent Dutch experience. The Dutch system, unlike the hierarchical British framework, is based on a public–private partnership in which lower- and middle-income citizens are required to have publicly overseen coverage while higher-income citizens must insure themselves through the private sector. Over the past two decades, the share of financing that comes from private sources has increased. As in Britain, however, this is almost certainly not because of major explicit alterations in the scope of public coverage. Indeed, the share of the population covered by the mandatory public framework (which covers hospital and physician services, pharmaceuticals and home care) actually increased over the 1980–2000 period. At the same time, attempts at modestly limiting core public services stalled while a new catastrophic insurance programme was extended to all citizens, including the well off. As three noted health policy experts recently concluded, 'The Netherlands group-based model has persisted in maintaining a remarkable consistency in the terms and conditions upon which care is provided across the population.'[43] The absence of good historical data on out-of-pocket spending and private insurance expenditures makes it difficult to pin down the exact cause of the rise of the private share in the Netherlands, but it appears to reflect three main trends, all relatively modest in effect: a general increase in cost-sharing, higher growth in private insurance outlays than in public outlays, and shifts towards pharmaceuticals and other interventions that have historically entailed user charges.

So far, too, the feared effects of private spending on equity and solidarity have largely failed to materialize. This is not because private finance cannot have such effects; the US case strongly indicates the contrary. Nor is it meant to gainsay the real hardships imposed. But despite the drop in the public share of spending in the veto-free/hierarchical regimes, as well as in the Netherlands, private finance remains marginal in most clinical areas.[44] The exception within the veto-free/hierarchical quadrant is New Zealand, where private insurance has historically played a much larger role than in Britain. New Zealand, however,

[42] On policy drift, see Jacob S. Hacker, 'Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States', *American Political Science Review*, 98 (2004), 243–60. See also the discussion of 'utility drift' in Douglas Rae, 'The Limits of Consensual Decision', *American Political Science Review*, 69 (1975), 1270–94. Although rarely acknowledged in current welfare state scholarship, policy drift was clearly recognized by Hugh Heclo in his classic *Modern Social Politics in Britain and Sweden* (New Haven, Conn.: Yale University Press, 1974). Heclo writes of the Swedish Pension Act of 1913 (p. 211): 'In large part, it was precisely because this basic framework remained unaltered in the midst of changing circumstances that the framers' intentions were unconsciously subverted. As noted throughout this volume, one of the easiest ways to change a policy is to fail to change a program to accord with the movement of events'. (I am grateful to Kent Weaver for this citation.) The term 'conversion' comes from Kathleen Thelen, 'How Institutions Evolve: Insights from Comparative-Historical Analysis', in James Mahoney and Dietrich Rueschemeyer, eds, *Comparative Historical Analysis in the Social Sciences* (Cambridge: Cambridge University Press, 2003), pp. 208–40.

[43] Tuohy, Flood and Stabile, 'How Does Private Finance Affect Public Health Care Systems?' p. 10.

[44] Private finance has, however, historically dominated dentistry, optometry and long-term care.

is atypical. In most nations where the public share has dropped, the strains of austerity have hit broadly. Cost-sharing has increased, rich patients are jumping queues, but the fundamental role of public finance and regulation remains.

THE VETO-RIDDEN CASES: CANADA, GERMANY AND THE UNITED STATES

In contrast with the common reduction in the public share of spending in veto-free/hierarchical regimes, more fragmented polities have demonstrated much greater diversity of response. And despite the possible affinity between the more heavily privatized structure of these nations' systems and market-based reforms, pro-competitive reform legislation has faced a rough road. In the United States, the Clinton plan met an inglorious fate, and the main legislative achievements of the period were increased regulation of health plans and an expansion of public coverage for the poor. In Germany, reforms promoted greater choice of sickness fund, but this package was a 'rather tame strategic contrivance' justified by a sprinkling of market rhetoric and 'so far … unspectacular' in its effects.[45]

Judged against the veto-free/hierarchical regimes, one pattern that unites the fragmented-decentralized regimes is the fairly consistent, and often striking, expansion of the public share of spending. In contrast with the near-universal decline among veto-free/hierarchical regimes, the only country in this cell where the public share dropped is Germany, while Australia saw an increase of almost 6 percentage points and Switzerland and the United States saw a roughly 3-point increase (in the Swiss case, in just the last decade). Indeed, if we expand our field of inquiry to all decentralized systems, what stands out is the degree to which they appear to have been 'catching up' with more hierarchical regimes.

