

**PUBLIC FINANCING OF HEALTH CARE
IN EIGHT WESTERN COUNTRIES**

The Introduction of Universal Coverage

BY

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Ph.D. Thesis

Submitted to Fulfill Requirements
for a Degree of Doctor of Philosophy at the
London School of Economics and Political Science

1991

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ABSTRACT

The public sector of all western developed countries has become increasingly involved in financing health care during the past century. Today, thirteen OECD countries have passed landmark legislative reforms that call for compulsory prepayment and universal entitlement to comprehensive services, while most of the others achieve similar coverage through a mixture of public and private voluntary arrangements. This study carried out a detailed analysis of *why, how* and *to what effect* governments became involved in health care financing in eight of these countries.

During the early phase of this evolution, reliance on direct out-of-pocket payment and an unregulated market mechanism for the financing, production and delivery of health care led to many unsatisfactory outcomes in the allocation of scarce resources, redistribution of the financial burden of illness and stabilisation of health care activities. This forced the state to intervene through regulations, subsidies and direct provision of services. Expansion in prepayment of health care gradually occurred through private insurance, social insurance and general revenues in response to different socio-economic, political and bureaucratic forces. Although improving health may have been the ultimate goal, offering universal access to affordable health care was the way the countries examined achieved this objective.

Universal comprehensive coverage was associated with a decade of stable public expenditure on health care compared with GDP, total government expenditure and government consumption expenditure. There were no disproportionate increases in health care expenditure or displacement of public funds away from social programmes that depended on cash transfer payments. Nor do the countries that offer such social protection have higher public debt or poorer economic performance compared with the rest of the OECD. Measures of health status are unfortunately still not sufficiently developed or standardised to permit a detailed analysis of this aspect of outcome through cross-national comparisons. Furthermore, the countries examined may be more vulnerable to political backlash because of the high visibility of their government involvement in health care financing.

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ACKNOWLEDGEMENTS

I am especially grateful to Professor Brian Abel-Smith, London School of Economics and Political Science, whose guidance and wisdom provided the main direction for this study. Special credit is given to Professor Rudolf Klein, University of Bath, whose constructive comments led to a critical revision of the final draft and more insightful analysis.

Financial support was obtained through a clinical Fellowship in Geriatric Medicine at University College Hospital, London. Preparation of a brief for Chairman Jean Rochon of the Québec Commission of Enquiry on Health and Social Services in 1986, permitted the international phase of the research and collection of the data for the detailed case studies.

PART I. INTRODUCTION

CHAPTER 1. THEORETICAL FRAMEWORK

A. HISTORICAL ROLE OF THE STATE

For centuries, political philosophers have debated the nature of the relationship between the state¹ and its citizens, "why, how and to what effect different governments pursue a particular course of action or inaction."² In recent times, social scientists have carried out extensive investigation on the **determinants (why), normative functions and instruments (how or what), and outcome (effects)** of policies that define the normative function of modern governments. The following brief historical sketch draws attention to the perennial dilemma between individualist and collectivist concerns about the role of the state, which has a significant impact on the issues and policy options that will be explored in the study. "In dilemmatic situations, the reasons on each side of a problem are weighty ones, and none is in any obvious way the right set of reasons."³ This debate can be extended to health care, which is one of the many complex expressions of modern welfare states -- the content of specific health policies, the reasons they were introduced and their impact on both the health sector and society in general.

Religious and natural law theory on the role of the state in western societies are deeply rooted in antiquity⁴ by the scriptures⁵ and classical thought⁶. Plato was an elitist who believed that knowledge was a virtue and ignorance, a vice. The privileged few were entrusted to govern the ignorant masses.⁷ Health systems are not only an integral subset of the state, but often microcosms of their socio-economic, political and administrative systems. The *papyri*, dating to the second millennium B.C., give fascinating evidence that

¹ The word "state" is generically used to connote an "organised political community under one government, commonwealth [or] nation." J.B. Sykes, ed., *Concise Oxford Dictionary of Current English*, 7th Edition (Oxford: Clarendon Press, 1982): 1037.

² Arnold J. Heidenheimer, Hugh Hecllo and Carolyn Teich Adams, *Comparative Public Policy: The Politics of Social Choice in Europe and America*, 2nd Edition (New York: St Martin's Press, 1983): 2-3. The expressions "comparative", "cross-national" and "international" are used interchangeably throughout the discussions which will follow.

³ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 2nd ed. (Oxford: Oxford University Press, 1983): 4. See also E.J. Lemmon, "Moral Dilemmas," *Philosophical Review* 71(1962): 139-152.

⁴ Emile Brehier, *Histoire de la Philosophie: Antiquité et Moyen Age*, Volume 1, Nouvelle edition (Paris: Presses Universitaires de France, 1938); and François Châtelet, Olivier Duhamel and Evelyne Pisier-Kouchner, *Histoire des Idées Politiques* (Paris: Presses Universitaires de France, 1982).

⁵ The Mishnah and Gemara of the *Talmud* still provide a basis for Jewish civil and ceremonial law. The *Bible* and *Koran* have played similar roles for Christian and Islam societies.

⁶ Aristotle, *Ethica Nichomachea*, Book 5, Chapter 1 and 2, in *The Works of Aristotle*, Volume 9, by W.D. Ross ed., (Oxford: Oxford, 1915). For early theories on democracy, see the works of Herodote and Thucydide.

⁷ Plato documented the ideas on the relationship between knowledge and power that were developed by Socrates. Religious orders support a similar position as does the paternalistic medical profession.

Imhotep, archetypal physician, priest and court official in ancient Egypt, introduced collective services with healers who were paid by the community.⁸ This early experiment in organised health care did not survive the test of time. The *Code of Hammurabi* (1792-1750 BC) laid down, *inter alia*, a system of direct fee-for-service payment based on the nature of services rendered and the ability of the patient to pay.⁹ For the next three thousand years, involvement of the state in health care revolved mainly around enforcing the rules of compensation for personal injury and protection of the self-governing medical guild.¹⁰ At best, financing, organisation and provision of health care was limited to the royal courts of kings, emperors and other nobility who might have a physician for their personal use and troops at the time of battle. The masses got by with local healers, midwives, natural remedies, apothecaries and quacks.

The Dark Ages, Renaissance and Reformation enshrined the twin sources of European civilisation -- religious and state absolutism.¹¹ Supported by the scourge of recurrent bouts of plague, superstition spread its poison across the continent through burning at the stake and executions. King Henry VIII gave sweeping powers to the College of Commonalty of the Faculty of Medicine of London in 1518 to punish quacks and pretenders, but did little else to change the *status quo*.¹² These events fostered an individualist backlash that eventually led to transfer of political power from absolute monarchies and feudal states to the rising property-owning classes. Hobbes believed that individuals entered into a social contract by which they mutually agreed to form a sovereign state (Leviathan) that would limit its role to providing peace, protection and justice: "the liberty each man, hath, to use his own power, as he will."¹³ Locke believed that the only valid state restriction on the innate right to liberty and freedom was to preserve "life, liberty, health, limb or goods of another."¹⁴ Organised care for the sick, disabled and

⁸ Papyri are ancient Egyptian clay tablets. J. K. Mason and R. A. McCall Smith, *Law and Medical Ethics*, 2nd Edition (London: Butterworths, 1987): 4, quoting A. Castiglioni, *A History of Medicine*, translated and edited by E.B. Krunbhaar, 2nd Edition, 1947.

⁹ This famous cuneiform legal code of the first Babylonian Dynasty has nine of its 282 Statutes relating to the services of healers. Statutes 215-217 and 221-223 deal with laws governing the fees to be received for certain services; Statutes 218-220 deal with penalties to be inflicted on the healer in the case of unsatisfactory therapeutic results and death. Careleton B. Chapman, *Physicians, Law, and Ethics* (New York: New York University Press, 1984: 4-5.)

¹⁰ Control of membership and secrecy, reflected in the *Hippocratic Oath*, was characteristic of all trades. British Medical Association (BMA), *Handbook of Medical Ethics*, (London: BMA, 1984): 6.

¹¹ Niccolo Machiavelli, *Le Prince*, [1513], Oeuvres (Paris: Pléiade, 1962).

¹² It later became the Royal College of Physicians in England. Florence had similar powerful, guild-like organisations of physicians and apothecaries by the 13th century. George Clark, *A History of the Royal College of Physicians* (Oxford: Clarendon Press, 1964): 63; Edward Meryon, *The History of Medicine*, Volume 1 (London: Longman, Green, Longman and Roberts, 1891): 436; and England, *Statutes at Large, 14 and 15 Henry VIII, C.5*, Volume 4, p.p. 155-57. The College reaffirmed its extraordinary powers by sending perceived offenders to prison in the City. England, *Statutes at Large, 1 Mary, Sec. Sess.*, C.9, 1553, volume 6, pp. 15-16.

¹³ Thomas Hobbes, *Leviathan*, [1651], Crawford B. Macpherson, ed. (Harmondsworth: Pelican, 1968): 189.

¹⁴ John Locke, *Two Treatises of Government*, [1690], Peter Laslett, ed., Revised Edition (New York: New American Library, 1960): 311.

poor, who according to natural law had brought their destiny upon themselves, was left to local parishes.¹⁵ The transition from Catholicism to Protestantism in northern Europe undermined these early efforts as sequestration of ecclesiastical properties left many reform movements without resources to carry out even minimal custodial care.¹⁶

The emergence of scientific thought during the Enlightenment of the eighteenth century confronted the tyranny of divine right and abuses of state sovereignty with critical reasoning.¹⁷ Kant stressed the responsibility of individuals to be autonomous and choose their own fate as a free and rational beings: "autonomy of the will ... the supreme principle."¹⁸ As was characteristic of the individualism of the times, he believed that freedom and liberty would protect civil and political rights. In contrast, Rousseau and other early defenders of collectivism favoured a social contract to protect economic and social rights.¹⁹ Adam Smith was specific in his description of appropriate limitations in the function of the *laissez-faire* capitalist state: protecting society from violence and invasion; protecting individuals from injustice and oppression of others; and maintaining necessary public works and institutions that are of no personal interest to individuals.²⁰ The first two functions are carried out by all organised societies in the form of defence, police, justice and administration. The third, which anticipates a role in the allocation of resources, is more complex because it leaves scope for interpretation. Poor law relief brought on by industrialization and urbanization, unintentional as it may have been, became one of the earliest expressions of secular involvement by the state in health care.²¹ The criteria for admission was "less concerned with the alleviation of poverty than with preventing public subsidy of the idle."²²

By the nineteenth century, utilitarian theories on the role of the state formally challenged the supremacy of religious and natural-law philosophies.²³ "Utilitarianism is a

¹⁵ Dorothy Wilson, *The Welfare State in Sweden* (London: Heinemann, 1979): 1; Brian Abel-Smith, *The Hospitals 1800-1948*, Heineman Books on Sociology, series editor Donald Gunn MacRae (London: Heinemann, 1964): 1-15; and Bede, *A History of the English Church and People* (Harmondsworth: Penguin Books, 1975 [1955]): 2.

¹⁶ The clergy was forbidden to study or practice medicine, which limited the care that they could give. Stanley Rubin, *Medieval English Medicine* (London: David and Charles, 1974): 189-92.

¹⁷ Norman Hampson, *The Enlightenment* (Harmondsworth: Penguin Books, 1968). The peaceful transfer of power that occurred in Britain exploded into a blood bath during the American [1775] and French [1789] Revolutions.

¹⁸ Immanuel Kant, *Metaphysical Foundations of Morals*, [1785], in *The Philosophy of Kant, Immanuel Kant's Moral and Political Writings* (New York: Modern Library, 1949).

¹⁹ Jean-Jacques Rousseau, *The Social Contract and Discourse on the Origin of Inequality Among Mankind* Lester G. Crocker, ed. (New York: Washington Square press, 1964): 7.

²⁰ Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations*, [1776] (Oxford: Oxford University Press Edition, 1976).

²¹ In Britain, unification of the Elizabethan Poor Laws took place in 1602.

²² A.W. Dilnot, J.A. Kay and C.N. Morris, *The Reform of Social Security*, The Institute of Fiscal Studies, London (Oxford: Clarendon Press, 1984): 6.

²³ Utilitarian theories can be linked to the pursuit of happiness and pleasure advocated by the hedonistic philosophy of Epicurus.

maximising and collectivising principle that requires governments to maximise the total net sum of the happiness of all their subjects ... in contrast to natural rights theory which is a distributive and individualising principle that assigns priority to specific basic interests of each individual subject."²⁴ Appealing to 'reasonable men', Bentham felt that natural rights were "simple nonsense ... nonsense upon stilts."²⁵ Mill believed that individuals should be free in their actions "to carry these out in their lives without hindrance, either physical or moral, from their fellow men, so long as it is at their own risk and peril."²⁶ Intended to liberate individuals from state intervention, his *laissez-faire* "invisible hand" left urban populations vulnerable to all sorts of social injustices in early industrial societies. This gave rise to Marx's collectivist vision of the socialist state: "Mankind must first of all eat, drink, have shelter and clothing, before it can pursue politics, science, art, religion, etc."²⁷ His philosophy on equity transcended the political rejection that it evoked in many western societies: "From each according to his ability, to each according to his need."²⁸ Poor law infirmaries,²⁹ the sanitary movement³⁰ and social insurance³¹ during the latter part of the nineteenth paved the way for health care as one of the legitimate functions of the state.

