Health Reform

Public success, private failure

Edited by
Daniel Drache and Terry Sullivan

Governance and Change in the Global Era

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Market Limits in Health Reform

This volume explores the deep-rooted tensions between publicly funded health care systems and the dynamics of markets in the delivery of privately financed health care. It lays bare the limitations of market-led health reform and argues for the indispensable role of a vibrant public authority in the renewal of modern health care systems. While markets may be back with a vengeance, health care remains a stabilizing instrument of citizenship at a time of economic uncertainty

International authorities in the field examine public—private conflicts in health policy, including cost-containment and privatization strategies in an international perspective, the virus of consumerism, and the role of business and the private sector in setting the agenda for health care reform. Special attention is paid to the restructuring of Anglo-Saxon health systems and the shift in state/market boundaries in Canada, US, Britain and Australia. Finally, *Market Limits in Health Reform* addresses the frontier of health care reform including health and social cohesion as well as the role of patient choice in health care reform.

Market Limits in Health Reform does not simply lay bare current trends in international health provisioning, but also reflects on the challenges facing health care in the advanced economies. More than simply analyzing the organization and financing of health care services, the contributors stress what is at stake is the establishment of social arrangements which produce health. Both as informed analysis and provocative reflection, *Market Limits in Health Reform* will be of great interest to students and researchers in health economics and policy, public economics, politics and political economy.

Daniel Drache is the Director of the Robarts Centre for Canadian Studies at York University, Ontario and Professor of Political Economy. He is the coeditor, with Robert Boyer, *of States Against Markets: The Limits of Globalization*. Terry Sullivan is the President of the Institute for Work and Health, Toronto, and is Adjunct Professor in Sociology at York University and in the Department of Health Administration, Faculty of Medicine, University of Toronto.

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Daniel Drache and Terry Sullivan

June 1998

1
Health reform and market talk
Rhetoric and reality

Daniel Drache and Terry Sullivan

INTRODUCTION

Less than a decade ago the notion that a publicly financed health care system would be competing with a privatized alternative would have been unthinkable. A previously inconceivable idea has now found its champions (Herzlinger, 1997). Governments everywhere, including the social market economies of Western Europe, have a new-found interest in privatizing services and redrawing the boundary between the public and the private (Boyer and Drache, 1996). The assumption that private markets somehow on their own could foot the bill for a comprehensive delivery system for most countries deserves a strong but careful rebuttal. This volume takes up the challenge and sets out to explore the deep-rooted tensions between publicly funded health care systems and the dynamics of private markets to deliver privately financed systems of health care.

The intent of the contributors is to offer a compelling, practical analysis of these difficult issues of health care reform. The volume is written for an informed public who want to comprehend the attraction and limitations of market-led health reform and the indispensable role of a vibrant public authority in the renewal of modern health care systems. Significantly, the health care reform agenda has been dominated by economists and policymakers narrowly focused on deficit reduction and spending controls. At the forefront of comparative reform efforts have been the OECD analyses. In many of its publications, the OECD points to an enlarged role for markets in health reforms as though efficiency was the primary reform objective (OECD, 1994; World Development Report, 1993). This is clearly inadequate.

Every industrial nation has had to cope with a range of issues as diverse as the urgency of fiscal restraint, the pressure to decentralize, increased citizen participation in health care decision-making, the need for harmonization of health arrangements across jurisdictions, partial or wholesale privatization, the rationing of expensive technology and drugs, the downsizing of the hospital sector, constraining the growth of doctors' incomes, the regulation of non-medical practitioners and democratic initiatives to strengthen public health. All advanced economies now admit some role for markets in their financing and delivery

systems. Recent reforms in Western Europe have generated competition between doctors within Germany and Britain, among pharmaceutical products in Germany and The Netherlands, between hospitals in Germany, the UK and The Netherlands, and insurers or fund-holders in the UK and The Netherlands (Saltman, 1995). By contrast, no country other than the US relies primarily on private markets to meet a comprehensive range of health needs, and the US system is the most expensive in the world (Kuttner, 1997). None the less, throughout the OECD, states continue to support publicly funded systems as a matter of principle and are steadfast in their commitment to shared responsibility in the field of health. But the fact remains that public authority in every kind of market-based economy has had to confront three essential health policy challenges driven by the new era of global competition.

HEALTH REFORM OBJECTIVES DEFINED

The first and the most important policy imperative remains how to sustain a public commitment to a comprehensive range of health services for all citizens. This is not easy to do. The public policy domain is now dealing with citizens who are increasingly suspicious of state-sponsored health schemes that have gone awry, doctors and drug companies whose livelihoods depend on expanding market opportunities, and the chronically ill who demand better and more compassionate therapies. What then remains of the legacy of universal health care in an era of global markets? It is this question that dominates the health reform agenda in advanced economies and so far states have discovered that they have to make trade-offs if they are to maintain affordable coverage for all. Government authorities have had to choose between the cost of expensive technology and the benefits of better primary care; between critical life-saving interventions and the need for spending more on effective public health programs; between expensive measures to extend life and an increase in resources on perinatal care; between more effective planning by central governments and increased reliance on devolution and decentralized organization of health delivery systems; and between an enhanced role for doctors and other medical elites who want to be paid more and the interests of the public for greater public accountability.

Most states are spending their scarce care resources on hospital beds, physician services and fees, community and chronic care as well as drug and biotechnology. The proportion varies markedly between jurisdictions; nevertheless all authorities are wrestling to find ways to promote the development of community and home-based care, reduce reliance on institutional and hospital care, manage the explosive growth of bio-technology costs, and keep physician fees within nationally acceptable limits. Health expenditures will continue to be the big ticket public spending item in all jurisdictions. An ageing population, the growth of biomedical technology and an ever-increasing supply of physi cians ensure that competition for public resources will be intense and preoccupy governments everywhere.