An obvious reason for this is the weaker control over expenditure that public programmes in these nations generally exercised. Nonetheless, one cannot avoid the conclusion that a major reason for the shift is the expansion of public programmes. In Australia and Switzerland, universal statutory coverage was achieved only after 1980. In Japan, public long-term care insurance was expanded in the 1990s, and the same was true in Germany. In the United States, public coverage for the poor under Medicaid expanded significantly in the 1980s and 1990s, though not enough to offset declining private protection. The US public share of spending rose to nearly 46 per cent in 1990s, and if the cost of tax breaks for private benefits are included, the share well exceeds half of spending.[46] Given recent challenges to the welfare state, the continued expansion of public health insurance in decentralized systems is a noteworthy development.

Explicit alterations in public policy are not, however, the only source of change within mature medical complexes. In two nations in particular, Canada and the United States, ground-level shifts within the context of relatively stable formal policies have been pervasive and consequential. In each, legislative stalemate has plagued the debate over reform, and in each stalemate has opened the door to transformation of policy through the erosion of public and private insurance, and the decentralized adjustment of private and subnational policy actors. In the United States, however, these forms of drift and convergence have been far more rapid and fundamental, reflecting the primary role of employers. Canada and the United States, in turn, are both distinct from Germany in

[45] Brown and Amelung, 'Manacled Competition', p. 84.

[46] Steffie Woolhandler and David Himmelstein, 'Paying for National Health Insurance – And Not Getting It', *Health Affairs*, 22 (2002), 88–98.

that inclusive coalitions have not formed behind structural reforms that remedy these trends as they have across the Atlantic.

Canada is the appropriate place to begin, because its experience is in key respects idiosyncratic. The Canadian policy framework relies on the provinces and territories to insure their citizens via public programmes that meet tight federal guidelines. Private health insurance is banned from duplicating public coverage, but has a large role in covering services not routinely covered by public programmes – most notably, pharmaceuticals. Between 1984 and the late 1990s, a period marked by deep provincial–federal conflicts and by a dire federal fiscal situation, the federal government slashed contributions to provincial programmes. The result, understandably, was acrimony, worsened by fierce disputes at the provincial level between cash-strapped provinces and providers. Amid the conflict, the legislative changes introduced have been modest and concentrated at the provincial level.

The immobilism that has marked recent Canadian health politics is an outgrowth of its singular veto-ridden/hierarchical regime. Canada bears close comparison with the United States, where the federal Medicare programme for the aged essentially adopted the private insurance model then prevalent among workers. In Canada, post-war provincial experimentation and parliamentary government facilitated the creation of a similar programme for the entire population. Yet in transporting the existing private insurance model into the public sector, Canada departed sharply from the corporatist framework of Germany, with its heavy reliance on pre-existing insurance funds. The Canadian path thus institutionalized a bilateral monopoly between the state and providers, which was inherently difficult to dislodge, and then overlaid it on a highly decentralized political structure. The resulting constellation of forces was highly inimical to large-scale reform. The provinces had exclusive policy jurisdiction but were constrained by the strict terms of federal transfers. The federal government, meanwhile, could shift blame for cost control downward by cutting funds. And given the stability of the professional–provincial divide and lack of an integral employer role, there was no obvious new coalition of interests that might appeal for change.

The exact effects of the resulting two decades of stalemate are difficult to pin down, but two are unmistakable. The first is a massive decline in public confidence, as we saw in Table 3. The second is a fairly dramatic drop in the public share of health spending, all the more notable because it runs sharply against the grain of the near-universal trend towards expanded public spending in other veto-ridden polities. The stability of the Canadian framework makes it implausible that this shift is a result of legislative reforms, and indeed no province has had the latitude or will to enact substantial changes. Instead, the decline in the public share of spending is a reflection mainly of policy drift. As in the veto-free/hierarchical regimes, the private sector in Canada is not governed by system-wide price controls and thus has grown faster than public payments. But another major cause of rising private spending has been what Tuohy felicitously terms 'passive privatization' caused by rapid growth in spending areas not traditionally covered by Medicare and the shift of many services on to an outpatient basis.[47] Though the exact distributional consequences of these changes are difficult to assess, their main effects seem to be to drive up costs for those who utilize uncovered services intensively – namely, the elderly and chronically ill – and to deter the seeking of uncovered care among the poor. Thus the highly segmented structure of Canadian coverage – which is shared with the US

[47] Tuohy, *Accidental Logics*, p. 235.

