

**NATIONAL VALUES, INSTITUTIONS AND
HEALTH POLICIES:
WHAT DO THEY IMPLY FOR MEDICARE REFORM?**

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by

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I. Introduction

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

Both the anti- and pro-amendment positions assume a fairly tight connection between what are called “*Canadian national values*” and the particular structural features of Medicare. Is that assumption warranted? What role do “*national values*” play in the shaping (or re-shaping) of health insurance programs in Canada, and more generally in the world of developed democracies?

Section II of this paper is first a methodological commentary on what is and can sensibly be meant by appeals to “national values.” It then addresses the general theoretical concerns about how such values might be embodied in the institutions of different Western democracies. Section III briefly reviews the large number of reports that have recently called for a variety of different reforms to the Canadian health care system; rather than commenting on the substantive policy recommendations of those reports, it concentrates on the surprising extent to which these various “calls to reform” share—or claim to share—underlying value presumptions. Section IV provides some comparative evidence showing how loose the connections really are between anything coherently termed “national values” and the concrete forms of social institutions. Many variables besides “values” are at work in shaping and re-shaping particular institutions of social policy. And, conversely, many quite differently shaped social institutions may reasonably be said to embody the same set of values. Section V returns to the Canadian discussion of Medicare, and argues that a range of possible amendments would be perfectly consistent with – and therefore would not greatly threaten – Canadian national values. Choosing among those options requires a degree of prudence – an attention to the political realities of conflicting interests, and to the practical realities of resource management and information – at least as important as the values that prudence aims to advance. That a social welfare institution expresses the right values is a necessary, but is not a sufficient, basis for its adoption as a wise course of action. Section VI concludes.

II. What Are “National Values?”: The Presumptions of the Inquiry

Social science has long been suspicious of the notion of “national values” (Schumpeter 1908). After all, values are held by persons, not by corporate entities that have neither minds nor desires. It is true that we may speak loosely of the “values of the common law,” or the “values of the Catholic church.” By such usage we mean to locate fundamental doctrines that emerge from the writings, or from the beliefs of the elite, within a certain tradition. But in general, “values” refers to subjective views of individuals about what is worthy or important. In politics, these are

views about the ends that social institutions ought to advance, and the virtues they ought to embody.

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

These cautionary observations should not, however, blind us to the important role that values may play in creating a political community and in guiding its actions. Statements of values may inspire, unite, even "constitute" a people: think of the Declaration of Independence and the Bill of Rights in the United States, or the Magna Carta in Britain. And public statements of shared values – even if the values come to be shared only after they are publicly stated – may serve as important guides to action. The fact that values are general and may compete with one another does not, after all, render them meaningless. Values are no policy straitjacket, but there are certain choices they rule out.

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

Before attempting to establish the truth of those plausible claims, however, it will be worthwhile to pause to distinguish values from a number of other important forces that shape public institutions. On the top of that list must be *interests*. Interests are states of affairs or courses of action that persons are motivated to pursue based on the powerful drive for self-aggrandizement (including self-aggrandizement's prerequisite, self-preservation) (Mansfield

1995, Hirschman 1992). Persons have multiple interests; these are calculable, predictable, objective, and – like values – can be traded off against one another (Mansfield 1995). Institutional arrangements that were created because they advanced shared values may survive because they further powerful interests. And institutions created from self-interested motives may well embody values, or serve to establish them in society over time (Immergut 1992).

Public opinion, too, can shape institutions.¹ Opinions are views, prudential or ethical, about states of affairs or courses of action. These are notoriously more subject to short-term amendment than either values (which, because they are general, are less subject to amendment in light of short-term factual changes) or interests (which one can, in principle, objectively calculate). General opinions grounded in values (“Access to health care should be universal.”) appear to be more “sticky” than opinions about particular states of affairs (“Medicare is working well.”) (Maioni and Martin 2001).