A first step beyond minimal provision would be to allow the state to carry out unanimously approved activities that lead to Pareto improvements.³² Pareto efficiency, or the point at which no further action could be taken without worsening the position of

²⁴ Jerome J. Shestack, *The Jurisprudence of Human Rights*, in *Human Rights in International Law: Legal and Policy Issues*, Volume 1, by Theodor Meron ed. (Oxford: Clarendon Press, 1984): 88.

²⁵ Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, in *A Fragment of Government and an Introduction to the Principles of Morals and Legislation*, by Wilfrid Harrison, ed. (Oxford: Blackwell, 1948): 78.

²⁶ John Stuart Mill, *On Liberty*, [1859], Currin V. Shields ed. (Indianapolis: Bobbs-Merrill, 1956): 67.

²⁷ Friedrich Engels, *Speech at the Graveside of Karl Marx*, in *The Marx-Engels Reader*, by Robert C. Tucker, ed. (New York: Norton, 1972): 603.

²⁸ Karl Marx, "Critique of the Gotha Program," in *The Marx-Engels Reader* by P.C. Tucker, ed. (New York: Norton, 1972): 388; Marx believed that emancipation would only be complete when capitalism had been transcended to establish a "direct relationship between labour to its products." Karl Marx, *Economic and Philosophic Manuscripts* (Paris Manuscripts) in *Writings of the Young Marx on Philosophy and Society*, Anchor Books, by Loyd D. Easton and Kurt H. Guddat eds. and trans. (Garden City: Doubleday, 1967): 291.

²⁹ The Poor Law Amendment Act was passed in 1834 and the Poor Law Outdoor Relief Regulation Order passed in 1852. Pat Thane, *Foundations of the Welfare State*, Social Policy in Modern Britain Series, Jo Campling, ed. (London: Longman, 1982): 4-47.

³⁰ Edwin Chadwick, *Report on the sanitary condition of the labouring population of Great Britain [1842]*, by M.W. Flynn, ed. (Edinburgh: Edinburgh University Press, 1965); Clauses Consolidation and Town Improvement Acts of 1846; Nuisances Removal and Diseases Prevention Acts of 1846; Public Health Act of 1848; and Health of Towns Commission in 1848. Municipal Corporations Act of 1835.

³¹ Otto Prince von Bismarck, *Bismarck: The Man and the Statesman*, Volume 1 and 2, A.J. Butler, trans. (London: Smith, Elder & Company, 1898).

³² V. Pareto, *The Mind and Society*, A. Bongiorno and A. Livingston, trans., A. Livingston, ed. (New York: Harcourt and Brace, 1935): Chapter 12; V. Pareto, *Manual of Political Economy*, A.S. Schweir, trans., A.S. Schweir and A.N. Page, eds. (New York: Kelly, 1971): Chapter 6, para. 33 and Appendix para 89; V.J. Tarascio, *Pareto's Methodological Approach to Economics* (Chapel Hill, University of North Carolina Press, 1968); and J.M. Buchanan, "A Hobbesian interpretation of the Rawlsian difference principle," *Kyklos* 2(1976): 5-25.

others, would define the acceptable limit to state involvement. An individualistic social welfare utility function can be written as $\Gamma(U^1, U^2, U^3, \dots, U^h)$, where U^h is the utility of individual h .³³ To go beyond this simple Pareto criterion, gains and losses could be optimised.³⁴ Benthamites would maximise each individual utility ($\Gamma = U^1, U^2, U^3, \dots, U^h$), while Rawlsians would maximise the welfare of the least well-off ($\Gamma = \min(U^h)$).³⁵ Egalitarian preferences would depart from both of these by aiming to decrease the "distance" between individual utilities ($U^2 > U^1$).³⁶ Most western countries go beyond these approaches to include non-individualistic, collective social preferences³⁷ through *welfarism*³⁸ in the case of social security benefits and *extra-welfarism*³⁹ in the case of health care. These theories have been extensively discussed in the literature on the development, evolution and future of the welfare state. Governments do this through paternalist social preferences that fix "not a strictly equal distribution but an assured universal minimum."⁴⁰ Decisions to tax alcohol and tobacco, while spending public funds on food, education, housing and health care follow this logic.

The dichotomy between individual and collectivist rights split the developed world into two political blocks during most of the twentieth century.⁴¹ Theories on the modern state have remained as divergent as ever, ranging from the "minimal" state,⁴² through states that ensure Pareto efficiency and justice⁴³ to maximisation of social welfare and communism.⁴⁴ Nozick's "night-watchman" is at one extreme of this spectrum: "a minimal state limited to the narrow functions of protection against force, theft, fraud, enforcement of contracts, and so on is justified [to prevent anarchy]."⁴⁵ This hypothetical state, which

³³ Antony B. Atkinson and Joseph E. Stiglitz, *Lectures on Public Economics* (London: McGraw-Hill, 1980): 339. Using a positivist approach, the state is described according to *what* it does rather than *why*.

³⁴ W.S. Vickrey, "Utility, strategy and social decision rules," *Quarterly Journal of Economics* 74(1960): 507-535; and J.C. Harsanyi, "Cardinal welfare, individualistic ethics and interpersonal comparisons of utility," *Journal of Political Economy* 73(1955): 309-321.

³⁵ A.K. Sen, "Interpersonal aggregation and partial comparability," *Econometrica* 38(1970): 393-409.

³⁶ J.E. Meade, *The Just Economy* (London: Allen and Unwin, 1976).

³⁷ J.M. Buchanan and G. Tullock, *The Calculus of Consent* (Ann Arbor: University of Michigan Press, 1962); M. Olson, *The Logic of Collective Action* (Cambridge, Mass: Harvard University Press, 1965).

³⁸ Richard M. Titmuss, *Essays on the 'Welfare State'*, 2nd ed. (London: Allen & Unwin, 1963); Brian Abel-Smith and K. Titmuss, eds., *The Philosophy of Welfare: Selected Writings of Richard Titmuss* (London George Allen and Unwin, 1987); Harold Wilensky, *The Welfare State and Equality* (Berkeley: University of California Press, 1976).

³⁹ Extra-welfarism as applied to health care requires that some of the informational restrictions of welfarism, such as equity and utility, be relaxed to include happiness, out of pain, freedom to choose, physical mobility, enjoyment of relationships with others and so on. Anthony J. Culyer, "Demand-side socialism and health care," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁴⁰ J. Tobin, "On limiting the domain of inequality," *Journal of Law and Economics* 13(1970): 266. James F. Childress, *Who Should Decide? Paternalism in Health Care* (Oxford: Oxford University Press, 1982).

⁴¹ Natural law, utilitarian and positivist philosophical orientations still dominate the debate. Theodor Meron, ed., *Human Rights in International Law: Legal and Policy Issues*, Volume 1 and 2 (Oxford: Clarendon Press, 1984).

⁴² Robert Nozick, *Reading Nozick: Essays on Anarchy, State and Utopia* (Oxford: Basil Blackwell, 1974).

⁴³ John Rawls, *A Theory of Justice* (Oxford: Oxford University Press, 1971).

⁴⁴ Vladimir Ilich Lenin, *State and Revolution* [1917], in *Selected Works*, Volume 2, (Moscow, 1961): 355.

⁴⁵ Robert Nozick, *Reading Nozick: Essays on Anarchy, State and Utopia* (Oxford: Basil Blackwell, 1974): ix.

does not exist anywhere, draws heavily on the earlier writings of Hobbes and Locke. At the opposite extreme are those who insist that the state should control all economic activities in an Orwellian centrally planned state to protect the collective interests of society. The traditional communist model, which draws heavily on Marx, Engels and Rousseau, was introduced as a tool of rapid industrialization by socialist states in response to the economic crisis of 1931-3.⁴⁶ The rigid interventionist communist model has now been rejected by most of the Eastern European countries that introduced it,⁴⁷ just as the "invisible hand" has been supplemented by extensive social security provisions in most Western European countries.⁴⁸ Positivist theories, based on observable legal and social infrastructures, have replaced religious, natural law and utilitarian theories on the role of the modern state.⁴⁹

⁴⁶ Michael Ellman, *Socialist Planning*, 2nd Edition (Cambridge: Cambridge University Press, 1989).

⁴⁷ Christine Kessides, Timothy King, Mario Nuti and Catherine Sokil, eds., *Financial Reforms in Socialist Economies* (Washington: Economic Development Institute, 1989).

⁴⁸ International Labour Office (ILO), *Social Security: Introduction to Social Security* (Geneva: International Labour Office, 1984), 9; and United States, Department of Health and Human Services (DHHS), *Social Security Programs Throughout the World - 1983*, Research Report No. 59 (Washington: Government Printing Office, 1984).

⁴⁹ Developed by Auguste Comte and heavily influenced by the Jeremy Bentham, it has become the basis for twentieth century jurisprudence. H.L.A. Hart, *The Concept of Law* (Oxford: Clarendon Press, 1961). This concept will be developed in greater detail in the section on methodology.

B. DETERMINANTS OF PUBLIC POLICY

The links between the extensive body of literature of comparative studies on the determinants of public and social policy and the emerging body of literature on health policy are weak. There are three dominant schools of thought on *why* governments try to influence public and social policy: level of socio-economic development such as industrialization, urbanization and accumulation of wealth; political processes such as ideology, democratization and political party formation; and bureaucratic structures such as the age of institutions and style of administration. In addition to these mainstream theories on the determinants of the welfare effort, a significant body of literature is emerging from a totally different source on the determinants of health policy -- economic theory about market failure. Although health policy cannot be analysed in isolation of the developments that have occurred in the welfare state, overemphasis of the latter risks distorting issues and policy options that are unique to health care as a specific programme feature of the welfare effort.

Transferability of phenomena observed in the broader sphere of public and social policy should therefore not be taken for granted when addressing problems in health policy. Many investigations of the determinants of the welfare state are highly aggregate, using data that is easy to quantify. Furthermore, they characteristically focus on cash benefits offered through social security programmes during times of occupational injury, illness, unemployment, disability and old age. Health care, on the other hand, is usually offered as a benefit in kind with financing coming from many sources, private and public, often making it difficult to identify total aggregate expenditure. Early studies of the welfare effort that included health care therefore tended to concentrate on descriptive, non-theoretical and non-comparative aspects. They ignored chronological sequencing of events, intrinsic programme features and the impact of health policy on other developments in the evolving welfare state. Theoretical issues were rarely validated through systematic cross-national comparisons. The closest analogous public service provided as a benefit in kind is social services. In education, the issues and debates on policy options are too different from those confronted in the health sector.¹

¹ For an extensive review of this literature, see Klaus Hüfner, John W. Meyer and Jens Naumann, "Comparative education policy research: A world society perspective," and Leslie C. Eliason, Ingemar Fägerlind, Richard L. Merritt and Hans N. Weiler, "Education, social science and public policy: A critique of comparative research," in Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., *Comparative Policy Research: Learning from Experience*, WZB-Publications (Hants: Gower, 1987): 188-261. Also see, Arnold J. Heidenheimer, Hugh Hecl and Carolyn Teich Adams, *Comparative Public Policy: The Politics of Social Choice in Europe and America*, 2nd Edition (New York: St Martin's Press, 1983): 21-52.

1. Level of Socio-economic Development

The dominant school of thought in cross-national analyses claims that the level of socio-economic development along with its bureaucratic and demographic correlates -- the number of years that social security systems have been in existence and the age structure of the population - are the most significant determinant factors in the formation of the welfare state.² Researchers have tried to prove this claim through multi-variant regression analysis of both cross-sectional and longitudinal time series for a variety of variables such as level of socio-economic development, stage of evolution of social security infrastructures, degree of affluence and so on. Commonly used measures of the welfare effort, or the degree to which a state is involved in the provision of social security benefits, include public expenditure on social security in relation to national wealth measured as by GDP, levels of energy consumption, urbanization and literacy rates.³ These studies consistently indicate that there is a strong correlation between the development of social insurance programmes and the level of socio-economic development and growth.⁴ Similar observations have been made about health care expenditure and health status as measured by life expectancy and infant mortality rates in relation to GDP.⁵

Scholars have found it more difficult to unravel the interplay between potential social determinants (historical, cultural and demographic) and socio-economic determinants (industrialization, urbanization and accumulation of wealth). Industrialization and urbanization lead to declining birth rates, ageing of populations, unemployment, industrial accidents and massive health and social problems associated with urban living. Changes in lifestyle and demographic shifts in populations lead to a loss of the traditional

² Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 384.

³ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975).

⁴ Phillips Cutright, "Political structure, economic development and national social security programs," *American Journal of Sociology* 70(March 1965): 537-50; Phillips Cutright, "Income redistribution: A cross-national analysis," *Social Forces* 46(1967): 180-90; Henry J. Aaron, "Social security: International comparisons," in *Studies in the Economics of Income Maintenance*, by Otto Eckstein ed. (Washington, D.C.: The Brookings Institution 1967); and Joseph A. Pechman, Henry J. Aaron and Michael K. Taussing, *Social Security: Perspectives for Reform* (Washington, D.C.: The Brookings Institution 1968).

⁵ J.P. Newhouse, "Development and allocation of medical care resources: Medico-economic approach," in *Development and Allocation of Medical Care Resources*, Proceedings of the 29th World Medical Assembly, Tokyo, Japan Medical Association, 1975; J.P. Newhouse, "Medical care expenditure: A cross-national survey," *Journal of Human Resources* 12(1)(Winter 1977): 115-125; Robert J. Maxwell, *Health and Wealth: An International Study of Health-Care Spending* (Lexington, Massachusetts: Lexington Books, 1981); OECD, *Measuring Health Care 1960-1983: Expenditure, Costs and Performance*, OECD Social Policy Studies. (Paris: OECD, 1985); OECD, *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*, OECD Social Policy Studies No. 2 (Paris: OECD, 1987); George J. Schieber and Jean-Pierre Poullier, "International health spending and utilization trends," *Health Affairs* 7(4)(1988): 105-112.

security offered by the land, families and local communities. Vulnerable populations gain some protection when industrialization and urbanization provide the state with the economic means to create social security programmes.⁶ Social transformation is therefore necessary for industrialization and economic growth itself, but by itself this is not sufficient to be a dominant factor for the formation of a welfare state.

Proponents of the importance of socio-economic development also claim that among affluent societies, an interplay of other factors such as political ideologies, mass pressures and bureaucratic structures may enhance differences among developed democracies, but fail to act as key determinant factors to explain observed variations: "Much useless controversy is generated by researchers who focus on programme structure and administration and complain that researchers who study aggregate spending and taxing are wasting their time."⁷ A country's affluence may have a stronger and more direct impact on social spending per capita than on its welfare effort because "a small effort by a very rich country such as the United States generally means more cash for each person than a large effort by a 'rich' country farther down the economic scale such as Austria."⁸

Although the occasional study may show a negative relationship between socio-economic level of development and welfare effort, these contradictions can largely be explained by differences in methodology, samples, indicators, cross-sectional sample and time series of the data used.⁹ "These findings stand up with or without the inclusion of measures of political systems."¹⁰ Comparing communist, authoritarian and liberal democratic societies, other investigators have concluded that system age was a more significant indicator of health, welfare and education spending than political orientation.¹¹ The public policies of both communist and democratic regimes have "converged" in adopting the same seven or eight basic programmes, extending coverage over time and rapid increases in public expenditure. When the analysis is controlled for level of socio-economic development, regime type was of no consequence in determining public expenditure on social programmes. Although the duration of the existence of a

⁶ Jerald Hage and Robert Hanneman, *The Growth of the Welfare State in Four Western European Societies: A Comparison of Three Paradigms* (Madison, W.I.: Institute for Research on Poverty, 1977).

⁷ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): footnote 2, p. 443.

⁸ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975): 17.

⁹ Koji Taira and Peter Kilby, "Differences in social security development in selected countries," *International Social Security Review* 22(2)(1969): 1939-53.

¹⁰ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 386.

¹¹ Frederick Pryor, *Public Expenditure in Capitalist and Communist Nations* (Homewood, I.L.: Irwin, 1968): 179-80, 205, 219. A notable exception are unemployment benefits which do not exist in communist countries.

programme may also be significant, when age is controlled over time, level of socio-economic development remains the key determinant factor.¹²

Studies that use multivariate regression analysis to establish determinant relationships potentially have a serious flaw. A high correlation between two observations does not establish causal relationships unless accompanied by path analysis, which authors of these studies rarely carry out. The social policy literature is filled with studies that claims to establish that *X* causes *Y* because there is a high correlation between the two variables. The high correlation that exists between socio-economic development and health care expenditure therefore does not prove that one causes the other. When the number of possible causal factors is very large, special techniques are necessary to ensure that observed correlations do not represent mere coincidences.¹³

2. Political Processes

Proponents of a second school of thought believe that the welfare state developed not only because of socio-economic level of development, but also because of a more complex interplay of political processes.¹⁴ These authors claim that over the past 50 years, political determinants have been equally, if not more, significant in explaining growth trends in some aspects of the welfare state than level of socio-economic development.¹⁵ Because of the scope and complexity of comparative public policy is "sometimes as broad as three-quarters of what governments do", investigators who limit their research to macro-analysis at the national level risk missing many of the subtleties that would appear at a more disaggregate level.¹⁶ Furthermore, determinant factors that appear true for social policy and the welfare state do not necessarily apply to specific programme and sub-

¹² Guy B. Peters, "Economic and political effects on the development of social expenditures in France, Sweden and the United Kingdom," *Midwest Journal of Political Science* 16(2)(1972): 225-38.

¹³ The section on methodological problems will discuss different techniques that can be used to minimise the chance that artifacts are misinterpreted as significant correlations.

¹⁴ Jens Alber, Gösta Esping-Andersen and Lee Rainwater, "Studying the welfare state: issues and queries," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 458-468; Peter Flora and Jens Alber, "Modernization, democratization and the development of welfare states in Western Europe," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 37-80; and Peter Flora, "The Growth of Mass Democracies and the Welfare States" in *State, Economy and Society in Western Europe 1815-1975: A Data Handbook*, Volume I (Frankfurt: Campus, 1983).

¹⁵ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 392; G. Esping-Andersen and W. Korpi, "From poor relief to institutional welfare states," in *The Scandinavian Model* by R. Eriksson et al., eds. (New York: M.E. Sharpe, 1985).

¹⁶ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 381.

programme features such as health policy and phenomena that occurs at the sub-national level.

a) Ideology

Both meritocratic and egalitarian values exist in most modern societies. Taxes, social spending and their political effects reflect complex mixes of individualism and collectivism. The political impact of *elite* ideology as expressed through official rhetoric and mass ideology through public opinion may be self-cancelling over time.¹⁷ "People love pensions and are only a shade less enamored of national health insurance. ... Citizens in Denmark, the United Kingdom, Canada and United States alike have serious reservations about unemployment compensation and are quite doubtful, if not downright hostile, to public assistance; they think the benefits too often go to the undeserving."¹⁸ Studies that lump these factors under a single measure or indicator will miss subtleties of individual sub-components. Although some authors claim that opposing abstract ideologies, such as the policies of ruling parties or dominant coalitions, have little impact on the welfare effort in terms of the level of social security expenditure,¹⁹ their analysis fails to eliminate the possibility that political processes have other significant impacts on the welfare state.

Some investigators have observed that political parties promote different programmes based on their underlying ideological orientation. When liberal ideologies dominate, governments are more likely to introduce subsidised voluntary schemes as was done in Denmark, whereas when socialist ideologies dominate, they are more likely to introduce compulsory plans such as was done in Norway and Sweden.²⁰ Unfortunately, when liberalism is inferred from the level of industrialization and urbanization, as it was in these studies, it becomes a superfluous variable of the level of socio-economic

¹⁷ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975).

¹⁸ Richard M. Coughlin, *Ideology, Public Opinion, and Welfare Policy: Attitudes Towards Taxing and Spending in Industrialized Societies*, Monograph Series No. 42 (Berkeley: Institute of International Studies, University of California, 1980): p. xii, discussed in Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 393-94.

¹⁹ Kenneth Janda, "Measuring issue orientations of parties across nations," *ICCP Reports* quoted in Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 392.

²⁰ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

development. This demonstrates the importance of careful attention to methodological design and the selection of indicators or units-of-measurement that are representative of the issues that be examined.

Proponents of the importance of more subtle political processes claim that studies on socio-economic development are misleading because they rely too heavily on aggregate indicators that hide the true determinants of the welfare effort. More complex indicators, such as a mixed index of per capita GDP, current general government revenues/GDP, education expenditure and infant mortality, are needed to illustrate society's welfare effort. When such composite indicators are used, the importance of ideology as a variable increases, while that of socio-economic development disappears.²¹ Aggregate expenditure also fails to reflect intent and effect. Subtle indirect redistribution may occur through restrictions on private education, private medical care, private transportation, tax deductions and so on without being directly portrayed as social expenditure. "The evidence, imprecise and incomplete as it is, suggests that in countries where left-wing parties have had powerful ruling positions over many years, as in Scandinavia and Austria, policies have reflected a conscious and generally successful effort to redistribute and restrain the privileges of private wealth by measures that fall outside of the social security catchment."²² Social democratic strategies focus on social reforms and income redistribution through taxation in mixed-market economies, while communist strategies emphasise government ownership through an elimination of the reward system of capitalism.

Similar arguments have led some investigators to conclude that countries whose constitutions are based on parliamentary monarchies as a national political culture lean towards paternalistic ideologies and are therefore more likely introduce social security programmes earlier.²³ "Monarchical regimes, experiencing neither the legitimation nor the ideological constraint of liberalism, had a greater need for and ability to institute the

²¹ Francis Castles, *The Social Democratic Image of Society* (London: Routledge and Kegan Paul, 1978): 55.

²² Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 404; and Erik Einhorn and John Logue, *Welfare States in Hard Times: Denmark and Sweden in the 1970s* (Kent O.H.: Kent Popular Press, 1979).

²³ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83; and Robert T. Kudrle and Theodore R. Marmor, "The development of welfare states in North America," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and HIWED Project, 1981): 81-121.

programmes of the welfare state.²⁴ The expansionary pressures of ageing systems soon effected the social security systems of the pre-war monarchies of Germany, Austria, Sweden and Denmark. Federal states such as Canada and Australia may be slower than central states to introduce such programmes because squabbles between provinces/states and central governments compound traditional party differences. Unfortunately, the small sample size of federal states among western developed countries make evidence for this theory impressionistic.²⁵

The influence of ideology on health policy has been the subject of heated debate in the literature for a number of years.²⁶ Conflicts between the medical profession and other health professionals, and between generalists and specialists often reflect underlying class struggles that are much more complex than the issues presented.²⁷ Whether or not public hospitals allow pay beds to exist may represent much deeper issues such as "near-State monopoly of health care in a pluralistic, liberal democracy."²⁸ The battle between trade unions and the medical profession sometimes reflects political conflicts between a Labour Party and Conservative Party as much as it does labour disputes within the profession itself. Inequality in health care between different classes of the population has been the focus of much of the debate in the United Kingdom.²⁹ Higher education, which is often regarded as meritocratic, may lead to complex trade-offs against other welfare provisions and be associated with a heavy political price. The associated increased employment opportunity leads to upward mobility, but it also leads to erosion of working class solidarity. Public expenditure on education offers greater equity in opportunity while that

²⁴ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 440.

²⁵ Australia, Austria, Switzerland, Germany and Canada are the only federal states among the OECD group of countries.

²⁶ K. Barnard and K. Lee, *Conflicts in the National Health Service* (London: Croom Helm, 1977); and J. Stacey, *Health and the Division of Labour* (London: Croom Helm, 1977).

²⁷ H. Eckstein, *Pressure Group Politics: The Case of the British Medical Association* (London: Allen & Unwin, 1960); R.F. Badgley, "Health worker strikes: Social and economic bases of conflict," *International Journal of Health Services* 5(1)(1975): 9-17; B. Ehrenreich, J.H. Ehrenreich, "Hospital workers: Class conflicts in the making," *International Journal of Health Services* 5(1)(1975): 43-51; T.R. Marmor and D. Thomas, "Doctors, politics and pay disputes: 'Pressure group politics' revisited," *British Journal of Political Science* 2(4)(1972): 421-442; Vicente Navarro, *Class Struggle, The State and Medicine: An Historical and Contemporary Analysis of the Medical Sector in Great Britain* (London: Martin Roverson, 1978; Vicente Navarro, "Social class, political power and the state and their implications in medicine," *Social Science and Medicine* 10(9/10)(1976).

²⁸ Rudolf Klein, *Ideology, Class and the National Health Service*, Project Paper No. RC4 (London: Kings Fund, 1980).