Medicare programme – means that the burdens of drift are more concentrated on the ill and disadvantaged than in more expansive systems, where the main divide is between the vast bulk of citizens who seek care within public insurance and the minority who rely on private coverage or can buy themselves off waiting lists.

The distinctiveness of the Canadian experience is easier to appreciate in comparison with developments in Germany and the United States, two other nations where federalism has loomed large. The German case is the less dramatic, but also the more hopeful for those who believe governments can cope with the strains of the post-1970s order. After more than a decade of stalemate, two major breakthroughs occurred under the Kohl government. Neither initiative can be described as market-oriented. Instead, in keeping with the inclusive coalitional bases upon which they rested, they were uneasy combinations of the interests of the right (higher cost-sharing), centre (increased reliance on the sickness funds) and left (greater equality across workers). Practically the only group truly abandoned in the process was medical professionals, who nonetheless managed to obstruct some reforms during implementation. In keeping with the pattern elsewhere, the single truly pro-competitive element of the reforms – greater choice of sickness funds in the context of increased risk-sharing – was centralizing, because it gave the state the authority to redistribute finances across funds to equalize risks. Since the reforms, contribution rates have in fact moved into harmony, and the number of sickness funds has dramatically dropped by more than half.

If the German reforms were scarcely revolutionary, it still remains to ask how they happened at all. The short answer is that the shifting and overlapping goals of the payers – specifically, employers, unions, and the *Länder* – made reform possible by allowing a new coalition to form against provider interests and by catalysing co-operation among disparate factions. Employers and unions were the key players and hence their shared interests were most important. As in the United States, employers were acutely worried about the cost of benefits. But because all employers were forced to bear this burden, they faced strong incentives to organize for the collective good of lower overall spending, rather than to try to achieve savings through individualized efforts.[48] Employers, however, did desire to shift costs on to patients, and their demands were one reason the reforms included new co-payments (many of which were later reversed). Yet employers were constrained in their cost-shifting goals by unions, which jointly managed the system and wanted greater equality of payroll contribution across sickness funds. Finally, strained by the cost of reunification, the *Länder* sought greater federal funds for long-term care, then principally a state responsibility.[49]

The importance of reunification in catalysing the 1992 reforms may make the German experience appear unique. But other aspects of German's successful reform drive seem highly useful for grasping the dynamics of reform in veto-ridden/decentralized regimes. For one, Germany's cautious but productive path suggests that a decentralized medical system may well give reformers some advantages in a fragmented polity (or at least temper their ambitions to the point that they are not tempted to pass legislation that cannot be implemented, as did overeager Dutch politicians, whose market dreams met the stark reality of corporatist bargaining once legislation passed). The fragmented overlay of corporatist health insurance, federal institutions and a bicameral parliament has clearly

[48] Giaimo, *Markets and Medicine*, pp. 172–3.

[49] In addition, the *Länder* had significant influence due to their control over the territorially based second chamber, which at the time was dominated by the Social Democratic Party.

thwarted swift change, but also given potential opponents of reform strong guarantees that their interests will be accommodated in any changes made and created the potential for new alliances of interests – alliances that were plainly not possible in Canada's bilateral interest network.

For another, the limited ground-level changes that have occurred in Germany, particularly in comparison with the United States, indicate that residualization of health protection through policy drift and conversion is not inevitable in decentralized systems. Indeed, Germany's policy of equalizing contribution levels across the sickness funds reflected a conscious effort to undo past drift caused by the gradual concentration of higher-risk workers in specific funds. Although co-payments have shifted some risk and costs to patients, elaborate protection schemes have mitigated their effects. Moreover, the extremely broad scope of German coverage has limited the sort of passive privatization seen in Canada.