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

The social democratic states of Northern Europe have, according to this line of argument, strong traditions of hierarchical collectivism, with moderate support of individualistic norms and weak embrace of sectarian modes of policy promotion (Okma 2002). The United States, by contrast, displays a weaker appeal to collectivism and an active streak of sectarian political mobilization. Market efficiency and individual liberty are, according to polling studies, leading American values. Yet, as Douglas and Wildavsky acknowledge, it is a mistake to assume a very close fit between value-informed modes of policymaking and actual policy. Even the United States, with its seemingly dominant competitive-individualist values in policymaking, managed to establish Medicare, Medicaid, the Veterans Administration health program, the Indian Health system, law mandating emergency medical care regardless of patients’ ability to pay, tax incentives to encourage the purchase of private insurance, tax incentives for the provision of private charity care, and publicly funded hospitals that give free or discounted care. No one could reason her way to this set of health care institutions and programs from a premise of “competitive individualism” in policymaking. And this is so even if one concedes the accuracy of the characterization of US values. The concrete details of health policy, in short, are not tightly linked even to styles of policymaking that reflect dominant value orientations.

Finally, social and political institutions, once created, develop lives of their own (Tuohy 1999). For example, the historically contingent fact that Britain’s National Health Service (NHS) was created just after the Second World War made its centralized organization likely, and that has shaped much of its subsequent development (Klein 1995). In the United States, the postwar development of private health insurance markets (driven, partly, by employer tax benefits) has

¹ Equally, institutions can shape opinions (Immergut 1992).

made it very difficult for government to assume as central a role in the delivery and financing of health care as it has in other developed countries. The constitutional model for Canada's Medicare required bargaining between provinces and the federal government. From the beginning, also, there was regular bargaining with medical associations. Those features have conditioned Canadian policymaking and further developments of Medicare have emerged to a large extent out of the institutional processes and rules of this Canadian "game" (Tuohy 1999).

The next section briefly characterizes the range of reform proposals that have marked the Canadian political scene in recent years. The purpose of this review is not to evaluate any of the policy proposals contained in these reports; that has been done adequately elsewhere. Rather, the aim is to set the Canadian context for the more concrete discussion of national values and health policy. Section IV will consider some concrete evidence regarding the question whether and to what extent different countries may, on the basis of similar distributions of values, establish quite different national institutions of social welfare. The evidence collected there shows that many of the core structural differences in national health care arrangements are the product not of differences in fundamental social values but of differences in political superstructure, of differing accommodations of clashing interests, and of the historically contingent "accidental logics" of established social institutions. This substantiates this paper's first core contention, namely, that national values are not a policy straitjacket. Section V turns to the second core contention: that contemporary Canadian values neither require a major change in Medicare nor do most of the reforms proposed require a change in values to be justified.

III. Calls for Reform in Canadian Health Care: Context and Convictions

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

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

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

What follows is not a summary of the various reports. Rather, it is an attempt to locate them on a value spectrum in connection with the purposes of this inquiry. Among the many recent reports making reform recommendations for Medicare, it is possible to distinguish three basic types: One type, in the course of recommending incremental improvements, ardently affirms the values of Medicare as unchangingly valid. Thus the report of the Tommy Douglas Institute of February 2001 proclaims: “[O]pponents [of Medicare] have always exaggerated its weaknesses. They now allege that Medicare’s principles of universality and public, not-for-profit care are ‘tired’ and no longer relevant. These claims are demonstrably false....” (Rachlis et al. 2001). At the other end of the spectrum, there are reports that propose changes in Medicare that, regardless of the report’s professed attachment to Medicare’s values, are in fact incompatible with the egalitarian values the program now embodies. An example of that category is the Mazankowski report of December 2001 (Mazankowski Commission 2001), which has been characterized as leaving “virtually no stone unturned in the quest to open Canada’s public healthcare system to the private sector,” (Marshall 2002) and as “adopt[ing] a thoroughly American neo-conservative political stance that declares government the worst of all possible actors, and taxation the worst of all possible financing mechanisms” (Lewis and Maxwell, 2002).

Between these points on the spectrum are many reports which urge “reinterpretation” or “modernization,” though not departure from, the core values of Medicare. They claim to propose reforms that are compatible with Medicare’s fundamental values, but that interpret them in light of a variety of different issues of practicality, political acceptability or managerial feasibility. These range from the 1997 report of the National Forum on Health, which explicitly recommended the preservation of Medicare’s public funding, “single payor” organization, and the five principles of the Canada Health Act (National Forum on Health, 1997) to the 2000 commentary of the Institute for Research on Public Policies, which recommended a broader

interpretation of the five principles as well as the addition of principles of quality and accountability (Decter et al. 2000). The Clair Commission in Quebec, for example, recommended many policy and managerial changes, none of which was thought to depend upon or imply changes in Canadian or Quebec values; instead, the Commission characterized its recommendations as a “modern interpretation” of the five Canada Health Act principles, which it characterized as “socially legitimate” and seriously challenged by “no one” (Clair Commission 2001). In Ontario, a restructuring commission struggled to implement substantial reforms in the structure of the province’s hospitals and provision of medical services. But, as with Quebec, this commission embraced Medicare’s value premises while promoting policy reforms (Ontario Health Services Restructuring Commission 2000).