²⁹ Julian Le Grand, *The Strategy of Equality* (London: George Allen and Unwin, 1982); Douglas Black, *Inequalities in Health: Report of the Research Working Group* (London: DHSS, 1980); and R. Illsley, "Occupational class, selection and inequalities in health," *Quarterly Journal of Social Affairs*, 3(3)(1987): 213-23; Peter Townsend and Nick Davidson, eds., *Inequalities in Health* (Harmondsworth: Penguin Books, 1982); R. Illsley and J. Le Grand, *Measurement of Inequality in Health*, Welfare State Programme Discussion Paper No. 12 (London: London School of Economics, Suntory-Toyota Centre for Economics and Related Disciplines, 1987); and M. O'Higgins, "Inequality, redistribution and recession: The British experience, 1976-82," *Journal of Social Policy* 14(3)(1985): 279.

on health care offers greater equity in results.³⁰ Health systems are vulnerable to such political developments that occur outside their direct realm.

b) Democratization

The importance of democratization as a determinants of the evolution of social policy is equally marked by contradictory evidence. In one sample of industrial societies, researchers found that differences in constitutional arrangements strongly predicted the timing of the introduction of new social security programmes at the turn of the twentieth century.³¹ Dualist-constitutional monarchies such as Austria, Denmark, Germany and Sweden had a 63 per cent success rate in enacting proposed legislation, while parliamentary democracies such as Belgium, France, Great Britain, the Netherlands Switzerland and Italy had only a 21 per cent success rate.³²

Although political enfranchisement did not seem to be a significant factor by 1900, social insurance legislation appeared to flourish more rapidly once a 'suffrage threshold' of 50 per cent of the male population has been reached. By contrast, neither level of socio-economic development measured by the labour force in secondary sector industry and populations in cities nor left-wing politics measured by the percentage of the population voting for working-class parties had a significant effect on progressive social policy in this study.³³ Political continuity, which increases the likelihood of successful enactment of legislation and fiscal commitment seems, however, to be associated with early introduction of progressive reforms.³⁴

The late democratization of the Nordic monarchical regimes and the multi-party system of proportional representation weakened the bourgeois parties of a divided right-wing opposition (conservative, agrarian, Christian and liberal parties) in face of the emerging working classes in Denmark, Norway, Sweden and Finland (Germany and Austria). This

³⁰ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975): 3-7.

³¹ Peter Flora and Jens Alber, "Modernization, democratization and the development of welfare states in Western Europe," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 37-80.

³² Norway and Finland were difficult to place in this series. Norway only became a parliamentary democracy in 1884 and Finland was neither a parliamentary democracy nor a constitutional monarchy, being a Grand Duchy of the absolutist Russian Tsar until it became a republic following the 1917 Revolution.

³³ Peter Flora and Jens Alber, "Modernization, democratization and the development of welfare states in Western Europe," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 37-80.

³⁴ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

cohesion of the left wing and disunity of the right wing provided a fertile political arena for progressive social reform.³⁵ By contrast, early democratizers such as Australia, New Zealand, Canada and the United States brought on strong anti-government bureaucracy sentiments.

The experience of Australia and New Zealand, which became welfare state pioneers during the 1930s, contradicts these theories. Unfortunately, the lack of quantitative demographic data prevents a more detailed analysis of the importance of the ageing of the population, urbanization, political mobilisation and socio-economic correlates. These and other shortcomings in the arguments fuel the challenge from critics who claim that democratization cannot be associated with the timing of the adoption of social security programmes.³⁶

The literature on democratization has not been linked to health policy in the same way as that on other political processes, level of socio-economic development or bureaucratic infrastructures.

c) Political Party Formation

Some authors maintain the the most significant aspect of the peaceful introduction of social reforms was the formation of modern political party systems. It has been suggested that the high levels of welfare effort in the Nordic countries is associated with a united left wing dominance at the expense of a divided right wing in the party system. To demonstrate this point, proponents of this theory have tried to use complex composite indices as measures of welfare effort, with left dominance being defined as socialist, social democratic and labour parties. When left wing majorities defined in this way dominate in coalition governments, they weaken non-socialist resistance to welfare policies. In contrast, based on a 15-country sample between 1945 and 1972, when right wing parties dominate the political scene, welfare efforts have a much harder time taking hold.³⁷ "The most satisfactory explanation for the exceptionally high levels of welfare effort in the Scandinavian countries is the ascendancy of social democratic parties."³⁸ This occurred largely through the significant size of the working class, the large middle class and socio-economic growth. Other authors have found similar positive associations between left wing political power and income redistribution policies.³⁹

³⁵ Francis Castles, *The Social Democratic Image of Society* (London: Routledge and Kegan Paul, 1978).

³⁶ Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press 1974).

³⁷ Francis Castles, *The Social Democratic Image of Society* (London: Routledge and Kegan Paul, 1978): 76.

³⁸ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 397.

³⁹ Christopher Hewitt, "The effects of political democracy and social democracy on equality in industrial societies: A cross-national comparison," *American Sociological Review* 42(1977): 450-64.

Countries that were late to democratize had small right wing political parties that were divided among traditional conservatives, agrarians, Christians and liberals. This led to weak support for free-market political policies. At the same time, disunity of the bourgeois parties created a fertile context for the evolution of working-class welfare ideologies. In Denmark, Norway, Sweden and Finland the impact of an ageing social security infrastructure was enhanced by this political trend. In contrast, countries that were earlier to democratize also had more time for nineteenth century liberal and right wing laissez-faire ideologies to take hold. They were later in introducing welfare state institutions and therefore later to experience the expansionary pressures of ageing social security infrastructures. These countries -- the US, Canada, Ireland and Switzerland -- remained welfare state 'laggards' well after other western countries had introduced sophisticated social security infrastructures.

Critics of this school of thought, however, point out that political structures and electoral procedures may lead to ambiguities when the resulting governments in power do not represent the majority political tendency: the Netherlands has enjoyed a rich history of social policies despite its weak social democratic politics, and Belgium, Switzerland and Luxembourg have been relatively slow to introduce social reforms despite their weak right wing governments.⁴⁰ They also point out that the proponents of theories on party formations have omitted other determinants in their analysis. By including traditional measures of welfare effort -- social security expenditure/GNP -- the impact of political party formation appears less conclusive. Right wing parliamentary strength inhibited public expenditure on education in the 1960s and 1970s, and public expenditure on health, income maintenance and total welfare in the 1970s. By contrast, social democratic rule was only associated with increased public expenditure in the 1960s, but inversely related to all other expenditure.⁴¹

For political ideology and political parties to have a significant effect on social reforms, the electorate must be offered distinct platforms, voters must make identified informed choices and governments must have the mandate to implement these choices.⁴² "There is no empirical basis for this 'rational' image of voting behavior. Students of political behaviour have shown that there are more compelling explanations of voting behaviour such as party identification, class, values, and increasingly the influence of mass

⁴⁰ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 398.

⁴¹ Francis Castles, "The impact of parties on public expenditure," in *The Impact of Parties: Politics and Policies in Democratic Capitalist States*, by Francis Castles, ed., (Beverly Hills: Sage 1982).

⁴² Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press 1974): 228.

movements, the mass media, and single issue groups."⁴³ Parties offer generalities, voters respond to distorted images of platforms and the media creates its own political agenda.⁴⁴ Election promises are easily forgotten in the face of new economic and political environments.

Other investigators found that there is no causal relationship between left wing power and welfare effort. They claim that left wing dominance promotes a "tax-welfare backlash" through their support of highly visible progressive income and proper taxes, and "political backlash" when they include communist parties in their coalitions. They broadly defined left wing power as governments committed to income redistribution and equality (economic, political and social) for the lower social strata of society. This included communist, socialist, social democratic, labour and liberal (American Democrat) party formations and in power between 1919 and 1976.⁴⁵ In contrast, Catholic parties that had anti-communist/socialist/labour/social democratic/liberal sentiments were found to support corporatism and boost a balanced tax structure through indirect taxation. This prevented the tax and political backlash. The debate on the importance of political parties is therefore unresolved as are those of the importance of other political processes such as ideology and democratization. None have been convincingly linked in the literature to health policy.

3. Bureaucratic Structures

A third school of thought remains convinced that it is the bureaucratic process and administrators that act as central agents in the development of a welfare state.⁴⁶ They concede that socio-economic development provides the physical resources, interest groups the human initiative, ideologies the reasons and political parties the instruments for reform. These investigators claim that it was corporatism -- the interplay of highly organised and centralised interest groups (labour, employers and professional associations) and centralised governments leading to political economies with a consensus-making machine -- that was principally responsible for the flourishing of social security provisions such as health care, pensions, unemployment, sickness, accident

⁴³ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 405.

⁴⁴ Nelson W. Polsby, "Party realignment in the 1980 election," *Yale Review*, 72(Autumn 1982): 42-54.

⁴⁵ Harold L. Wilensky and Gunn Johannson, eds., "Leftism, catholicism, democratic corporatism: The role of political parties in recent welfare state development," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 345-82.

⁴⁶ Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press 1974).

insurance and family allowance.⁴⁷ By representing corporatism as a continuum, Norway, Sweden, Finland and Austria ranked among the most corporatist countries by the late 1970s, followed by the Netherlands, Denmark, Belgium and West Germany, and trailed by Britain, the US, Canada, Australia, New Zealand, Japan, France and Italy.

Considerable support for the importance of the bureaucratic process in influencing the timing, scope and content of social insurance legislation has come from detailed analysis of Denmark, Norway, Sweden and Finland from the 1880s onward: political setting was measured as the extent of suffrage, systems of representation and appearance of mass parties; level of socio-economic development as industrialization, urbanization and accumulation of wealth; organisational characteristics as poor-law provisions, experience with voluntary social insurance funds and trade union strength; and ideological climate as the extent of liberalism.⁴⁸

Although socio-economic, political and bureaucratic determinants become confused in this type of analysis, Denmark, the most socio-economically and politically advanced country, was ahead of the other Nordic countries in proposing reforms, passing legislation and financing such schemes with public funds. Norway followed suit, trailed by Sweden and finally Finland. Unfortunately they have the same rank order among the Nordic countries as legislative continuity, making it impossible to distinguish the relative importance these determinant factors.

Where liberal democratic political processes developed early, such as in Great Britain, the US, Canada, France, Switzerland, Belgium and the Netherlands, progressive social security legislation was impeded. Although their parliamentary institutions legitimised the process, their liberal ideology discouraged interference in the market economy. Monarchical regimes lacking such ideological restraints felt a more pressing need to use their control over the bureaucratic machinery to appease militant labour movements.⁴⁹

⁴⁷ Gerhard Lembruch and Philippe C. Schmitter, eds., *Patterns of Corporatist Policy-making* (Beverly Hills: Sage, 1982); Philippe C. Schmitter "Interest intermediation and regime governability in contemporary Western Europe and North America," in *Organising Interests in Western Europe: Pluralism, Corporatism and the Transformation of Politics*, by Suzanne Berger, ed. (Cambridge: Cambridge University Press, 1981); and Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 432.

⁴⁸ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

⁴⁹ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 409.

Once established, 'expansionary pressures' of evolving bureaucracies lead to further proliferation of these tendencies.

Furthermore, the depolarised party system of highly corporatist countries forces planners (working groups, committees and commissions) into a long-term consensus policy process with broad comprehensive and responsible objectives, which is often respected by elected officials and bureaucrats. By contrast, the confrontational bipolar party systems of non-corporatist countries often leads planners into a short-term, narrow and ideological policy process, which is exploited or ignored by politicians and bureaucrats according to the degree of partisan ammunition it provides rather than its own merits. The latter also leads to single-policy analysis, which obscures the hard to measure long-term consequences of recommended policies by focussing on immediate political impact and costs, while overlooking the interdependence among social policies.

The centralised, highly disciplined and organised interest groups in the corporatist countries keep a lower political profile than the hype and banner-waving used by those in non-corporatist countries. Yet, they may be more effective in influencing reforms by successfully infiltrating the policy-making machinery. As an example, 48 per cent of the administrative board posts in Norway are occupied by interest-group representatives.⁵⁰ In Norway and Sweden, a government contemplating legislation or administrative reforms that would effect a particular interest group is obliged by law to contact them at an early stage in the policy formulation process. "Groups and interest organisations are given full representation on such commissions and are thus able to use this device already at an early stage in order to reach agreement with political parties, with other groups and with administrators. The tendency is to attempt the greatest possible amount of agreement already at this stage."⁵¹

Under this arrangement, parliament, the government and political parties are forced to share power, not just in planning but also in implementing and administering key policies with many, often opposing, interest groups. This limits the range of radical options available to political leaders who often depend on co-operation and compromise to stay in government. Support of extreme positions will alienate groups whose support the government depends on to stay in office. Governments are forced to formulate policies through persuasion, negotiation and consensus to reconcile a wide range of competing interests, which greatly limits their political choice. Official working groups, committees and commissions that exaggerates or sensationalises issues is avoided because

⁵⁰ Francis Castles, "Scandinavia: The politics of stability," in *Modern Political Systems: Europe*, by Roy C. Macridis, ed. (Englewood Cliffs, N.J.: Prentice-Hall, 1978).