A sense of the differential effect of drift and conversion in these nations can be gleaned from comparative data on out-of-pocket health spending. As Table 4 shows, the first simple conclusion is that citizens in most advanced industrial democracies were paying a larger share of national health spending out of pocket at the end of the 1980–2000 period than at the beginning. Although some of the rise may well have been due to the introduction of co-payments and other forms of explicit cost-sharing, the evident paucity of such legislated changes and the large magnitude of the increase witnessed in a number of nations suggest that most of the shift is an indirect result of patients buying out of public programmes or purchasing services that are only modestly covered by public programmes, such as pharmaceuticals.

The second conclusion, however, is that the average increase obscures substantial variation across different nations and regime types in the degree to which cost control has precipitated increases in out-of-pocket spending. At the extremes, for example, the share of health care financed by direct consumer payments increased by more than 7 percentage points in Italy, while it fell by almost 9 points in the United States, as the share of the population covered by Medicaid and Medicare expanded. Not surprisingly, given the large decline in the public share of spending in the veto-free/hierarchical nations, the role of out-of-pocket spending increased the most in these regimes (3.1 percentage points, on average). It rose more modestly in the veto-free/decentralized regimes and Canada, and actually declined in the veto-ridden/decentralized regimes – although the decline is entirely due to the United States and data are unavailable for Switzerland. Germany, for its part, saw only a modest increase in out-of-pocket spending (0.3 percentage points), suggesting, again, that German reforms have produced little of the dislocations seen in Canada or the United States.

At first glance, the United States might be thought to represent a polar opposite to Germany – the breakdown lane of reform versus the Autobahn. But, in fact, the institutional context and reform process, and even some of the achievements, were similar in the two nations. In both, reform emerged on to the agenda in the early 1990s in response to concerns about economic decline; in both, employers and state governments, fearful of medical inflation, were key instigators; and in both, reform was eventually taken up by a moderate conservative – Kohl in Germany; Bush in the United States – who faced strong pressures from the left. Had Bush returned to office, there is reason to believe he would have pursued a cautious course similar in aim to that of Kohl's (but, of course, vastly different in content) and reason to believe that modest but meaningful reforms would have passed, just as in Germany.

TABLE 4 *Out-Of-Pocket (OOP) Health Spending in Selected OECD Nations, 1980–2000*

Nation/Type	OOP spending as a share of total health spending, 1980	OOP spending as a share of total health spending, 2000	Percentage-point change in OOP share
Veto-Free/Hierarchical			
Denmark	11.4%	16.4%	+ 5.0
Finland	18.4	20.6	+ 2.2
Iceland	11.8	15.2[a]	+ 3.4
Italy	15.7[b]	22.9	+ 7.2
New Zealand	10.4	15.4	+ 5.0
Norway	14.6[c]	14.3	− 0.3
United Kingdom	8.6	11.0[d]	+ 2.4
Mean (weighted by years between observations)			+ 3.1
Veto-Free/Decentralized			
Austria	14.6[e]	18.6	+ 4.0
France	11.5[c]	10.2	− 1.3
Japan	17.7[f]	17.1[a]	− 0.6
Mean (1990–2000, weighted)			+ 0.3
Veto-Ridden/Decentralized			
Australia	16.1	18.4[f]	+ 2.3
Germany	10.3	10.6	+ 0.3
United States	24.2	15.3	− 8.9
Mean (weighted)			− 2.2
Veto-Ridden/Hierarchical			
Canada	14.7[b]	16.1[a]	+ 1.4
Mean for all fourteen nations (weighted)			+ 1.1

Source: Organization for Economic Cooperation and Development, *OECD Health Data 2003* (Paris: OECD, 2003). Data are not available for Belgium, the Netherlands, Sweden and Switzerland.
[a] 1999 [b] 1988 [c] 1990 [d] 1996 [e] 1995 [f] 1998.