The Saskatchewan Commission on Medicare proposed a major reorganization of provincial hospital and medical services. Again, its recommendations did not rest on either the claim that Canadian values had changed substantially or that changes in values were needed to support reform: “There is nothing wrong with the principles of Medicare (as a solid majority of Canadians continue to believe); one can make a strong case that they are essential in a humane and efficient society” (Fyke Commission 2001).

In 2000, Senator Kirby’s committee began its own two-year review of health care. Its final report, issued in October 2002, was a virtual catalogue of the various reform proposals (Kirby Committee 2002). It did not call for comprehensive change in Medicare, but suggested that the “public administration” feature needed revisiting and piecemeal alteration.

In early 2001, the Romanow Commission began its effort “to examine the state of health care in Canada including the benefits and negatives of the current system.” It had a substantial mandate, conducted extensive research and consultation, and prompted intense media interest. Both its interim report and its final report of November 2002 prompted considerable debate, an indication of just how much interest Medicare arouses in Canadian life (Romanow Commission, 2002). The Romanow final report recommended a “new Canadian Health Covenant” be established “as a common declaration of Canadians’ and their governments’ commitment to a universally accessible, publicly funded health care system.” It also reaffirmed the five principles of the Canada Health Act, though it recommended limiting “portability” to portability within Canada; recommended a more expansive view of “comprehensiveness” to include not just physician and hospital care, but also diagnostic services and home care; and recommended the addition of a sixth principle of “accountability.” (Romanow Commission, 2002).

Despite the rhetoric of crisis and the appeal to needed reforms, then, very few of the Canadian reform proposals actually challenge the fundamental values. Most reform proposals were cast as efforts to realize those values in a more modern way, with greater efficiency and accountability. This, itself, is an interesting and important feature of Medicare’s place in Canada. The program is more than a vehicle for financing hospital and medical insurance. It is best understood as an icon. For this reason there is understandable political reluctance to challenge directly the program’s premises. On the other hand, the iconic status of Medicare makes it perfectly clear why the media – and Medicare’s advocates – are on the hunt for threats to this widely “valued” program.

And such threats do exist; not *every* proposal for reform is compatible with Medicare's values. Most proposals – calling for increased integration and improved co-ordination of services, greater oversight of costs, and so on – are efforts to improve Medicare managerially and keep its outlays under reasonable control; they reflect different views about management and governance rather than fundamentally different values concerning the social provision of health care to the sick or injured. But as Lewis and Maxwell (2002) have pointed out, alone among the most prominent reform reports, the Mazankowski Commission's report—with its attacks on Medicare in Alberta as an inefficient “command and control” monopolistic system, and its recommendations for the introduction of more private-sector competition—constitutes a real (if veiled) effort to transform the values on which Medicare was founded.

Given that the reform reports, for all their policy differences, involve so few challenges to values and embody so little disagreement as to them, the question naturally arises: what relationship is there, if any, between national values and the details of national health policy? This question will be approached first through examination of evidence from other industrial democracies and then by addressing Canadian data more directly.

IV. European Values and Medical Care: Similar Values, Divergent Arrangements

IV.1. Public Attitudes Towards Government's Role in Health Care

Public attitudes towards “government provision” (or financing) of medical care in the European Union show, according to both recent and older research, “surprisingly constant patterns of popularity” (Ardigo 1995 and Coughlin 1980, *cited in* Gevers et al. 2000). On the basis of data from seven European countries and the United States, Ardigo concluded that “citizens considered good medical care ‘very important’ and its provision an ‘essential responsibility’ of the government.” Coughlin's earlier research had come to the same conclusion. On the surface, then, there are grounds for believing that the “Western European welfare state [can] be regarded as an organized system of solidarity” in the sense of redistribution from the healthy to the sick, from the young to the old, and from the employed to the unemployed (Gevers et al. 2000, 302). This is the standard interpretation of polling data from Western Europe and forms the background to more sophisticated investigations of variation in views and values among the European citizens.