The second policy imperative is to improve the efficiency of health care services at a time of fiscal constraint. Improved health care for millions of people is one of the undisputed achievements of the modern age. More than any other single program of the welfare state, it transformed the way we live, our spending patterns, our gender identity and the structure of the family. Citizens in most advanced economies no longer need to worry about basic medical coverage, and the fact that they have secure access to hospitals, doctors and life-saving drugs for the majority has transformed people's lives in ways that few could have predicted. Despite this, the advances in health care are reaching the point of limited returns in life-extending benefits. Even if more people than ever are receiving expensive body part transplants, life expectancy in the total population is not rising appreciably as a consequence. A sustained rise in GDP is likely to do more to extend the life expectancy of the total population. Seizing on this fact, governments in the advanced economies are cutting spending—sometimes judiciously, but more often than not in an unplanned way. They are relying on privatization and quasi-market mechanisms to strike a different balance between private and public provision and the financing of health care. Here also states have had to contend with growing expectations from their middle classes and their ageing populations for improved quality of care. For policy-makers, this presents a variety of questions from who pays, who delivers and who benefits to what percentage of national resources should be devoted to expenditures for health.

Among the privatization mechanisms that states are looking at are: the divestiture of public assets; contracting out of health services, self-management of hospitals and the privatization in some cases of hospitals, market deregulation and liberalization of delivery systems, and withdrawal of state provision of health services (Bennett *et al.,* 1997).

The third imperative that so far has eluded a ready-made solution is to devise social arrangements which engender healthy populations. Many years ago the Nobel Laureate Gunnar Myrdal articulated the notion of a vicious cycle of poor health and low income for both the developed and underdeveloped world. His point was that people were sick when they were poor; they became poorer when they were sick, and sicker because they were poorer (Myrdal, 1957). He wanted development to promote social arrangements that generated prosperity and radically improved health as a consequence. If socially cohesive populations are healthier and generate a virtuous cycle of prosperity and health improvements, what (non-health care) measures do public authorities need to adopt to improve people's health (Evans *et al.,* 1994; Blane *et al.,* 1996; Wilkinson, 1996)?

Among the measures that governments need to promote are: healthy child development, safe and fulfilling work environments, reducing social distance and social isolation, and promoting neighbourhood and community engagement. These determinants must be matched by a vibrant and sustainable economy to maximize their health effects (World Development Report, 1993). These social determinants of health are often talked about, but governments have found few ways to take real action in these areas that count the most. In the modern era,

efforts to constrain health care spending must be met with an equally strong resolve to promote health-enhancing areas of public policy. At the present, governments are preoccupied to make the state smaller with less of a presence in the economy and to cut back on their role as regulators. Promoting social health requires a new activism on the part of the state. Is this going to happen when government appears to be moving in the opposite direction? There may be some room for optimism.

Increasingly governments need to minimize the social dislocation when markets expand beyond the moral and political boundaries within which they are necessarily constrained to operate. The emergence of new policy capabilities for different market economies is a distinct likelihood. The important repositioning of government can only occur with strategic changes in the functioning of the state —having institutions that learn, that effect long-term and strategic change, and that create high quality and crisis-sensitive modes of policy reasoning. Building a strong central capacity for formulating health policy is the first step towards revitalizing decision-making in the public domain. The 'public domain' refers to assets held in common which cannot be bought and sold in the open market. For society to function smoothly, public authority will be increasingly under pressure to exercise its supervisory role 'when there are no other strong social values to compete with that of money and wealth' (Albert, 1993:104). If Albert's principal assumption is valid, public authority will be hesitant about transferring many of its prerogatives to the private sector including principal responsibility for health.

An 'effective state', to employ the recent terminology of the *World Bank Development Report 1997,* requires rethinking the framework for social health in highly contrasted market-driven economies. Increasingly, health cannot be separated from policies to create employment, promote social trust and generate a productive economy. The reform of health policy in an era of globalization requires not only institutional innovation but shared policy learning based on the actual experience of other states and not just on what happens in some abstract neo-classical economic model.

In practical terms, this appears to be a small step—in reality it is not. There are many stumbling blocks in the way. The first is the widespread misunderstanding of what kind of commodity health care is and the many costly after-effects arising from unchecked reliance on the market logic in health care. Second, the health reform movement has to come to grips with the widespread disenchantment with public health care bureaucrats and the loss of faith by the public in health care administrators. This brings us logically back to the fundamentals of Beveridge's universal health care scheme as part of modern governance. Does it have any relevance in an age of globalization? Modern health governance has to forge a new relationship between health care programs and the social production of health in childhood development, the workplace and beyond. In order to satisfy this new policy awareness that social health matters, what mix of health reform policies best meets our three policy imperatives? In the post-Beveridge era, health reform is now one of the principal avenues redefining the boundaries between

states, markets and civil society (Dahrendorf, 1995). Readers of this volume will quickly discover that somewhere between market USA and social market Europe, the Canadian system provides a valuable prototype or window on reform for other jurisdictions as they struggle with these modern health policy dilemmas. Canada is a hybrid model, with a strong role for public insurance coupled with a diverse private delivery system.[1] It is to these considerations we now turn.

WHAT KIND OF COMMODITY IS HEALTH CARE: THE DEFINING ISSUE

Despite much debate among health economists, there has been little agreement on the core issue: what kind of commodity health care is. Is it a public good that only states can really effectively provide? Is it closer to what Adam Smith described as a non-market 'necessary' for the support of life that no society can afford to be without? Or is it a service to be bought and sold like any other commodity and subject to market rules and discipline (Albert, 1993)?