Indeed, such reforms *did* pass. The spectacular implosion of the Clinton health plan has obscured the substantial track-record of smaller scale legislative achievements that marked the 1980s and 1990s, including a stealth expansion of the state-federal Medicaid programme for the poor and the creation of a new Children's Health Insurance Program (CHIP) in 1997. (More recently, the expansions include the extension of Medicare to include limited prescription drug coverage for the aged in 2003.) Medicaid, in fact, stands out as a remarkable oasis of spending and coverage growth amid a parched desert of hamstrung antipoverty programmes. These expansions gained support from a broad alliance of conservatives and liberals, and in the case of CHIP, from state leaders eager for greater flexibility under Medicaid. In comparative perspective, the Medicaid expansions are also of a piece with a larger pattern of compensatory intervention where assistance for poor families has been cut: government health benefits facilitate the movement of former welfare clients into low-wage employment, where private coverage is rare. As in Germany, therefore, cost containment was coupled with expansions in public coverage.

There, however, the similarities end. For what stands out in the American experience is the profound constraints on expansive reform imposed by America's fragmented polity and heavily privatized social welfare framework, and the devastating declines in private social protection that have occurred in the absence of public action. Exhibit A here is the stunning defeat of the Clinton plan – arguably the most dissected legislative failure in modern history. Like other pro-competitive proposals, the Clinton plan turned out to be highly regulatory and complex once the ideal of managed competition had been translated into legislative details. It is now customary for competition advocates to dismiss the Clinton plan as a big-government wolf in competitive sheep's clothing. Yet among Clinton's key advisers, the commitment to aspects of pro-competitive reform was in fact genuine and strong.[50] The problem was not insincerity, but inherent barriers to translating the pro-competitive ideal into politically saleable policy.

The failure of the Clinton plan suggests that the inherited path of policy in the United States represents an even more substantial barrier to government-led structural reform than do the well-known hurdles posed by America's fragmented polity. Business concern about rising costs, for example, helped push structural reform on to the agenda, as it did in Germany. Yet, in contrast with their counterparts abroad, American employers were deeply split along multiple lines by the highly uneven incidence of health costs in America's voluntary employment-based system.[51] These divisions plagued the Clinton administration's efforts and ultimately doomed any chance for employers to play a constructive and relatively united role. Indeed, the stark difference between US policy reversals and the more consensual pattern in other veto-ridden/decentralized regimes cannot be explained without an appreciation of the divisions and barriers created by America's distinctive reliance on private insurance. In the end, the Clinton plan was brought down by much the same political phenomenon that stymied efforts to scale back *public* programmes abroad: easily ignited public fears that reform would compromise the main protection upon which citizens relied – in this case, employment-based insurance.

Although the Clinton plan died, health reform did not – which brings us to

[50] Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton, N.J.: Princeton University Press, 1997).

[51] Employee Benefits Research Institute (EBRI), *Databook on Employee Benefits* (Washington, D.C.: EBRI, 1992), Table 6.23.

the final and most striking feature of American policy developments: the extent to which change occurred independently of the initiative or control of policy makers. The scope of private control over health benefits is the key reason why. Because policies encouraging private benefits allow considerable discretion on the part of private actors, they allow substantial changes *within* the confines of existing policy through conversion. Furthermore, these non-governmental actors do not have to engage in collective political action to achieve their ends. If they are able to overcome internal resistance, they can adopt changes unilaterally.[52]

And thanks to these largely unilateral changes, the private foundation of the American system has undergone what can only be described as a radical contraction. From a peak of more than 80 per cent of Americans, private coverage fell during the 1980s and early 1990s to less than 70 per cent.[53] Employment-based protection was the biggest casualty: between 1979 and 1998, the share of workers who received health insurance coverage from their own employers fell from 66 per cent to 54 per cent; among the poorest 20 per cent of workers, it fell from 44 per cent to 26 per cent.[54] For more than a decade, the number of Americans without health insurance has been rising at the rate of about 1 million per year and now hovers around 44 million. A stunning 75 million Americans, a third of the non-elderly population, are without insurance at some point in a two-year period, and spells without insurance are growing longer, with more than half lasting over two years.[55] With employers free to drop coverage, and workers under financial pressure to decline it even when it is offered, the risk of medical costs is being shifted from insurers and employers on to workers and their families. For policy makers abroad who wish to increase the role of private insurance in their medical systems, the continued erosion of American health insurance sounds a distinctly cautionary note.