⁵¹ Gunnar Heckscher, "Interest groups in Sweden: Their political role," *Interest Groups on Four Continents* (Pittsburgh: University of Pittsburgh Press, 1958).

of the risk of being exposed by vocal opponents. "Under such circumstances, traditional political power (e.g. the number of legislative votes controlled) is devalued and persuasive power is enhanced."⁵² The resulting broadly defined statutes leave much room for real policy to be defined by the administrators after the legislative phase.

The more polarised the political system, the greater the chance that stalemates, deadlocks and hung parliaments will result. Italy, having a less corporatist, more polarised system than the Nordic countries, is a case in point.⁵³ In a polarised political arena, where there are no corporatist pressures, executives, legislatures and regulatory agencies can introduce partisan policies that ignore the concerns of interest groups. Media presentations and mass political leverage take priority over responsible research, and the findings of working groups, committees and commissions are often rejected by oppositions and interest groups, with a resulting compromise in credibility.

The literature on health policy has not emphasised the potential role of bureaucratic infrastructures as a significant determinant of government involvement in health care.

4. Market Failure

A fourth school of thought that says that the role of market failure is a significant determinant of government intervention in the economic affairs of the state has been largely ignored by the comparative literature on public and social policy, but is at the centre of much of the polemic in health policy. In a perfect market economy, governments could limit their role to a minimal range of activities such as those suggested by Adam Smith in the eighteenth century: establishing law and order, and providing a few public works that would be of no interest to individuals. Unhampered competition between households and firms, free entry and interaction in a full set of markets, and complete knowledge of products would allow economic activity to be self-regulating.⁵⁴ An equilibrium would be established that would require little input or interference by governments in the economic affairs of the state. The three normative functions performed by all modern governments that were described above -- allocation of resources, redistribution of income and stabilisation of economic activity -- would be unnecessary because they would occur spontaneously in response to consumer preferences and decentralised market forces. The allocation of resources would be

⁵² Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 436.

⁵³ Geoffrey Pridham, *The Nature of the Italian Party System* (London: Croom Helm, 1981).

⁵⁴ K.J. Arrow and F.H. Hahn, *General Competitive Analysis* (Edinburgh: Oliver and Boyd, 1971); E. Malinvaud, *Lectures on Microeconomic Theory* (Amsterdam: North-Holland, 1972); and H.R. Varian, *Microeconomic Analysis* (New York: Norton, 1978).

carried out in a way that would achieve Pareto efficiency. The collection of taxes and lump-sum transfers would be costless. Finally, the equilibrium established in the market would remove the need for internal and external stabilising measures.

The market fails to behave in this utopian way in a number of areas. Perfect competition breaks down for several reasons.⁵⁵ Information available to consumers about products is imperfect⁵⁶ and costly to acquire.⁵⁷ Producers try to artificially influence prices by colluding with each other, forming monopolies⁵⁸ and inducing demand.⁵⁹ In the case of social goods, products lack rivalness and excludability which prevents them from being marketed efficiently and equitably.⁶⁰ Free riders⁶¹ do not pay their fair share, but take advantage of positive externalities⁶² that may result from the transaction between individual suppliers and users.⁶³ The market fails to distribute income or wealth in such a way that individuals have equal access and opportunity to express their true preferences in a competitive market. Finally, the market cannot regulate employment, ensure price stability or promote economic growth. Insurance, the standard market response to uncertainty by pooling risk, fails for three reasons.⁶⁴ Inflated loading charges or retention rates may occur when weak competition leads to inefficiency or monopolies. Moral hazards may lead to increased demand by consumers, supplier-induced demand and

⁵⁵ J. Robinson, *The Economics of Imperfect Competition* (London: Macmillan, 1933), Chapter 5.

⁵⁶ J.D. Hey, *Uncertainty in Microeconomics* (Oxford: Martin Robertson, 1979); J.D. Hey, "Whither uncertainty?" *Economic Journal* 92(1982): 130-39.

⁵⁷ G. Stigler "The economics of information," *Journal of Political Economy* 69(1961): 213-25; J.E. Stiglitz, "Information and economic analysis," in *Current Economic Problems* by M. Parkin and A.R. Nobay, eds. (Cambridge: Cambridge University Press, 1975); S.J. Grossman and J.E. Stiglitz, "Information and competitive price systems," *American Economic Review* (Papers and Proceedings 66(1976): 246-53; and J.E. Stiglitz, *Information and Economic Analysis* (Oxford: Oxford University Press, 1980); Michael Rothschild and Joseph Stiglitz, "Equilibrium in competitive insurance markets: An essay on the economics of imperfect information," *Quarterly Journal of Economics* 90(1976): 629-49.

⁵⁸ D.J. Roberts and H. Sonnenschein, "On the foundations of the theory of monopolistic competition," *Econometrica* 45(1976): 115-128

⁵⁹ D.J. Roberts and A. Postlewaite, "The incentives for price-taking behavior in large exchange economies," *Econometrica* 44(1976): 115-128.

⁶⁰ K.J. Arrow, "Political and economic evaluation of social effects and externalities," in *The Analysis of Public Output*, by J. Margolis, ed. (New York: Columbia University, National Bureau of Economic Research, 1970).

⁶¹ G.J. Stigler, "Free riders and collective action," *Bell Journal of Economics* 5(1974): 359-365; and J. Green, E. Kohlberg and J-J. Laffont, "Partial equilibrium approach to the free-rider problem," *Journal of Public Economics* 6(1976): 375-94.

⁶² J. Green and E. Sheshinski, "Direct versus indirect remedies for externalities," *Journal of Political Economy* 84(1976): 767-808; J.M. Buchanan and W.G. Stubblebine, "Externality," *Economica* (1962): 371-84; and Richard Cornes and Todd Sandler, *The Theory of Externalities, Public Goods and Club Goods* (Cambridge: Cambridge University Press, 1986).

⁶³ A. Deaton and J. Muellbauer, *Economics and Consumer Behavior* (Cambridge: Cambridge University Press, 1980).

⁶⁴ F.H. Knight, *Risk, Uncertainty and Profit* (Boston: Houghton Mifflin, 1933); M. Friedman and L.J. Savage, "The utility analysis of choices involving risk," *Journal of Political Economy* 56(August 1948): 279-304.

careless behaviour by the insured.⁶⁵ Adverse selection leads those with higher risk to be more likely to apply for protection while concealing their risk.⁶⁶

Health care as an economic good is especially vulnerable to many of the **market failures** that have been observed in other areas of economic activity.⁶⁷ Although it is a significant sub-component of the welfare state, health care is usually provided as a benefit in kind, whereas most other social security benefits are provided as cash reimbursements or direct transfers payments. The other most significant benefit in kind is education. Reflecting these differences, the need for government intervention and the instruments used to implement health policy are significantly different from those observed in other areas of public and social policy.⁶⁸ It requires that some of the traditional informational restrictions of welfarism, such as efficient maximisation of utility and equity, be relaxed to include elements of extra-welfarism such as comfort, physical mobility, enjoyment of relationships with others, freedom to choose and so on.⁶⁹ The subjects treated are nevertheless similar to those encountered in mainstream neoclassical economics:⁷⁰ supply, demand, competition, prices, production, firms, monopolies, efficient resource allocation, income redistribution, labour markets, employment, unemployment, inflation, stagflation, growth, general equilibrium, cyclical trends, stability, growth, risk management and insurance. But the rules of the game are different.⁷¹ Health economics⁷² is therefore not a

⁶⁵ K.J. Arrow, "The economics of moral hazard: Further comments," *American Economic Review*, 1(1968): 537-39; M.V. Pauly, "The economics of moral hazard: comment," *American Economic Review* 1(1968): 531-37.

⁶⁶ Michael Crew, "Coinsurance and the welfare economics of medical care," *American Economic Review* 59(1969) 906-908; Martin Feldstein, "The welfare loss of excess health insurance," *Journal of Political Economy* 81(1973): 251-280.

⁶⁷ A.J. Culyer, "The nature of the commodity 'Health Care' and its efficient allocation," *Oxford Economic Papers* 23(2)(July 1971): 189-211.

⁶⁸ H. Aaron, "Economic aspects of the role of government in health care," in *Health, Economics and Health Economics*, by J. van der Gaag and M. Perlman, eds., (Amsterdam: North Holland, 1981).

⁶⁹ A. Sen and B. Williams, eds., *Utilitarianism and Beyond* (Cambridge: Cambridge University Press, 1982). Anthony J. Culyer, "Demand-side socialism and health care," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁷⁰ Paul A. Samuelson and Antony Scott, *Economics* (London: McGraw-Hill, 1975).

⁷¹ S. Darbon and J.B. Letourmy, "La micro-économie des soins médicaux doit-elle nécessairement être d'inspiration néoclassique?" *Sciences Sociales et Santé* 2(1983): 31-75.

⁷² Robert G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984); Alan Williams, *Health and Economics* (London: Macmillan, 1987); Gavin H. Mooney, *Economics, Medicine and Health Care* (New York: Harvester Wheatsheaf, 1986); Alistair McGuire, John Henderson and Gavin Mooney, *The Economics of Health Care: An Introductory Text* (London: Routledge & Kegan Paul, 1988); John G. Cullis and Peter A. West, *The Economics of Health: An Introduction* (Oxford: Martin Robertson, 1979); Paul J. Feldstein, *Health Care Economics*, 2nd Edition (New York: John Wiley & Sons, 1983); and Victor R. Fuchs, *The Health Economy* (Cambridge: Harvard University Press, 1986); and Philip Jacobs, *The Economics of Health and Medical Care*, 2nd Edition (Aspen: Aspen, 1987); M.H. Cooper and A.J. Culyer, *Health Economics* (Harmondsworth: Penguin, 1973); A.J. Culyer, J. Wiseman, and A. Walker, *An Annotated Bibliography of Health Economics English Language Sources* (London: Martin Robertson, 1977); M.M. Hauser, *The Economics of Health and Medical Care* (London: George Allen & Unwin, 1972); M. Perlman, *The Economics of Health and Medical Care* (London: Macmillan, 1974); J. van der Gaag and M. Perlman, eds., *Economics and Health Economics* (Amsterdam: North Holland, 1981).

mere extension of welfare economics,⁷³ public economics⁷⁴ or centralised socialist planning.⁷⁵

First, the supply of health care does not have the usual characteristics of a production function and is therefore poorly regulated by market forces. Health care professionals and institutions do not react in the same way as they would in a perfect competitive market environment.⁷⁶ Professional and ethical constraints⁷⁷ oblige doctors to perform activities that are not profit-maximising and which could be performed more cheaply by less-trained personnel.⁷⁸ They often engage in honorary and academic activities for no pay other than the prestige that they derive from the association. There is limited entry into the profession, professional control over certification of competence and exclusion of competing disciplines.⁷⁹ There are great variations in medical practice styles that cannot be explained by a response to need and demand alone.⁸⁰ Providers can artificially stimulate demand.⁸¹ It has led to the observation that it is much easier to introduce

⁷³ K.J. Arrow, and T Scitovsky, *Readings in Welfare Economics* (Harmondsworth: Penguin, 1969); J.M. Buchanan, *The Demand and Supply of Public Goods* (Chicago, Rand McNally, 1968); Le Grand, *The Economics of Social Problems: The Market Versus the State*, 2nd. ed. (London: MacMillan Press, 1984); D.M. Winch, *Analytical Welfare Economics* (Harmondsworth: Penguin, 1971); A.D. Collard, *Altruism and Economy* (Oxford: Martin Robertson, 1978); A.J. Culyer, *The Political Economy of Social Policy* (Oxford: Martin Robertson, 1980).

⁷⁴ Antony B. Atkinson and Joseph E. Stiglitz, *Lectures on Public Economics* (London: McGraw-Hill, 1980); Robert Millward, David Parker, Leslie Rosenthal, Michael T. Summer and Neville Topham, *Public Sector Economics* (London: Longman, 1983).

⁷⁵ Michael Ellman, *Socialist Planning*, 2nd Edition (Cambridge: Cambridge University Press, 1989); A.P. Lerner, *The Economics of Control* (London: Macmillan, 1944); M. Dobb, *Welfare Economics and the Economics of Socialism* (Cambridge: Cambridge University Press, 1969).

⁷⁶ D.S. Lees, *Economic Consequences of the Professions*, Research Monograph (London: Institute of Economic Affairs, 1966).

⁷⁷ Tom L. Beauchamp and Laurence B. McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* (Englewood Cliffs, N.J.: Prentice Hall, 1984); Charleton B. Chapman, *Physicians, Law, & Ethics* (New York: New York University Press, 1984); Marshal Cohen, Thomas Nagel, and Thomas Scanlon eds., *Medicine and Moral Philosophy* (Princeton: Princeton University Press, 1981); Charles M. Culver and Bernard Gert, *Philosophy in Medicine* (Oxford: Oxford University Press, 1982); Ian Kennedy, *The Unmasking of Medicine: A Searching Look at Health Care Today*, Revised ed. (London: Granada, 1983); J.K. Mason and Alexander R. McCall Smith, *Law and Medical Ethics* (London: Butterworths, 1983); Peter D.G. Skegg, *Law, Ethics, and Medicine: Studies in Medical Law* (Oxford: Clarendon Press, 1984).