At the heart of the dispute is a simple idea that divides economists: namely, health care does not 'trade' like other goods and services (Kuttner, 1997; Evans, 1997a). This is because there is no limit to the amount which consumers will pay when it comes to preserving their health or the health of their families. Unlike other goods or services, health care does not have a line of people clamouring voluntarily for gall bladder surgery; it is driven by need rather than want. Also, most purchasers of health care do not pay at the point of provision for the service; they have insurance and it is the insurer who signs the cheques and pays the doctor. It makes little sense to look to universal laws of supply and demand to discipline health markets when there is no apparent limit to the amount of service they can buy under such an insurance arrangement. With such 'imperfect competition' private health care markets become very expensive, particularly when there is indeed a very large asymmetry between what consumers need to know and the information that health-care providers have.

Knowledge about health and illness is closely guarded as a professional commodity. It is the intellectual property of health care professionals and health care vendors. Information flows are not like capital movements and are subject to many non-tariff intellectual property barriers erected by private individuals and organizations. This asymmetry of knowledge drives the growth of health care costs in private markets because of the push from provider-induced demand. At least on theoretical grounds, there is a strong analytical case that the market model cannot be easily applied to the health care domain. In the view of the American health economist Victor Fuchs (1996), a narrow preoccupation with markets fails to acknowledge the diversity of human wants and the difference between what may be technically best and what is socially desirable.

Another reason that there has been so much disagreement on the economic nature of health is that it is always easier to control costs through integrated public payment systems rather than through multiple, privately financed alternatives

(Brousselle, 1998). Private insurance markets fail, for instance, because insurers are unwilling to assume the expensive risks associated with genetic anomalies and catastrophic illness such as AIDS. Even private insurance for middle-of-the-road coverage is often expensive and the benefits are capped to ensure limited coverage in the event of serious illness, as many Americans have discovered to their chagrin. The idea that individuals will simply assume co-payments to match their level of risk constitutes 'an example of academic theorizing of breathtaking proportions' (Kuttner, 1997).

After a decade of market-style reforms in the UK and New Zealand, overall health expenditures as a portion of GDP have gone up, not down (OECD, 1994). Privately financed health care is almost always more expensive than publicly financed alternatives. Hsiao (1995) recently provided an evaluation of the systematic attempt to introduce private medical savings accounts as the market solution of preference in Singapore. He concluded that this private financing model led to rapid cost escalation, excess institutional capacity and rapid increases in doctors' incomes. By contrast Stewart (Chapter 4 in this volume) commends the Scandinavians for relying on non-market solutions and quasi-market style reforms to reduce expenditures. Most sensible health economists have argued that competitive contracting for health care services in the hands of a socially responsible institutional purchaser can provide clear incentives for a good performance (Culyer *et al.,* 1990). This is quite a different nuance from Herzlinger's wide-open competitive marketplace. There is no simple market mechanism which will provide health care insurance for all citizens without some direct regulatory intervention from the state. Such market failures are indeed the economic rationale for a continued state presence.

For quite different reasons, the state's presence may paradoxically be understood —not so much because of incipient market failure but because of the market's success, particularly when private interests masquerade as public concern. Markets appeal to rational self-interests and so require regulation to serve collective social objectives such as the broadest pooling of health risk. The unwarranted assumption in *laissez-faire* economies is that physicians can be looked to as disinterested, self-regulating groups who can be guardians of the public interest. Nothing is further from the truth. They have a complex and contradictory role in health care reform initiatives in modern economies (Rachlis and Kushner, 1994).

A simple, if not straightforward, example of how the private income needs of professionals masquerade as public concern is found in the debate regarding the de-listing of so-called non-essential services. In every province in Canada, for example, there has been constant pressure by organized medicine to remove public compensation for services which are regarded as not medically necessary, such as hair removal, tattoo removal, torn ear lobes, etc. Physicians' organizations are leading the charge on behalf of private markets when they can exploit the pinch of public restraint for private gain. When organized medicine benefits from each new private revenue opportunity, it is not surprising that this vested interest finds it difficult to embrace compensation based on the effectiveness of procedures

rather than complete professional discretion. Many public authorities support such initiatives because they look like cost savings, but with various methods of income capping public spending on physicians, de-listing merely involves substituting one form of public spending for another while simultaneously creating new private market opportunities.

When governments extend an open hand to private health care entrepreneurs as typified in the US, there is a double consequence. They effectively deinsure a range of citizens while charging higher prices to the lucky few who can pay the market rate, and they substitute the sometime inefficiency of public insurance for the unproductive overhead of private profit! US Health Secretary Donna Shalala summed up this sentiment by describing the notion of affordable quality health care for all Americans as an idea which has 'collapsed in ruins' (*Financial Times,* 23 January 1998).

What the public has understood intuitively better than many public policymakers is that the culprit behind rising health care costs is not profligate governments nor rampant citizen abuse (see Feldberg and Vipond, Chapter 3 this volume). Rather, powerful physician organizations and large corporate actors can always inflate health care needs to meet their private income objectives as governments have slowly and painfully learned. As Evans (1997b) acerbically notes, what is offered by advocates is always some form of managed or regulated market —managed and regulated by and/or in the interests of the advocates.

It comes as no surprise that market-driven health policy has proven disappointing even though the state's role in the organization, financing and management of health care is now broader and more complex than ever before (World Development Report, 1993, 1997). Hayek's belief in the universal perfect market may be back, but Keynes and Beveridge have by no means beaten a hasty retreat! Yet, the Beveridge system is in trouble nonetheless.

THE PRECIPITOUS FALL FROM GRACE OF STATE BUREAUCRATS

In Beveridge's model, the state was to be an enlightened guardian of the public interest. By the end of the 1990s, modern pollsters revealed that in the public's mind nothing could be farther than the truth (Hutton, 1995; Zussman, 1997).