Gevers et al. have produced detailed data on contemporary sentiments² in Western Europe towards the provision and financing of medical care. Table 1 shows evidence about the degree of agreement concerning the role of government in *assuring access* to medical care. It clearly reveals general disagreement with the idea that government should play only a minimal role.

2 The terms “sentiments” and “attitudes” are used as synonyms in this section. Both can be based upon (the more fundamental) values, perhaps in combination with factual understanding and emotional commitment.

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

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

This same point emerges with reasonable clarity in the findings summarized in Table 2. The variations in respondents’ answers to the three articulated views show that differences exist among the welfare states of the European Union. Though substantial majorities in every country chose the generally-egalitarian alternative 1, Gevers et al. interpret the standard deviations and skewness to indicate clusters of countries with different attitudes toward the support of public health care.

These data establish two central points: First, they do indicate a broad similarity in the central, solidaristic conception of the role of medical care in the Western European welfare state. This general value orientation, however, exists side by side with substantial differences in the detailed administration, policies, and rules of European medical care arrangements. Second, the variation across Europe suggests that arrangements in more egalitarian (and homogeneous) societies like Sweden and Denmark reveal links between views about equal access to medical care and programmatic arrangements that minimize the role of income in access or financing.

Question 2	<p>Here are three opinions. Please tell me which one comes closest to your own?</p> <p>1) The government has to ensure that health care is provided to all people residing legally here, irrespective of their income;</p> <p>2) The government has to ensure that health care is provided only to those people residing legally here, with low income;</p> <p>3) The government does not have to ensure that health care is provided to people residing legally here, not even those with low income (Gevers et al. 2000).</p>
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Table 2					
Distribution Measures for Question 2					
Country	Percent choosing alternative 1	Mean	Standard deviation	Skewness	
Denmark	86.50	2.86	0.38	2.52	
West Germany	71.80	2.67	0.57	1.52	
Greece	87.20	2.83	0.47	2.85	
Italy	71.70	2.68	0.53	1.44	
Spain	90.10	2.88	0.40	3.39	
France	76.20	2.70	0.58	1.79	
Ireland	58.90	2.55	0.58	0.84	
Netherlands	77.70	2.75	0.50	1.84	
Portugal	72.00	2.66	0.59	1.53	
Great Britain	85.90	2.84	0.41	2.60	
Finland	79.60	2.79	0.43	1.70	
Sweden	94.80	2.94	0.27	4.87	
Austria	65.00	2.59	0.61	1.18	

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

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

IV.2. Funding and Provision of Health Care in the OECD: Institutional Arrangements

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

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

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

Source: OECD 1994.

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

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

In the Scandinavian countries, local and regional authorities have primary responsibility for funding and providing health care and related social services to their populations. They bear the financial risk of acute medical and nursing care and have developed extensive social services, which include home care, support for adjusted housing for elderly or handicapped persons, and support for independent living. In the United Kingdom, there is a clear split between the administration of the NHS covering the costs of medical care and the social services provided by local authorities. The Netherlands (in 1988), Germany (in 1992) and Japan (in 1995) introduced separate population-wide social insurance covering the costs of long-term care and home care for their ageing populations. In those three countries, the long-term care insurance serves as a supplement to the existing schemes for acute medical care. The three countries accept a mix of public and private providers in this field, and all three are experimenting with cash benefits allowing consumers to directly contract providers of care instead of services in kind. Policy and institutional variation across the OECD world, then, is undisputable.

IV.3. Styles of Policymaking

The variation extends to styles of policymaking as well. The centralist policy processes of the United Kingdom and France sharply contrast with the functionally decentralized models of Germany, Belgium and the Netherlands (Klein 1995). In the latter three countries, the label of *neo-corporatism* is broadly applicable, a decision-making model where governments and private actors (represented through their interest organizations) share responsibility for the shaping and

outcome of social policies (Wilson 1990). This model implies that private actors are willing and able to take on public responsibilities in the form of active participation in the policy process as well as self-regulation. For example, the representative organizations or interest associations of the German and Dutch hospitals and physicians represent their members in regional or countrywide negotiations with the health insurance agencies over tariffs and volume of their services. Medical associations are empowered with public authority to regulate access to the medical profession, to set standards for medical education and for professional conduct, and to police the professional conduct of all medical professionals (members and non-members alike) with rules and sanctions. The main administrative bodies of social health insurance, the sickness funds, are legally independent actors, and their organizations have collective bargaining power to contract health services on behalf of their insured. In some Western European countries, a large share (and in the Netherlands, the largest share) of health facilities has always been under private, non-governmental ownership and management.