⁷⁸ U.E. Reinhardt, "Manpower substitution and productivity in medical practice: Review of research," *Health Services Research* 8(1973): 800-27; J. Rafferty, ed., *Health Manpower and Productivity* (Lexington Mass.: D.C. Heath, 1974); P. Slayton and M.J. Trebilcock, *The Professions and Public Policy* (Toronto: University of Toronto Press, 1978).

⁷⁹ A. Williams, "Health economics: The end of clinical freedom?" *British Medical Journal* 297(5 November): 1183-86; A. Williams, "Ethics, clinical freedom and the doctors' role," in *Competition in Health Care: Reforming the NHS*, by A.J. Culyer, A.K. Maynard and J.W. Posnett, eds. (London: Macmillan, 1990): 178-91.

⁸⁰ Tavs Folmer Andersen and Gavin Mooney, eds., *The Challenges of Medical Practice Variations*, (Basingstoke: Macmillan, 1990); Klim McPherson, "International differences in medical care practices," *Annual Supplement, Health Care Financing Review* (1989): 9-19.

⁸¹ R.G. Evans, "Supplier induced demand: Some empirical evidence and implications," in *The Economics of Health and Medical Care*, by Mark Perlman, ed., (Tokyo: Proceedings of the International Economic Association Conference, 1974): 162-73; U.E. Reinhardt, "The theory of physician induced demand: reflexion after a decade," *Journal of Health Economics* 4(1985): 187-93; L. Rochaix, "Academic dispute or political debate? The issue of physicians' discretionary power: A review of the theoretical literature," *Notes du G.S. Santé* (January 1986); Sophie Bejean, "Information asymmetries and supplier induced demand: An econometric study for the French

policies that increase services, such as the number of beds in hospitals, than to reduce them.⁸² The increasing cost of medical care in western countries has spurred public and private efforts to control professional autonomy.⁸³ The surpluses, shortages and congestion that occurs reflect the market failure in the allocation of health care resources, as they become increasingly scarce compared with demand.

Second, demand⁸⁴ for health care is usually derived from utilisation⁸⁵ statistics even though this is a poor indicator of consumer preference.⁸⁶ Utilisation reflects a complex interaction between needs, demands and available services.⁸⁷ Normative needs relate to

market," Document de travail, 9005, Université de Bourgogne, Dijon, 1990; R.D. Auster and R.L. Oaxaca, "Identification of supplier induced demand in the health care sector," *Journal of Human Resources* 16(1981): 327-42; J. Cromwell and J.B. Mitchell, "Physician-induced demand for surgery," *Journal of Health Economics* 5(1986): 293-313; V. Fuchs, "The supply of surgeons and the demand for surgical operations," *Journal of Human Resources* 13(1978): 21-34; J.R. Green, "Physician induced demand for medical care," *Journal of Human Resources* 13(1978): 21-34; C.E. Phelps, "induced demand - can we ever know its extent?" *Journal of Health Economics* 5(1986): 355-66; G.R. Wilensky and L.F. Rossiter, "The relative importance of physician-induced demand in the demand for medical care," *Milbank Memorial Fund Quarterly* 61(1983): 252-77; J. Richardson, "The inducement hypothesis that doctors generate demand for their own services," in *Health, Economics and Health Economics*, by J. van der Gaag and M. Perlman, eds., (Amsterdam: North Holland, 1981).

⁸² M. Roemer and M. Shain, *Hospital Utilisation Under Insurance* (Chicago: American Hospital Association, 1959); and B. Ginsburg, and K.M. Koretz, "Bed availability and hospital utilisation: Estimatees of the 'Roemer effect'," *Health Care Financing Review* 5(1983): 87-92;

⁸³ David Wilsford, "The fiscal imperative in health care: Responses in advanced industrial democracies to increased demand and scarcer resources,' Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990; Theodore R. Marmor, *The Politics of Medicare* (London: Routledge and Kegan Paul, 1970); Deborah A. Stone, *The Limits of Professional Power* (Chicago: University of Chicago Press, 1980).

⁸⁴ P.J. Feldstein, "Research on the demand for health services," *Milbank Memorial Fund Quarterly* 44(1966): 128-62; M. Grossman, *The Demand for Health: A Theoretical and Empirical Investigation* (New York: National Bureau of Economic Research, 1972); J. Dowie, "The portfolio approach to health behaviour," *Social Science and Medicine* 9(11/12)(1975): 619-31; and J.M. Muurinen, "Demand for health: A generalised Grossman model," *Journal of Health Economics* 1(1982): 5-28; J.P. Newhouse and S.E. Marquis, "The norms hypothesis and the demand for medical care," *Journal of Human Resources* 13(1978): 159-82. ; J.P. Newhouse, "The demand for medical care services: A retrospective and perspective," in *The Economics of Health and Medical Care*, by M. Perlman, ed. (London: Macmillan, 1974).

⁸⁵ G.L. Stoddart and M.L. Barer, "Analysis of demand and utilisation through episodes of medical services," in *Health, Economics and Health Economics* by J. van der Gaag and M Perlman, eds., (Amsterdam: North Holland, 1981); J.C. Hershey, H.S. Luft and J.M. Gianaris "Making sense out of utilisation data," *Medical Care* 13(1975): 838-54.

⁸⁶ A. Wagstaff, "The demand for health: some new empirical evidence," *Journal of Health Economics* 5(1986): 195-233; A. Wagstaff, "The Demand for health: a simplified Grossman model," *Journal of Epidemiology and Community Health* 40(1986): 1-11; W.G. Manning, J.P. Newhouse and J.E. Ware, "The status of health in demand estimation: Beyond excellent, good, fair and poor," in *Economic Aspects of Health* by V.R. Fuchs, (Chicago: NBER, University of Chicago Press, 1984); R.G. Evans and A.D. Wolfson, "Faith, hope and charity: Health care in the utility function," Discussion Paper No 80-46, Department of Economics, University of British Columbia, Vancouver 1980.

⁸⁷ A Williams, "'Need' as a demand concept, (With special reference to health)," in *Economic Policies and Social Goals: Aspects of Public Choice* by A.J. Culyer (London: Martin Robertson, 1974); A.J. Culyer, *Need and the National Health Service* (Oxford: Martin Robertson, 1976); A. Williams, "Need – an economic exegesis," in *Economic Aspects of Health Services* by A.J. Culyer and K.G. Wright, eds. (Oxford: Martin Robertson, 1978); D.A. Nevitt, "Demand and need," in *Foundations of Social Administration*, by Heisler H. ed. (London: Macmillan, 1977); Michael Ignatieff, *The Needs of Strangers* (London: Chatto and Windus, 1984); Patricia Springborg, *The Problem of Human Needs and the Critique of Civilization* (London: George, Allen & Unwin,

desired standards; felt needs relate to individual perceptions; expressed needs relate to demands for services; and comparative needs relate to the needs of others in society.⁸⁸ Uncertainty of illness, disability and ageing⁸⁹ prevents the individual from perceiving risks or needs for protection when young or in good health.⁹⁰ This renders him more vulnerable as he ages and faces increasing prospects of illness.⁹¹ Insurance is the standard market response to cover such risk. Market failure due to the problems of moral hazards and adverse selection have been observed in other areas that rely on insurance to deal with uncertainty. These phenomena are accentuated in the case of health care. Asymmetry of information between consumers and providers is especially pronounced,⁹² and imperfect knowledge about the nature of illness and treatment outcome make an informed choice impossible.⁹³ Adverse selection leads patients to hide their underlying illnesses when they know that their insurance premiums are risk-related and insurers, to try to attract clients with the least risk.⁹⁴ The existence of prepayment of health care, whether through taxation, social insurance or private insurance, influences demand and willingness to pay.⁹⁵

Third, there is no free entry to a full **competitive market** in health care or unrestricted interaction between consumers and suppliers.⁹⁶ Institutional and professional groups allow suppliers of medical services to manipulate prices, influence quality, stimulate

1981); Paul Chapman, *Unmet Needs and the Delivery of Care*, Series No. 61 (London: Occasional Papers on Social Administration, 1979).

⁸⁸ J. Bradshaw, "A taxonomy of social need," in *Problems and Progress in Medical Care*, 7th Series, by G. McLachlan (London: Oxford University Press, 1972);

⁸⁹ K.J. Arrow, "Uncertainty and the welfare economics of medical care," *American Economic Review* 53(1963): 941-73.

⁹⁰ D. Kahneman and A. Tversky, "Prospect theory: An analysis of decisions under risk," *Econometrica* 47(1979): 263-91.

⁹¹ Frank T. Denton and Byron G. Spencer, "Health care costs when population changes," *Canadian Journal of Economics* 8(1975): 130-35; M.L. Barer, R.G. Evans, C. Hertzman and J. Lomas, "Aging and health care utilisation: New evidence on old fallacies," *Social Science and Medicine* 24(1987): 851-62.

⁹² R.G. Evans and H.D. Walker, "Information theory and the analysis of hospital cost structure," *Canadian Journal of Economics* 5(1972): 398-418; J.P. Bunker and B. Brown, "The physician-patient as an informed consumer of surgical services," *New England Journal of Medicine* 290(1974): 1051-55.

⁹³ J. Hay and M.J. Leahy, "Physician-induced demand: An empirical analysis of the consumer information gap," *Journal of Health Economics* 1(1982): 217-309.

⁹⁴ M.V. Pauly, "Is cream skimming a problem for the competitive medical market?" *Journal of Health Economics* 3(1984): 87-95; Wynand P.M.M. van de Ven, "How can we prevent cream skimming in a competitive health insurance market? The great challenge for the 90s," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990; H.S. Luft, "Compensation for biased selection in health insurance," *Milbank Quarterly* 64(1986): 566-91.

⁹⁵ C.E. Phelps and J.P. Newhouse, "Effects of co-insurance: A multivariate analysis," *Social Security Bulletin* (35(1972): 20-9; C.E. Phelps and J.P. Newhouse, "Co-insurance and the demand for medical services," Santa Monica, RAND Corporation, 1974; W.G. Manning et al., "A controlled trial of the effect of a prepaid group practice on use of services," *New England Journal of Medicine* 310(1984): 1505-10; R.N. Rossett, and L.F. Huang, "The effect of health insurance on the demand for medical care," *Journal of Political Economy* 18(1973): 281-305; M.B. Pauly, "Taxation, health insurance and market failure in medical economy," *Journal of Economic Review* 24(1986): 629-75.

⁹⁶ V.R. Fuchs, "The 'Competition Revolution' in health care," *Health Affairs* 7(3)(1988): 5-24.

demand and prevent free competition among its members by forming monopolies⁹⁷ or cartels.⁹⁸ When the Treasury or national insurance funds try to control public expenditure⁹⁹ or professional power¹⁰⁰ by acting as monopsonies,¹⁰¹ they destroy any vestiges of a competitive market. The very concept of preferred provider organisations to constrain health care costs is contrary to the open access of a competitive market.¹⁰² The medical profession, labour organisations and other pressure groups respond in kind to these measures by forming political lobbies to influence government policies at the national level¹⁰³ and by controlling the implementation of such policies at the local level.¹⁰⁴ The style of negotiation during collective bargaining may itself be a significant factor in determining the outcome of such conflicts.¹⁰⁵ These problems have led an increasing number of authors to question the legitimacy of competition as a valid basis for regulating the transactions that occur in the health sector.¹⁰⁶

⁹⁷ D.S. Lees, et al., *Monopoly or Choice in Health Services* (London: Institute of Economic Affairs, 1964); H.E. French, and Paul B. Ginsburg, "Imposed health insurance in monopolistic markets," *Economic Inquiry* 13(1975): 55-70; P.J. Feldstein, "The emergence of market competition in the US health care system: Its causes, likely structure and implications," *Health Policy* 6(1986): 1-20; As an example of professional restrictions, see the Hippocratic Oath and British Medical Association (BMA), *Handbook of Medical Ethics 1984* (London: BMA, 1984).

⁹⁸ Wynand P.M.M. van de Ven, "From regulated cartel to regulated competition in the Dutch health care system," *European Economic Review* 34(1990): 632-45.

⁹⁹ Klaus-Dirk Henke, "Cost containment in health care: Justification and consequences," to be published in *Health Economics Worldwide* by P. Zweifel and H.E. French (Kluwer, 1991); Alexander S. Preker, "Expenditure control through public financing in the OECD," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990; Antony J. Culyer, "Cost Containment in Europe," Annual Supplement, *Health Care Financing Review* (1989): 31; and Brian Abel-Smith, *Cost Containment in Health Care*, Occasional Papers on Social Administration (London: Bedford Square Press, NCVO, 1984); Paul Joskow, "Reimbursement policy, cost containment and non-price competition," *Journal of Health Economics* 2(1983): 167-74; Brian Abel-Smith, "Who is the odd man out? The experience of western Europe in containing the costs of health care," *Milbank Memorial Fund Quarterly* 63(1985): 1-17.