Rising health standards have not granted people greater authority to hold the state accountable for its actions in the health sectors. Beveridge's breakthrough was a macro solution for national management, but many of today's health concerns devolve to the local and community level. For example, a fiscal solution to a health care budget will not provide the equality and recognition demanded by the gay community. Nor can central policies deal easily with the gender politics associated with an oversupply of invasive surgical procedures for women. Only sensitive and local democratic governance can respond to such identity needs expressed as health concerns. Such unmet identity expectations have also

turned the public against the best of medical science and the public guardians of the Beveridge system.

This is not a case of 'a wilderness of single instances'. The public feel repeatedly betrayed by government's failure to protect them from avoidable cataclysmic health hazards whether they be defective products, communicable disease or bureaucratic bungling. Many governments have repeatedly failed in their fiduciary and health surveillance responsibilities. Of course, this is an exaggeration because public authority is better informed than ever and dramatic health care improvements have benefited the total population. Yet, it is germane to ask, what have governments really learned from the Thalidomide, contaminated blood supply, injurious vaccines, cyanide-laced Tylenol, legionnaires' disease, Lyme disease and DES (diethylstilboestrol)? It would be comforting to give an unequivocal, positive response that health authorities have learned a great deal from these medical disasters that harmed so many. Unfortunately, it is not so simple (Garrett, 1994).

States have continued to fail to protect the public from avaricious and reckless corporations. Silicone breast implants, asbestosis, and tobacco have cast a long shadow on governments' capacity to protect the public and occupational groups such as miners from unsafe products and unsafe work. Governments too have also harmed the health of the public in more direct ways. We now know that in a disturbing number of jurisdictions ranging from Alberta, Sweden to Norway, states of all political stripes routinely sanctioned sterilization practices on those deemed to be inferior or unfit—a practice that continued well into the 1960s. The public has also discovered that on too many occasions hospitals and hospital administrators have betrayed the public's confidence. Negligent and intentional infant deaths and malpractice have convinced many that the public authority is an ill-suited steward of the sacred trust Beveridge conferred on them. It is difficult to think that these episodes of tragedy could be surpassed by events even more dramatic and damaging to public confidence; but they have.

There are still many unanswered questions connected with the role of government public health administrators in allowing the blood system to be contaminated with HIV virus, hepatitis C, and Creutzfeld Jacob disease (CJD) — the human equivalent of mad cow disease (BSE). Initially, public administrators tried to downplay the seriousness and prevalence of these often lethal blood-borne diseases. In fact, the public record documents a kind of administrative mentality that encourages administrators to lie to protect the public interest. Scientists too have been complicit and withheld information in the public interest. When trusted public officials could no longer hide behind technical obfuscation they were forced to acknowledge the scale of the disaster. It is now admitted in Canada alone, more than one hundred thousand people have been infected with hepatitis C, a potentially life-threatening condition, and not ten thousand—the discredited estimate that public authorities used initially to downplay the seriousness of the tragedy.

It used to be thought that these failures of public surveillance were isolated instances of dereliction of responsibility to incorporate biological science into public health practice. They may well be, but the public mood has hardened because too many systemic failures have called into question the underlying assumptions, principles and organizational arrangements of state-sponsored health care systems. Although it may be tempting for those with means, it would be foolhardy to conclude that a disenchanted public should look to markets for protection, the same markets that produced many of these defective products. Indeed only a more vigilant public health authority with a well-resourced infrastructure can identify problems quickly and provide a stronger national and global surveillance system (Foreman, 1994).

Today, when global markets require all governments to take coordinated measures to reduce global health risks, new initiatives and new practices are needed. The advanced market economies face new policy demands having largely eliminated infectious disease and extended life expectancy. Chronic diseases are costly to treat and require policy solutions which marry health care and labour market attachment. The twin challenges of sustaining solidarity and the collective bearing of risk remain principally the responsibility of national governments

This is why it is important to recall Beveridge's larger vision in which health care was at the epicentre of a national project with international significance. His time was much like our own in which countries were under pressure to cooperate internationally. Like today, Beveridge faced an array of critics who questioned the capacity of the state to administer such a broad and complex program. It is worth briefly revisiting his radical ideas in order to recall the foundation principles of health care and the need for clearly articulated and comprehensive public objectives. In Beveridge's plan, health care was never a stand-alone program. It was linked to the other pillar of the modern welfare state—the full employment imperative. Why was this so important?

BEVERIDGE'S FIRST PRINCIPLES AND THEIR RELEVANCE TODAY

In its original form, his grand scheme called for health care to be provided for all those who needed it. Full employment protected society against the ravages of a crude *laissez-faire* market system. Through a system of progressive taxation, states ensured that there would be an adequate and sufficient level of job creation and when there was a shortfall, unemployment insurance was the fall back. As for income distribution, a universal health care system was designed to give greater discretionary spending to the working classes (Esping-Andersen, 1990).

It is not sufficiently recognized that by removing the financial burden of catastrophic illness from their wage packets, their disposable incomes would rise. No longer would they have to pay doctors from their pockets when their children were born or they fell sick and when they went to hospital; lack of money did not constitute a barrier to good care. These reforms, along with the

spread of collective bargaining in advanced industrial economies, enabled people to enjoy the benfits of an expanded notion of social citizenship. Health care and full employment thus constituted a forward-looking framework for social health and not simply clinically provided health care. If, then, Beveridge conceived of full employment as essential to the preservation of fundamental liberty the ancillary question, and one that is far more intriguing, is why did he think of a universal health care system as 'a daring adventure' capable of transforming *laissez-faire* capitalism? (Beveridge, quoted in Williams and Williams, 1987:78).