REFORM WITHOUT CHANGE, CHANGE WITHOUT REFORM

The reform of medical systems has been an important aspect of welfare state restructuring in recent decades. As constrained budgets have sagged under the weight of rising medical costs, leaders have found themselves spurred to action, despite the potent risks of threatening established stakeholders or cherished benefits. Yet once we look past the feverish talk of reform, the legislative changes undertaken appear at once more modest and more variable than commonly recognized. As welfare-state scholars have emphasized in other policy contexts, the dominant pattern of reform over the past two decades is not radical retrenchment.[56] Containing costs rather than cutting benefits has been the major aim, and these changes have mostly restricted public programmes only at the margins. No country has seen a contraction of the share of the population entitled to statutory protection

[52] On this general point, see Stewart Wood, 'Labour Market Regimes under Threat? Sources of Continuity in Germany, Britain, and Sweden', in Pierson, ed., *The New Politics of the Welfare State*, pp. 368–409, at p. 374.

[53] Health Insurance Association of America (HIAA), *Source Book of Health Insurance Data* (New York: HIAA, 1996); Kaiser Family Foundation (KFF), *The Uninsured: A Primer* (Washington D.C.: KFF, 2002).

[54] James L. Medoff and Michael Calabrese, 'The Impact of Labor Market Trends of Health and Pension Benefit Coverage and Inequality', Center for National Policy, 2000.

[55] Families USA, *Going without Health Insurance* (Washington, D.C.: Families USA, March 2003); KFF, *The Uninsured*.

[56] See, for example, Pierson, 'Coping with Permanent Austerity', and *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (New York: Cambridge University Press, 1994); Huber and Stephens, *Development and Crisis of the Welfare State*; and Giulano Bonoli, Vic George and Peter Taylor-Gooby, *European Welfare Futures* (Cambridge: Polity Press, 2000).

(although *private* coverage has been eroded in the United States), and in fact many nations where coverage was less than universal or left out important benefits have seen expansions of protection.

Nonetheless, cost containment has imposed visible and unpopular strains in many nations – from waiting lists and eroding facilities to co-payments and coverage gaps. These strains have been magnified in popular perception by the persistent acrimony of relations between the state (and, in decentralized systems, insurers and employers) and medical professionals. In this environment, leaders have found themselves impelled to take action not just to cope with fiscal constraints or rising medical spending, but also to avoid blame for perceived deterioration of strained medical complexes.

My survey of recent developments suggests, however, that the reality of structural reform has so far lagged markedly behind the rhetoric. In the first place, the market-based reforms that have attracted the most attention from health policy analysts have scarcely been universal. Ironically, in fact, it is in nations with the most statist and expansive systems that market-based reform ideals have been most likely to take root, rather than the decentralized systems where the idea of competition would seem most congenial. Perhaps most striking of all, in nearly every case of alleged pro-competitive reform, the largest and most enduring change was a substantial increase in the power of the state.

More generally, the evidence that I have reviewed suggests that structural reform is not the crucial catalyst of change we usually assume it to be. Instead, explaining the most critical shifts – the rise in the private share of spending, the real hardships at the margins of coverage, and the ongoing privatization of risk in the United States – requires attention to two powerful sources of *internal* policy change to which neither health policy experts nor students of the welfare state have given sufficient emphasis: *conversion*, or the decentralized restructuring of policies by actors empowered under them; and *drift*, or the failure to update policies to reflect changing circumstances. In a climate characterized by formidable barriers to expansionary reforms, the scope and effect of welfare states are crucially evolving despite (and in important respects because of) the hurdles to formal policy change. New risks are arising with which existing programmes are poorly equipped to grapple. Gaps in coverage that once seemed tolerable are increasingly hard to close. Strains on programmes threaten networks of solidarity that once united rich and poor, healthy and sick. And employers, insurers and even patients – when they have the latitude – are changing their behaviour and benefits on their own. Because of the semi-sovereign role of employers in the United States, the effects have been most pronounced, and inegalitarian, there. But reform without change and change without reform is the dominant health policy dynamic in advanced industrial states.