¹⁰⁰ Deborah Stone, *The Limits of Professional Power: National Health Care in the Federal Republic of Germany* (Chicago: University of Chicago Press, 1980).

¹⁰¹ M. Pauly, "Market power, monopsony and health insurance markets," *Journal of Health Economics* 7(1988): 111-28.

¹⁰² Peter Boland, *The New Healthcare Market: A Guide to PPOs for Purchasers, Payors and Providers* (Homewood, Illinois: Dow Jones Irwin, 1985); J. Gabel and D. Ermann, "Preferred provider organisations: Performance, problems and promise," *Health Affairs* 4(1)(1985): 24-40; S.B. Jones, "Can multiple choice be managed to constrain health care costs," *Health Affairs* (Fall 1989): 50-59;

¹⁰³ Rudolf Klein, *Ideology, Class and the National Health Service*, Project Paper No. RC4 (London: Kings Fund, 1980); Harry Eckstein, *Pressure Group Politics: The Case of the British Medical Association* (London: Allen & Unwin, 1960); and Theodore R. Marmor, Wayne L. Hoffman and Thomas C. Heagy, "National health insurance: Some lessons from the Canadian experience," *Policy Sciences* 6(4)(1975): 447-66.

¹⁰⁴ Rudolf Klein, "Values, power and policies," in *The Welfare State in Crisis* by OECD (Paris: OECD, 1981).

¹⁰⁵ Theodore R. Marmor and David Thomas, "Doctors, politics and pay disputes: Pressure group politics revisited," *British Journal of Political Science* 2(October 1972): 421-42.

¹⁰⁶ J.P. Newhouse, "Is competition the answer?" *Journal of Health Economics* 1(1982): 109-16; A.C. Enthoven, "Managed competition in health care: An unfinished agenda," *Health Care Financing Review Annual Supplement* (1986): 105-119; A.C. Enthoven, "Managed competition of alternative delivery systems," *Journal of Health Politics, Policy and Law* 13(1988): 305-21; A.C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (Amsterdam: North Holland, 1988).

Fourth, even in highly competitive market economies, a breakdown occurs in the **pricing mechanism** of health care as an economic commodity.¹⁰⁷ The imperfections of the competitive market for health care make it too easy for providers of services and producers of goods such as equipment and pharmaceuticals to artificially influence what might otherwise appear to be legitimate market prices.¹⁰⁸ The 'Gift Relationship' or charitable relationship between health care workers and their patients makes it impossible to determine the real market value of services rendered.¹⁰⁹ In the case of direct payment, charges may be overlooked when the patient is unable to pay. In the case of prepayment, restrictions in access due to lack of entitlement are difficult to enforce. Governments have come to realise that the public sector absorbs a significant part of the hidden cost of health care even when it is not directly involved in its financing, administration and service delivery.¹¹⁰ Because a significant part of the positive and negative externalities of health care such as illness, disability and ageing falls on society as a whole, its provision has an impact which reaches far beyond the individual himself.¹¹¹

Finally, bureaucratic rigidities prevent health care institutions from adapting to market pressures as **firms** would do in an ideal competitive environment.¹¹² The production function of health care in providing health has therefore been challenged by a number of authors.¹¹³ Hospitals, doctors and other health care providers continue to operate in their traditional ways long after circumstances warrant that such behaviour be changed in response to market pressures.¹¹⁴ Morbidity and mortality statistics are however poor

¹⁰⁷ J.P. Newhouse and C.E. Phelps, "Price and income elasticities for medical care services," in *The Economics of Health and Medical Care* by M. Perlman, ed. (London: Macmillan, 1974); J.P. Newhouse and C.E. Phelps, "New estimates of price and income elasticities of medical services," *The Role of Health Insurance in Health Service Sector* (New York: National Bureau of Economic Research, 1976).

¹⁰⁸ John W. Pratt, David A. Wise and Richard J. Zeckhauser, "Price differences in almost competitive markets," *Quarterly Journal of Economics* 93(1979): 189-211; Joseph P. Newhouse, "Pricing and imperfections in the medical care marketplace," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990; M.L. Weitzman, "Prices vs quantities," *Review of Economic Studies* 41(1974): 477-91; M.L. Weitzman, "Is the price system or rationing more effective in getting a commodity to those who need it most?" *Bell Journal of Economics* 8(1977): 517-24.

¹⁰⁹ Richard M. Titmuss, *The Gift Relationship* (London: George Allen & Unwin, 1970); K.J. Arrow, "Gift and exchanges," *Philosophy and Public Affairs* 1(1974): 343-62; S.J. Grossman and O.D. Hart, "An analysis of the principal agent problem," *Econometrica* 1(1982): 7-45; R.S. Downie and Elizabeth Telfer, *Caring and Curing: A Philosophy of Medicine and Social Work* (London: Methuen, 1980).

¹¹⁰ A.J. Culyer, "The nature of the commodity 'health care' and its efficient allocation," *Oxford Economic Papers* 23(1971): 189-211.

¹¹¹ Paternalistic, altruistic and self-serving externalities resulting from health care were described by A.J. Culyer and H. Simpson, "Externality models and health: A rückblick over the last twenty years," *Economic Record* 56(1980): 222-30.

¹¹² R.M. Cyert and J. March, *A Behavioral Theory of the Firm* (Englewood Cliffs, N.J.: Prentice Hall, 1964).

¹¹³ Ivan Illich, *Limits to Medicine: Medical Nemesis, The Expropriation of Health* (Harmondsworth: Pelican, 1976); Tom McKeown, *The Role of Medicine* (Oxford: Blackwell, 1979); A.L. Cochrane, *Effectiveness and Efficiency: Random Reflections on Health Services* (London: Nuffield Provincial Hospital Trust, 1972.)

¹¹⁴ The same observations have been made of non-health related organisations once they reach a certain critical size. Lynne G. Zucker, "Institutional theories of organization," *Annual Reviews of Sociology* 13(1987): 443-64.

indicators of quality of life,¹¹⁵ and the iatrogenic problems created by health care are readily dramatised by critics of health care at the expense of more subtle benefits.¹¹⁶ This makes it difficult health care firms to adapt the way they operate in response to outcome.

Governments have become increasingly active in all western countries during the twentieth century, partially as a result of market failures in the general economy.¹¹⁷ At any one given point in time, most governments have nevertheless felt that public expenditure should be kept to a bare minimum to avoid excessive tax burdens and public debt. At the turn of the twentieth century, some authors considered a taxation ratio of ten per cent of national income as a serious threat to economic growth.¹¹⁸ By the 1920s, these rates had doubled¹¹⁹ and by the 1980s, they had more than tripled.¹²⁰ Tax revenues in the OECD today range from less than 30 per cent of GDP in Japan to over 50 per cent in Sweden.¹²¹ Claims that the public sector has overstepped the limits of its expenditure capacity are as emphatic today as they were over a century ago.¹²² As total health care expenditure, and more particularly, public sector expenditure per GDP on health care continues to rise, health policy is caught up in the debate on the legitimate role of the state in a mixed-market economy.¹²³ Authors are increasingly questioning at which point expenditure on

¹¹⁵ C.J. Culyer, ed., *Health Indicators* (London: Martin Robertson, 1983); Rachel Rosser, "A history of the development of health indicators," in *Measuring the Social Benefits of Medicine*, by George Teeling Smith, ed., Proceedings of a meeting held at Brunel University 16-19 May 1983 (London: Office of Health Economics, 1983): 50-62; Ann Carthwright, *Health Surveys in Practice and in Potential: A Critical Review of their Scope and Methods* (London: King's Fund Publishing Office, 1983); Michael F. Drummond, Greg L. Stoddart and George W. Torrance, *Methods for the Economic Evaluation of Health Care Programmes* (Oxford: Oxford Medical Publications, 1987).

¹¹⁶ V. Navarro, "The industrialization of fetishism or the fetishism of industrialization: A critique of Ivan Illich," *International Journal of Health Services* 5(3)(1975).

¹¹⁷ Vito Tanzi, "Public expenditure and public debt: An international and historical perspective," in *Public Expenditure: The Key Issues*, by John Bristow and Declan McDonagh, eds. (Dublin: Institute of Public Administration 1986): 6-37.

¹¹⁸ Paul Leroy-Beaulieu, *Traité de la Science des Finances*, Tome Premier, Des Revues Publics (Paris: Guillaumin et Cie, Librairis, 1988): 127-28.

¹¹⁹ Edwin R.A. Seligman, *Studies in Public Finance* (New York: Macmillan, 1925).

¹²⁰ Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York McGraw-Hill, 1984); and A.R. Prest and N.A. Barr, *Public Finance: In Theory and Practice* (London: Weidenfeld and Nicolson, 1985).

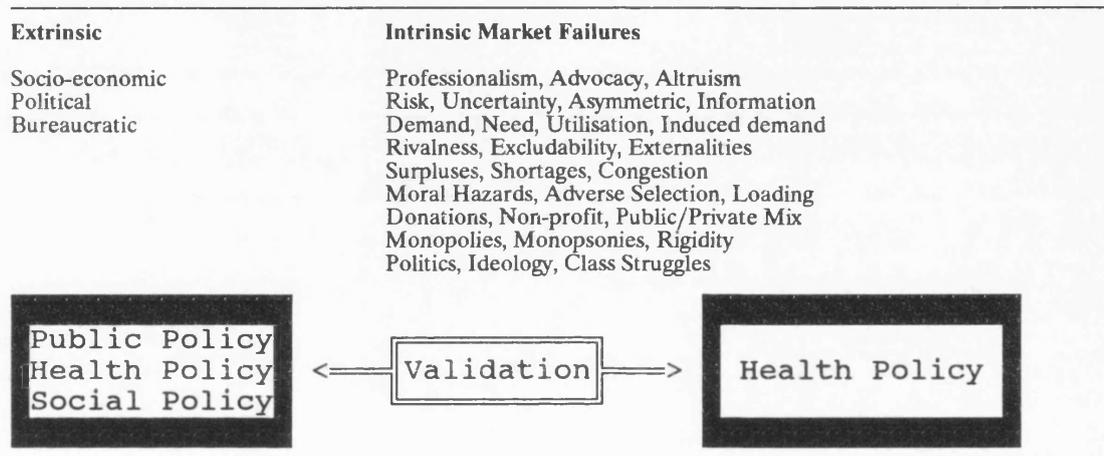
¹²¹ OECD, *Revenue Statistics of OECD Member Countries, 1965-1985* (Paris: OECD 1986).

¹²² John Bristow and Declan McDonagh, eds., *Public Expenditure: the Key Issues* (Dublin: Institute of Public Administration 1986); and Henry Cavanna, ed., *Public Sector Deficits in OECD Countries: Causes, Consequences and Remedies* (London: Macmillan, 1988).

¹²³ J.P. Newhouse, "Development and allocation of medical care resources: Medico-economic approach," in *Development and Allocation of Medical Care Resources*, Proceedings of the 29th World Medical Assembly, Tokyo, Japan Medical Association, 1975; J.P. Newhouse, "Medical care expenditure: A cross-national survey," *Journal of Human Resources* 12(1)(Winter 1977): 115-125; Robert J. Maxwell, *Health and Wealth: An International Study of Health-Care Spending* (Lexington, Massachusetts: Lexington Books, 1981); OECD, *Measuring Health Care 1960-1983: Expenditure, Costs and Performance*, OECD Social Policy Studies. (Paris: OECD, 1985); OECD, *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*, OECD Social Policy Studies No. 2 (Paris: OECD, 1987); George J. Schieber and Jean-Pierre Poullier, "International health spending and utilization trends," *Health Affairs* 7(4)(1988): 105-112.

health care has overstep its acceptable threshold.¹²⁴ The role of market failure as a significant determinant that led to public sector involvement in health care is implied through the literature on health economics, but attempts to validate this hypothesis empirically through cross-national comparisons have been sporadic and unsystematic.

Figure 1.1 Determinants of Health Policy



¹²⁴ Rudolf Klein, ed., *Social Policy and Public Expenditure 1975: Inflation and Priorities* (London, Centre for Studies in Social Policy, 1975); A.K. Maynard and A. Lodbroom, "Thirty years of fruitless endeavour?: An analysis of government intervention in the health care market," in *Health, Economics and Health Economics*, by J. van der Gaag and M. Perlman, eds., (Amsterdam: North Holland, 1981).