What was path-breaking was his visionary idea that health insurance would be obligatory and on a scale sufficient to satisfy the health needs for an entire nation. It was intended to cover all citizens without upper income limits, but was fine-tuned to take into account different ways of life. The scheme would recognize diverse social situations and needs and would also provide coverage for those outside of the labour market, including housewives, the young and the aged. His most radical innovation was the notion of health as a right of citizenship for the industrial working classes rather than a need to be met through charity or overtaxed public facilities. The very idea of universal citizenship entitlement to health care eschewed any need to ration care. But it also assumed a great deal more. In particular, the risks inherent in modern society would be borne collectively (Marquand, 1997). The provision of welfare, including health insurance, would cover a whole population against all the main risks of modern life: industrial accidents, sickness, unemployment, destitution, and old age. This entailed fundamental administrative reform because all existing social welfare schemes would have to be welded into, in Beveridge's words, 'one autonomous system without gaps and over-lapping.[2]

If these were the essentials, there was much more to Beveridge's action plan. It required a modern and efficient bureaucracy that did not exist in most countries in order to organize a national health service. All these experts would have to be recruited and become part of the public service. The plan also assumed that the state would be a good manager in the stewardship of public funds and that competing bureaucratic rivalries could be re-channelled to serve the public interest. As well, the scheme presumed that public and private interests would be mutually reinforcing, well-delineated, and balanced. It was further anticipated that initially, health care spending would increase dramatically and then level off as the health of the population improved. So it was the state's principal responsibility to invest in public health and, equally, to be the cost-accountant of the system. In this vision of things, a modern public health system would be the great leveller—the poor and working classes would have access to the same facilities as the wealthy and the elites. Yet Beveridge's vision was, also, about generating new resources for doctors, nurses and those working in the health care sector, and their loyalty would be ensured by the promise of rising incomes and revitalized hospitals.

So, all in all it was a dazzling mix of first principles and organizational arrangements to extend citizen rights and accommodate the professional interests

of doctors and health care experts. The genius of his model was that states with very different needs and social and institutional arrangements would be able to adapt it to local conditions. In this way, Beveridge captured the attention of the world with his bright ideas for an insurance plan 'all embracing in scope of persons and needs' (Williams and Williams, 1987).

In an era of trade agreements and market liberalization, there is much that endures in Beveridge's original formulation even if many of the theoretical postulates are now stale-dated. Most advanced economies now possess reasonable health care infrastructures as a function of increased national wealth, even where chronic unemployment is prevalent. As a function of market liberalization, health inequalities have been growing as market income inequality has intensified (Wilkinson, 1996). In all jurisdictions these gaps have widened in the past decades as public policy-makers have embraced market-favouring policies. Many of the new challenges cannot be met within the old health care framework (Vegero, 1995). For instance, with globally competitive marketplaces workers in advanced economies now face not only the health threats posed by unemployment, under-employment, and over-employment but also a speeding up of the pace of work and changes in the organization of work associated with technology and new management practices (Drache and Glasbeek, 1992).

Our understanding of the health effects of work organization has advanced beyond early notions of health and safety (Karasek and Theorell, 1990; Siegrist, 1996). Big occupational class differences in health status were presumed to be largely accounted for by differences in lifestyle—diet, smoking, and exercise. Recent breakthroughs in research on occupational gradients suggest that while these 'lifestyle' factors may be important, by far a greater predictor of differences in heart disease between occupational groups is tied up with structural factors such as individual control on the job (Marmot *et al.,* 1997). The challenge for governments and firms is to abandon a nineteenth-century manufacturing model of occupational health and safety and replace it with one that ensures that job redesign takes into account this new knowledge. These labour market and occupational examples demonstrate that Beveridge's notion that universal access would equalize health disparities was mistaken (Macintyre, 1997).

By contrast, the single best predictor of a country's health status is its long-term economic growth and policies which benefit the poor and reduce disparities. In the words of the 1993 World Bank Report, 'government policies which promote equity and growth together will therefore be better for health than those that promote growth alone' (World Development Report, 1993:7). Contrary to Arrow's assertion that 'recovery from disease is as unpredictable as its incidence' (Arrow, 1963:951), the most reliable correlate of disease is none other than social class—a category frequently ignored. It is now recognized that health is not a thing apart which can be studied or understood separate from the general organization of society (Blane *et al.,* 1996). From this perspective, the production of health requires a prosperous economy, a reasonably equitable distribution of wealth, and social cohesion (Evans *et al.,* 1994; Sullivan, 1998; Wilkinson, 1996). These

notions may not win the applause of neoclassical economists, but they go a long way in explaining why market models do not produce superior health outcomes in terms of life expectancy, infant mortality or other comparable health status indicators (Evans *et al.,* 1994).

Even so, it is significant to note that few governments have been able to broaden their health schemes to include the dimensions of gender, age, occupational status and class as essential goals in comprehensive health reform. Indeed, health policy specialists have an arcane discourse of treating the social determinants of health as a separate health matter from health care delivery. Health is all too frequently seen as primarily a service provision challenge. For this important reason, mechanisms must be found to ensure that the care and comfort giving elements of the health care system are not in competition with the equity imperatives of a modern health policy. The key seems to be that health authorities have to link macro policy objectives with policies which transform the macro environments in which people live and work. There are numerous instances where this has been the case.