The German corporatist model limits the role of the state in social arenas like housing and health care. Moreover, its federal state has shifted much of administrative responsibilities for its social policies to the provinces or *Länder*. In this policymaking model, most if not all organised interests meet with government in the annual round of consultation, the Concerted Action or *Konzertierte Aktion*, to decide on spending levels and the broad allocation of public funding for health care. After establishing this financial framework, regional representatives of health insurers and providers negotiate contracts with detailed and binding agreements on the volumes and prices of health services.

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

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

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

IV.4. Interest Bargaining

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

V. Canadian Values and Medical Care Arrangements

Section III of this paper noted that nearly all of the recent reports on Medicare support the five basic principles of the *Canada Health Act* (*universality, accessibility, comprehensiveness, portability, and public administration*), as well as Medicare's basic values of public funding and egalitarianism. Several polls conducted in the 1980s and 1990s also demonstrated strong public support of those principles, even as general confidence in government has declined. In the late 1980s, one poll reported a more general erosion of the public confidence in the state (Graves 1988). The Graves study concluded that public institutions in the industrialized world were facing a legitimacy crisis. Interestingly, Canadians did not share a categorical, negative judgement of government. But they expressed the wish to strengthen the public institutions. In explaining those results, the survey found evidence that the media played a role in fuelling cynicism about all major public institutions.

Polling data from the 1980s and 1990s showed that Canadian support for the CHA's principles remained quite high (HayGroup 1999; Maioni and Martin 2001; and *Hospital Quarterly* 2000). Though public support for "public administration" fell significantly during the 1990s, a commanding 59 percent continued to regard that principle as "very important," with additional respondents regarding it as "important." Higher percentages rated "universality" (89), "accessibility" (81), "portability" (79) and "comprehensiveness" (80) as "very important."

Despite concerns about the future of Medicare, Canadians express high satisfaction with the services they actually received (Picard 2000). (This finding, incidentally, is consistent with that in other industrial democracies.) About one-third of those Canadians polled feel that Medicare needs major reform. But over 44 percent think that minor changes will do.

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

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

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

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

the origins of Medicare – whether the hospital insurance program of the late 1950s or the medical insurance program promoted by the Hall Commission – have concluded that the overwhelming support for the egalitarian values of the Medicare program preceded the passage of national health insurance legislation (Taylor 1987). Instead, the story is one of strengthened commitment to these values as Canadians discovered in disputes what was at stake. And, most important for comparative purposes, Medicare is more restrictive than any other OECD country in restricting the role of private payment and private insurance in gaining differential access to care (Marmor, Mashaw and Harvey, 1990).

VI. Conclusion

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

It is not surprising that calls for Medicare reform arose in the 1990s, at a time of relative economic prosperity, when a long period of health care belt tightening seemed to be coming to an end. It is to the political advantage of every interest group to attempt to secure a larger share of public financial resources by stressing the sacrifices it has made and the fiscal challenges it faces. “Crisis talk” – allegations to the effect that these times are extraordinary, and extraordinarily dangerous – is in fact a quite ordinary tool of interest-group politics. Canadian policymakers have thus far resisted the temptation to allow an unwarranted fear of collapse – or an unwarranted allegation of “abandonment of Canadian values” – to guide their deliberations. By every indication we reviewed, Canadian Medicare stands firm on its foundations of still-shared Canadian national values. The question for Medicare reformers, we suggest, is not whether to abandon or re-think those values. It is, instead, how best to embody those values in 21st century institutions. That question requires, for its answer, a prudent attention to the ground-level political and economic realities of Canada, and a prudent review of the health care managerial and financing arrangements that have been tried, for better or for worse, in other nations. That is not to claim that Medicare's values are consistent with just any prudential or managerial adjustment. The program's iconic status assures attention to the issue. And there is little doubt that some of the suggestions for “reforming” Medicare are actually threats to its continuation and do express values inconsistent with the values that Medicare's fundamental principles express. Most Canadians do not believe that access to medical care should depend on the size of their bank accounts. That is indeed a fundamental value, and there are some prominent Canadians who do not share it and yet will not explicitly say so. Clarity on this topic is, we suggest, hard to find and to maintain.

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