That is the crucial message of this article, and it motivates my main explanatory task: to tease out how and why this contradictory dynamic plays out differently in different nations. Without insisting on the absolute primacy of one set of factors, I have highlighted two main sources of variation: whether political systems are veto-free or veto-ridden and whether medical systems are hierarchical or decentralized. Countries on the same sides of these twin divides have followed surprisingly similar paths. The veto-free/hierarchical regimes, for example, have seen a sharp general decline in the state's financing role, while the decentralized financing regimes have actually witnessed a general overall increase. Equally important, reform efforts in veto-ridden and decentralized regimes have not, as of yet, produced the retrenchment that doomsayers have prophesied. New coalitions have formed to navigate the shoals of reform, and their efforts have been tempered and sometimes facilitated by the pluralism of interests in these nations. Even in

the United States, significant expansions of public coverage have come about through this route.

The picture that emerges, in sum, is one of widespread strains that, at times, have produced major shifts, but usually without legislative direction. The character of this non-legislated adjustment is not, however, identical across nations. To the contrary, four distinct patterns emerge from the analysis, each associated with a distinctive financing structure: 'buying out', 'passive privatization', 'cost sharing', and 'risk privatization'. In hierarchical financing systems, the most prominent form of drift has been buying out in response to (comparatively effective) restraints on public spending, which have threatened the timely availability of high-quality care. The Canadian experience is an exception in the world of hierarchical systems (though it is paralleled by the trajectory of the US Medicare programme): there, the limited public role at the beginning of the 1980s – which focused on physician and hospital services, to the exclusion of drugs and other services – has allowed passive privatization, as spending on services poorly covered by the public sector has increased.

In more decentralized financing regimes, by contrast, policy drift and conversion have not generally produced either buying out or passive privatization. Indeed, the trend has been towards an *expanded* role for public coverage. Rather, to the extent that cost control has produced strains, it has resulted mainly in higher consumer cost-sharing. Here, the United States, as the only nation in which employers have had the latitude to remake health benefits along the lines they prefer, is the great exception. Only in the United States have the strains of recent decades produced a true dismantling of key areas of risk protection. The effect, I have argued, has been a marked privatization of risk, as private coverage has been eroded and responsibility has shifted from collective risk pools on to families and workers themselves.

Although I have grouped these diverse trends under the common labels of *conversion* and *drift*, their distributional effects are likely to vary greatly. Buying out, to the extent that it is limited to the very well off, is likely to exacerbate inequities in access relatively little – and in fact, if anything, reflects the special dissatisfaction of affluent citizens. Modest cost-sharing, too, especially when focused on the wealthy, is also likely to have relatively limited consequences.[57] The same cannot be said, however, of passive privatization and risk privatization, which impose the greatest burden on those with limited resources. It is notable that among the nations for which adequate opinion data exist, only in Canada and the United States do lower-income citizens have substantially less favourable perceptions of the quality of care than do higher-income citizens – in the US case, dramatically so. In the United Kingdom, in stark contrast, quality is perceived much more favourably among *lower-income* citizens, in keeping with the buying-out pattern.[58] Researchers would do well to investigate such varied distributional effects more fully in analyses of health care reform.

Above all, however, the politics of health policy deserves a more prominent place in our understanding of welfare-state restructuring. Health care reform represents something

[57] The available evidence suggests, however, that it also does relatively little to encourage the allocation of services to those who most need them. Cf. Joseph P. Newhouse, *Free for All? Lessons from the Rand Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1996); and Robert G. Evans, Morris L. Barer and Greg L. Stoddart, 'Charging Peter to Pay Paul: Accounting for the Financial Effects of User Charges' (Toronto: Ontario Premier's Council on Health, Well-Being, and Social Justice, 1994).

[58] Robert J. Blendon *et al.*, 'Inequities in Health Care: A Five-Country Survey', *Health Affairs*, 21 (2002), 182–91.

of a blind spot in contemporary political analysis, obscured by the emphasis on policy details in much comparative policy research and by the fascination with classic income-replacement programmes in much welfare-state scholarship. This article has suggested that it is a blind spot that contains much of interest for comparative political analysis. Health care is among the most personal of issues, and this is one reason why it is also among the most politically volatile. Yet the main message of this article is that behind the rhetoric and emotion lie powerful and intriguing patterns of policy development that could deepen our understanding not only of the large corner of social welfare provision that we call health policy, but also of the modern welfare state and its political future.