Community programs which serve disadvantaged children can contribute as much to adult health as any other single measure (Blane *et al.,* 1994; Carnegie Corporation, 1994). Top of the line sex education can lead to dramatic reductions in sexually transmitted diseases (STD) which account for 250 million new cases of debilitating and sometimes fatal STDs each year. Improved access to family planning clinics could save many children from dying each year and eliminate many of the 100,000 maternal deaths which occur annually, particularly in developing countries (World Development Report, 1993:10). Companies which have strong workplace representation and which delegate authority to workplace committees demonstrate fewer injuries and ill health conditions (Shannon *et al.,* 1997). Reining in the power of physicians by reducing their monopoly of knowledge and privilege in the delivery of health would be a major step towards restoring such balance.

Social market economies with stronger equity arrangements appear to be better positioned to take the long view by attending to the social determinants of health. The elites in *laissez-faire* market economies have yet to abandon the rugged individualism inherent in market-driven policies. They continue to think, wrongly, that the old welfare state is exhausted and many of its programs are obsolete. They have not absorbed the important lesson that the significant improvements in health have resulted from the success of public sector health efforts.

CANADA: MORE STATE, MORE MARKET?

Paradoxically, Canada is thought of as the prototype where the tensions between state and market have always co-existed, often uneasily[3] (Tuohy, 1992). The health policy community in Canada remains sceptical about market solutions in health reform (Evans *et al.,* 1994). Nevertheless, Canada's health system combines

the efficiency of public payment (72 per cent is publicly financed) with the advantages of private delivery, both profit and not-for-profit. It is the only OECD country which makes no charges for most medically necessary services. Short of crossing the US border, there is no way to 'buy your way to the front of the line'. Virtually all hospitals are publicly regulated. In most provinces, physician salaries are in some way capped, albeit at a generous level. Despite Canada's status as a higher spender in the OECD, the Canadian system is becoming lean and efficient as many of the contributors to this volume candidly describe. Yet Canadians display the highest satisfaction with their system overall, compared to the Americans who display the lowest among ten nations (Blendon *et al.* 1990).

The Canadian story is that Ottawa and the provinces have not simply used persuasive talk of 'managing health care expenditures', they have actually reduced spending as a portion of GDP from 10.4 per cent in 1992 to 9.4 in 1996, despite much public criticism and worry about funding cuts. The fear is that Canada's publicly funded medicare system does not have the funds to survive in its present form. Based on current trends and the size of the existing cuts, the public is worried that Canada seems to be moving towards a US-style system, a dubious notion that is championed by those who stand to gain from such a move and opposed by most Canadians. Even so, its spending record stands in stark comparison to the US, the oddity of the international community currently at over 14 per cent of GDP. The relationships among the amount of money spent on health care, quality of care, and health outcomes remain unclear (Arweiler, 1998; Contandriopoulos, 1998). Not surprisingly, to the outside observer and many Canadians as well, Canadian reforms appear to involve not only a larger role for private finance, but also a larger role for the state! Evidently Ottawa, under the Liberal government, is intent on having the best of both worlds. On the one hand, private payments for pharmaceuticals, long-term care and certain medical services have grown in recent times. On the other hand, there is now significant debate about extending public insurance to include home care and pharmaceuticals (National Forum on Health, 1997). It is doubtful that the compromise between the public and private will remain what it is today without injecting large new resources from Ottawa, a move which is likely to be resisted by some provincial governments. Unless Ottawa is ready to invest heavily in Canadian medicare, Canadians will be facing a more overtly two-tier medical system.

Beyond these short term adjustments, there are more fundamental questions to be addressed. Is Canada moving closer to the market in social policy or strengthening the fundamentals of a publicly anchored system (Drache and Ranachan, 1995)? Has the reduction of GDP spending on health care irreparably harmed the quality of health care in Canada or simply reduced the supply of money for health care? Are the newly evolving regional health authorities bold new experiments in democracy, or a covert exercise to download costcutting? By giving markets wider scope, is Canada's health system on the point of being integrated into a more market-oriented North American health market (Appleton,

1994)? Finally, all health authorities are facing the new challenge of reconciling their international trade obligations with the maintenance of a strong, high quality health care system. The lessons derived from the recent Canadian experience in health reform have useful application for academics and policy-makers in other jurisdictions. The National Forum on Health recently conducted intensive qualitative research on whether Canadians continue to value their health care system. Their strong finding was that the Canadian health care system is a fundamental tenet of being Canadian and a majority of Canadians do not wish to see its quality compromised. In a time where markets are relied on more than ever as an adjustment mechanism, Canada stands out as a country that continues to balance market pressures with state activism and a continuing commitment to the social market policies, despite powerful continental harmonization pressures in health policy. Canada, of course, may not be unique. In all market economies there is an active 'residual' of Keynesian public trust nurtured by public commitment to universal health care. Markets may be back with a vengeance but health care remains a stabilizing instrument of citizenship at a time of global instability.

OVERVIEW OF THE VOLUME

The contributors to this volume comprise many leading Canadian experts in the fields of health economics, sociology, political science, medicine and nursing. They are complemented by health policy authorities from our Anglo-Saxon neighbours, the US and Australia.

Part I of the volume, entitled 'Public—Private Conflicts in Health Policy' explores the factors and forces that are causing the Canadian, British and American authorities to re-examine their health policies in response to market liberalization. Health care is not only a matter for doctors, patients and politicians, it is also in Bob Evans's words, 'the business of business'. Business spokespersons have largely been silent on health care policy, but one should not confuse their silence with consensus. Evans demonstrates that health care is big business and the people who like to make it bigger are those whose business interests such as health care vendors, as distinct from the majority of businesses which are purchasers. His most powerful insight is that the mixed model of health care financing now being considered by many governments will result in higher costs with perverse distributional consequences. States have to think carefully about the conflicting economic interests in their health care systems.

In 'The Virus of Consumerism' Feldberg and Vipond tackle head-on one of the most contentious issues in the reform debates—whether consumer abuse is a myth or widespread practice. Little empirical evidence exists to support or refute claims that the Canadian system is systematically abused. The important point is that no taxonomy of abuse exists and the term is used to describe a range of behavior and moral attitudes which should be kept analytically distinct. They go on to explore the twin narratives of citizenship and consumption, which are both

ideological flashpoints in health reform debates, and they have distinct meanings in Canada from those in the US. Here too, the Canadian discourse is markedly distinct from its American counterpart. The Canadian Keynesian welfare state and its universal social rights were always more than US-style consumer rights because there was always a redistributional aspect to them. In other ways Canada and the US share parallel experiences.

Concluding Part I, Art Stewart provides us with an international comparison of cost containment and privatization. Stewart challenges the way much of the literature on health care reform is presented as a false dichotomy. He underscores the fact that presenting the issues as markets versus regulation is often motivated by ideology and that there is a very real danger that policymakers will lose sight of fundamental social policy objectives. He concludes that the introduction of market elements and competition need not result in wholesale privatization if there is a strong commitment to sustaining access and equity and public accountability.

In Part II, 'Restructuring Anglo-Saxon Health Systems: Shifting State/ Market Boundaries', Barry Appleton examines the impact of NAFTA on health care. Economic integration in North America and Europe is driven by multilateral trade agreements, regional trade blocs and transnational organization. It is notable that the multilateral agreement on investment (MAI) has drawn heavily on the regional North American Free Trade Agreement for investment rights. Significantly, one of the areas in which there is little clarity is the relationship between national health plans and market liberalization in the health sector. Barry Appleton's analysis of this issue represents the first authoritative exploration of the ways in which regional trade agreements affect health care.

Australia's health care system, often compared with Canada's, is not as well known as it should be. For comparative purposes, its system has many incongruous features that appear to work rather well. However, with the election of the Howard Conservative government in 1996, it has given the green light to private for-profit medicine. Peter Botsman's chapter examines the contradictory consequences of relying on markets to restructure Australia's national plan. Overall health costs have been contained compared to their dramatic rise in the US, but the deep cutbacks have raised concerns about the capacity of Australia's delivery system to respond to future demands.

Mary Ruggie, in a wide-ranging examination of the many meanings and implications of privatization, challenges the idea that the state is better off (or worse off) because the private sector has a larger role to play in health care. Although it is commonly thought that regulation is a public sector activity, she makes the important point that it too is subject to privatization. The great value of her chapter is her examination of the contrasting role of the state in Britain, the US and Canada in the social construction of the health care system. She stresses that many of the changes in the health care field are not adequately captured by conventional categories of the public and private domain.

Part III, 'Decentralization and Devolution', examines new institutional forms and practices. The single most dramatic level of change in Canada and other jurisdictions is occurring at the sub-national level of government. Governments everywhere are interested in devolution and decentralization. The question is whether such changes in government practice have more to do with style than substance. Furthermore, it is also important whether these new arrangements actually empower communities with a greater say in decisionmaking at the local level. Compared to most other jurisdictions, Canada is a unique political and social laboratory and has gone further than most other public authorities in creating an array of regional boards, distinctive province by province.

Part III begins with the chapter by Trottier *et al.* Quebec has been a vigorous supporter of decentralization—not primarily for fiscal reasons but to reestablish an equilibrium between national spending authority and Quebec's desire for greater autonomy. In Quebec the centralization/decentralization dynamic is driven by three different visions of the role of the state—the liberal, the social and the community. As Trottier *et al.* demonstrate, the social vision seeks to maximize the role of state in order to strengthen social solidarity. The community vision tends to minimize the role of the state while increasing freedom of choice for local communities. The liberal vision seeks to minimize the role of state and expand individual liberties. In contrast to the analysis presented by Mary Ruggie, the Quebec tradition has been a strongly social one, designed to enhance a collective sense of identity through the state.

Jonathan Lomas has written a pioneering study examining the evolution of devolution, and documents what kind of authority communities want. Contrary to conventional wisdom, decentralization is not a panacea which automatically empowers people or communities. The community is not always reaching for greater authority, particularly when they are being asked to cut their own budgets as they take on authority.

Church and Noseworthy in 'Fiscal Austerity Through Decentralization' examine the health care reform policies in Alberta and provide another view of market rhetoric and reality. The Alberta reforms have in fact created a weak state presence in the health sector consistent with Alberta's liberal vision of the state.

Significantly, in Ontario with 40 per cent of Canada's population, the politics of local control of health care have been at the centre of a continuous debate for over twenty years, beginning with the *Report of the Health Planning Task Force,* popularly known as the 'Mustard Report'. The election of a Conservative government in June 1995 has meant drastic change in Ontario's medicare sector—numerous hospitals have been closed and others merged. Harden describes how the debate over local control has been hijacked to ensure a reform agenda that offloads cutbacks to local communities.

Part IV, 'The Political Economy of Health Reform in Canada', provides three unique perspectives on the Canadian cost-containment experience. Frequently it is difficult to develop a comprehensive view of the many pressures that are reshaping Canada's health system and the degree to which government policy is

capable of responding to them. The central question to be addressed is whether a downsized system will force a re-examination of the principles of The Canada Health Act. Carl Sonnen and Mike McCracken weigh in on this question and provide a detailed overview of the political economy of recent Canadian reforms from a macroeconomic perspective and with a view to a revitalized federal role.

The idea that money can be saved by modifying patient demands is taken on directly by Gail Donner. Her chapter is highly revealing because she challenges the accepted wisdom that cost control is an effective way to implement health reform. She argues that rather than focusing on the limited impacts of demand modification in a system which has global budget caps, primary care reform presents more fruitful possibilities for real structural change.

Ted Marmor provides some straight talk on the ‘intellectual acid rain’ that drifts northward to Canada from US health interests. President Clinton’s failed health reform provides Marmor with ample material to analyse the politics of cross-national claims in health policy. He urges Canadians to steer a prudent course away from a privately financed alternative.

Part V, ‘On the Frontier of Reform’, addresses four unique health policy problems. The problem of patient choice and decision-making, the unique challenges of constraining the drug industry and the special challenge of overcoming our policy legacies in health are addressed in turn. Deber and Sharpe begin with an important empirical look at patient preferences in decision-making. The economic argument that health care can be bought and sold and that consumers behave like shoppers faced with competing choices is worth testing. They employ original data from people facing health information choices for problem-solving in angiography and those facing surgery decision making options arising from prostate problem. One of their chief conclusions is that patients do wish to be involved in decision making when they have the necessary information. The relationship between the providers and the recipients of care is not one structured on the market but in their view is better conceived as a partnership of mutual respect. Genuinely shared decision-making does not necessarily threaten doctor—patient relations.

The single fastest growing expenditure item in health budgets has been pharmaceuticals. Relatively little is known about why drug costs have risen so dramatically. Joel Lexchin documents the cost effects of new drugs, changes in drug pricing and the patent conflicts between Canadian generic drug manufacturers and their multinational brand name competitors. His chapter can be profitably read alongside Appleton’s analysis of the patent protections which are a key feature of the NAFTA.

Lavis and Sullivan explore the role of interests in shaping and hindering policy reform in the health sector. They argue that new institutional arrangements are required if states are to consider the social determinants of health in decision-making. In particular they single out the important roles for multistakeholder bodies and policy entrepreneurs. Economic integration has produced large scale adjustments for many countries. Coordinating social and health care programs

with neighbouring states appears, in principle at least, a reasonable and attractive objective. Cross-national diffusion of health care practices is not simply a North American issue but requires close scrutiny because many European countries are also facing similar prospects

The final word belongs to Fraser Mustard in 'Health, Health Care and Social Cohesion'. He examines the new realities which face health policy-makers. In much of the debate on health policy throughout the OECD, there has been intense focus on the concept of community and social organization and the role of communities in solving social problems. Terms like 'social capital' and 'social trust' have been frequently invoked, particularly in relationship to the hollowing out of the state and polarized labour markets. Mustard contributes to the long tradition of medical practitioners in contributing to our understanding the determinants of health. His chapter concentrates on the role of social trust in promoting human development in the health domain. He is highly critical of government reform efforts that sacrifice social capital objectives in the rush to implement short-sighted cost-cutting measures.

NOTES

1 With respect to health care delivery, there is no universal model but only different public-private mixes reflecting institutional arrangements. At one end is Sweden with largely public providers; in the middle is Australia and New Zealand with a mix of public and private providers; Canada has a unique niche with its largely not-for-profit private delivery system. The US completes the spectrum with a private, for-profit delivery system. Even the US, however, has a significant not-for-profit component. Most OECD nations have predominantly publicly financed systems, with the US as the main outlier (OECD, 1994).

2 Prior to the Beveridge reform in the UK and social market economies, the principle of social insurance—the operative premise of Beveridge's reform zeal— had already been accepted by public authorities for industrial accidents and old age pensions (Stone, 1986). Social welfare legislation made modest but uneven progress between the wars in most jurisdictions.

3 Canada has never produced a social reformer of the stature of Beveridge, but Norman Bethune, who hailed from Gravenhurst, became a Canadian hero of the Chinese revolution for his work in promoting the barefoot doctor as a model of primary care. He brought medicine to people without professional affectation, self-interest or profit motives. The Canadian political landscape has always been home to radical political figures like the early feminists, trade union activists, the Co-operative Commonwealth Federation (CCF), the forerunner of Canada's modern social democratic party, the NDP, political leaders like former NDP parliamentary leader Tommy Douglas, Monique Begin, and radical liberals like her who have made health care reform a central political goal. These reform movements and state-sponsored health innovations have long interested practitioners and policymakers the world over.

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Part I

Public—private conflicts in health policy

2
Health reform
What 'business' is it of business?

Robert Evans

IN PURSUIT OF INTERNATIONAL STANDARDS

Canadians are justifiably proud of Medicare. This national (strictly, federalprovincial) program is not merely a mechanism for reimbursing hospital and physicians' services. It is one of the (few) institutions expressing the unity and distinctness of the Canadian people, and our commitment to each other both symbolically and in hard cash. But in fact all (but one) of the major industrialized countries have established universal public payment systems for health care, and most are similarly proud, or at least highly supportive, of them. National systems differ in important details but in broad outline all share the characteristic features that White (1995:271) labelled the 'International Standard':

- universal coverage of the population, through compulsory participation;
- comprehensiveness of principal benefits;
- contributions based on income, rather than individual insurance purchases;
- cost control through administrative mechanisms, including binding fee schedules, global budgets, and limitations on system capacity.

All have also developed the physical and technical capacity, and the personnel, to make appropriate and up-to-date health care available to their whole populations without financial barriers—though some do impose such barriers. And in all these systems 'the state' is either the principal source of finance, or a powerful force regulating the behaviour of other, quasi-public funding organizations (Abel-Smith, 1992; Abel-Smith and Mossialos, 1994). Where market-like mechanisms exist, they are typically 'managed markets' (Ham, 1994), manipulated to further public (or sometimes private, professional) objectives. They are never the free competitive markets of the economics textbooks.

The great exception, the United States (Abel-Smith, 1985), demonstrates the potential consequences of failing to achieve the international standard. The alternative—it is deceptive to speak of a 'system' *or* a 'free market'—that evolves in the absence of comprehensive public intervention turns out to be extremely