C. NORMATIVE FUNCTIONS OF MODERN GOVERNMENTS

Apart from their role in establishing law and order, the governments of all western countries have, over time, assumed three significant additional functions:¹ allocation of social goods,² distribution of income³ and stabilisation of economic activity.⁴ The reasons they perform these functions, the instruments used and reactions to such involvement vary greatly from country to country, and has changed over the years.⁵

Whatever its accepted role, the state needs the financial means to carry out its business. This requires policies on *how* to collect public revenues, *how* to spend them and *what* to do when expenditure exceeds receipts.⁶ Adam Smith described public finance as "the sources of the general or public revenue of the society ... the expenses of the sovereign or commonwealth ... and public debts."⁷ This view remained unchanged until severe inflation and unemployment that accompanied the Great Depression and World Wars convinced western mainstream economists and legislators to consider including the regulation of employment, prices and economic growth as a legitimate stabilisation function of government.⁸ The economic shocks of the late 1960s and 1970s rekindled the debate about such macro-economic policies⁹ which become embodied in the dialectic

¹ Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York: McGraw-Hill, 1984): 6-19.

² Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations*, [1776] (Oxford: Oxford University Press Edition, 1976).

³ Although extensively written about in the socialist literature, mainstream economists and policymakers did not recognise this as a legitimate role of the state until the mid-twentieth century. Richard A. Musgrave, *The Theory of Public Finance* (New York: McGraw-Hill, 1959).

⁴ John Maynard Keynes's, *The General Theory of Employment, Interest and Money* (London: Macmillan, 1936).

⁵ Vito Tanzi, "Public expenditure and public debt: An international and historical perspective," in *Public Expenditure: The Key Issues* by John Bristow and Declan McDonagh, eds. (Dublin: Institute of Public Administration 1986): 6-37.

⁶ Henry Cavanna, ed., *Public Sector Deficits in OECD Countries: Causes, Consequences and Remedies* (London: Macmillan, 1988).

⁷ Adam Smith, "The revenue of the Sovereign or Commonwealth," in *An Inquiry into the Nature and Causes of the Wealth of Nations*, [1776] (Oxford: Oxford University Press Edition, 1976), Chapter 5. See also D. Richardo, *Principles and Essay on the Funding System*, J.S. Smith *Principles of Political Economy* [1848], Hugh Dalton, *Public Finance* [1922] and A.C Pigou, *Public Finance*, 1st Edition [1928] For a historical review see A.R. Prest and N.A. Barr, *Public Finance: In Theory and Practice* (London: Weidenfeld and Nicolson, 1985): 1-5.

⁸ John Maynard Keynes's, *The General Theory of Employment, Interest and Money* (London: Macmillan, 1936). Extensively written about in the socialist literature, this notion was first incorporated into the third edition of A.C Pigou, *Public Finance*, 3rd Edition [1947]. See also Richard A. Musgrave, *The Theory of Public Finance* (New York: McGraw-Hill, 1959).

⁹ Milton Friedman, "The Role of Monetary Policy," *American Economic Review* (March 1968): 1-17; Milton Friedman, *Monetary Corrections: A Proposal for Escalator Clauses to Reduce the Costs of Ending Inflation*, Series No. 41 (London: Institute of Economic Affairs, 1974); Milton Friedman, *Inflation and Unemployment: The New Dimension of Politics*, The 1976 Alfred Nobel Memorial Lecture, Series No. 51 (London: Institute of Economic Affairs, 1978).

between Keynesianism and monetarism.¹⁰ One is concerned with employment, control of the business cycle and economic growth as instruments of stabilisation and the other with the quantity of circulating money and control of inflation. Neither professes to address the historical tension between individualism and collectivism that remains embodied in the allocation and distribution functions.

Health care provides an instrument by which governments can, at least in part, achieve all of these objectives. The most recognised function is its role in resource allocation. Regulations, subsidies and direct provision of health care goods and services are all instruments by which governments exercise this function. The budget process and access to services are adjuncts to these mechanisms. The revenues that are collected through the prepayment of health care, whether added to the consolidated fund or social/health insurance fund become a significant instrument of income redistribution in the form of cash reimbursements and transfer payments, or benefits in kind such as the direct provision of health services. Most of the literature treats prepayment of health care as a pooling of risk to protect individuals against the uncertainty of illness rather than as part of the distributive function of government. Finally, the way public funds are spent on health care becomes an instrument of economic stabilisation when it leads to employment in the public sector, when cost containment measures influence prices, and when the production of goods and services promote economic growth. Monetarists may challenge the wisdom of such activities as instruments of stabilisation, but it is difficult to isolate the mechanisms of resource allocation and income redistribution from employment practices, expenditure policies and investments in the health sector, which could be considered Keynesian stabilisation instruments.

Figure 1.2 Normative Functions of Modern Governments

Functions	Allocation	Distribution	Stabilisation
Instruments	Regulations Subsidies Services	Revenue collection Reimbursements Benefits in Kind	Employment Cost Controls Production

¹⁰ Similar arguments were made as early as the sixteenth century when a rise in prices was attributed to an inflow of gold and silver to Britain from the New World. Charles P. Kindleberger, *A Financial History of Western Europe* (London: Allen & Unwin, 1984); Charles P. Kindleberger, *Keynesianism vs Monetarism* (London: George, Allen & Unwin, 1985); Daniel Bell and Irving Kristol, eds., *The Crisis in Economic Theory* (New York: Basic, 1981).

D. OUTCOME TO HEALTH POLICY

It is difficult to evaluate the outcome of given policy interventions in terms of health status, health services and welfare of society in general.¹ The lack of universally accepted indicators and standardised outcome measures weaken the arguments made by most of existing studies. Authors who have examined the first issue remark that there is a lack of consensus on what constitutes outcome in terms of health and illness.² Even when agreement is reached at the philosophical level, it is difficult to translate the resulting abstract ideas into concrete concepts that can be measured and validated in a consistent and reliable way.³ Yet these criteria must be met before the researcher can carry out an empirical validation of the hypothesis under investigation. There are few standard health indicators that can be used in cross-national comparisons. In developing countries, even mortality statistics are unreliable because they reflect only deaths in hospitals, while those occurring in the community remain largely unrecorded. Morbidity, quality of life and daily function indicators rely entirely on surveys that are not designed in a standard way nor collected routinely in all countries.⁴ International comparisons of such data are therefore unreliable.

In recent years, there has been an explosion of studies that attempt to measure the effects of social and health policies on health services in terms of costs, resources, performance, effectiveness, efficiency and quality.⁵ The most striking conclusion that one can be drawn from the work of these authors is that there is a lack of standard definitions

¹ D. Schwefel, ed., *Indicators and Trends in Health and Health Care* (Berlin-Heidelberg, Springer Verlag, 1987).

² R.S. Downie and Elizabeth Telfer, *Caring and Curing: A Philosophy of Medicine and Social Work* (London: Methuen, 1980): 15-21; and Constitution of the World Health Organization in 1946.

³ David Streiner and Geoffrey R. Norman, *Health Measurement Scales: A Practical Guide to their Development and Use* (Oxford: Oxford University Press, 1989); I. McDowell and C. Newell, *Measuring Health* (Oxford: Oxford University Press, 1987); Antony J. Culyer, "Need, values and health status measurement," in *Economic Aspects of Health Services*, by Antony J. Culyer and K.G. Wright, eds., (London: Martin Robertson, 1978): 9-31; R.A. Carr-Hill, "Assumptions of the QUALY procedure," *Social Science and Medicine* 29(3)(1989): 469-77; G. Loomes and L. McKenzie, "The use of QUALYs in health care decision making," *Social Science and Medicine* 28(4)(1989): 299-308; I. McDowell and C. Newell, *Measuring Health: A Guide to Rating Scales and Questionnaires* (New York: Oxford University Press, 1987).

⁴ Ann Carthwright, *Health Surveys in Practice and in Potential: A Critical Review of their Scope and Methods* (London: King's Fund Publishing Office, 1983).

⁵ A.L. Cochrane, *Effectiveness and Efficiency: Random Reflections on Health Services* (London: Nuffield Provincial Hospitals Trust, 1972); George Teeling Smith, *Measuring the Social Benefits of Medicine*, Proceedings of a meeting held at Brunel University 16-19 May 1983 (London: Office of Health Economics); Andrew F. Long and Stephen Harrison, eds., *Health Services Performance: Effectiveness and Efficiency* (London: Crom Helm, 1985); Michael F. Drummond, Greg L. Stoddart and George W. Torrance, *Methods for the Economic Evaluation of Health Care Programmes* (Oxford: Oxford Medical Publications, 1987).

of what is being measured and a lack of routine collection.⁶ The OECD Health Database has made a significant contribution in this area by trying to define a minimum data set for health status and health services.⁷

Another group of authors have been looking beyond health status and health care by examining outcome in terms of the welfare and "happiness" of a given society, or the impact on economic growth. In technical terms, positive outcome can be viewed as those policies result in a maximisation of the social welfare utility function U over a common set of commodities ($X_{i...n}$) that would include health care (HC), health status (HS) and other factors (K). The goal of a society would be to maximise the common good for all of its citizens.⁸

$$U = U[X_{i...n}, HC, HS, \dots K]$$

Once again, there are several problems associated with this approach. First, it is difficult to actually measure welfare or happiness. Second, there may be a negative interdependence between health care and health status. Affluent societies may have reached a point of diminishing and even decreasing marginal returns in the provision of health care.⁹ In such a case, additional health care would lead to decreasing health status.¹⁰

$$dHC = F(1/dHS)$$

Different authors have convincingly shown a correlation between socio-economic development, welfare provisions, health care expenditure and decreasing mortality.¹¹ Whether or not one acts as a determinant for the others is much less clear. There are clear limits to relative growth and the social sectors cannot continue to consume an increasing part of GDP.¹² At one point or another, the converse should logically be true, yet no study has shown that persistent economic contraction is associated with

⁶ François Champagne, André-Pierre Contandriopoulos, Anne Lemay and Alexander S. Preker, "Evaluation of health care performance in the OECD," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁷ OECD, *Health Care Systems in Transition: The Search for Efficiency*, Social Policy Studies No. 7 (Paris: OECD, 1989).

⁸ Robert G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984): 5; G.W. Torrance "Measurement of health state utilities for economic appraisal," *Journal of Health Economics* 5(1986): 1-30; and J.R.G. Butler, "Welfare economics and cost-utility analysis," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁹ Ivan Ilich, *Medical Nemesiss: The Expropriation of Health* (Toronto: McClelland and Stewart, 1975).

¹⁰ Robert G. Evans "Faith, hope and charity: Health care in the utility function," Department of Economics Discussion Paper #80-46 (Vancouver: University of British Columbia, 1980).

¹¹ This was described in detail on the section on correlations in social policy.

¹² Jens Alber "Germany," in Peter Flora, ed., *Growth to Limits: The Western European Welfare States Since World War II* (New York: de Gruyter, 1988).

concomitant contractions in welfare programmes.¹³ "In Europe, as elsewhere, income per capita is the main determinant [of health care spending.] ... Existing cross-sectional regression analyses do not permit any independent measure of the impact of such policies [to control health care expenditure] other than the general conclusion that centralised cash-limited budgets have a significant negative impact on the total and that public finance also reduces total expenditure."¹⁴

The impact of excessive health care expenditure on economic growth is equally controversial.¹⁵ Critics of public expenditure programmes claim that there is a threshold beyond which public sector expenditure has a negative effect on economic performance.¹⁶ They argue that expenditure on social programmes, such as health care, increases the cost of production, increases prices, lowers demand, displaces the productive labour force and makes industries less competitive. It may also in some unknown way "intrude" on economic growth and capital formation.¹⁷ Social programmes may lead to heavy public expenditure, and in the absence of economic growth, to mounting public debt. The impact of such debt on health and health care expenditure still needs to be clarified.¹⁸

Those that argue against this logic claim that expenditure on health care keeps workers healthy, increases their productivity and lowers expenditure on social benefits by creating employment. Taxes, cash transfers and indirect benefits lead to income redistribution and greater economic equality for the non-working poor -- the aged, single mothers, older workers and other unemployed.¹⁹ Left wing rule is often associated with

¹³ Rudolf Klein and Michael O'Higgins, eds., *The Future of Welfare* (Oxford: Basil Blackwell, 1985).

¹⁴ Antony J. Culyer, "Cost Containment in Europe," Annual Supplement, *Health Care Financing Review* (1989): 31.

¹⁵ Uwe E. Reinhardt, "Health Care in Transition: Issues and Options," Conference on The Economics of Health Care: Challenges for the Nineties, The Woodrow Wilson School of Public and International Affairs, Princeton University, 28-30 October 1990.

¹⁶ David Cameron, "On the limits of the public economy," *Annals of the American Academy of Political and Social Science* 459(1982): 46-62; Manfred G. Schmidt, "Does corporatism matter? Economic crisis, politics and rates of unemployment in capitalist democracies in the 1970s," in *Patterns of Corporatist Policy-Making* by G. Lehmbruch and Philippe C. Schmitter, eds. (Beverly Hills: Sage, 1982); Richard Rose, ed., *The Dynamics of Public Policy: A Comparative Analysis* (Beverly Hills: Sage, 1976); and Richard Rose and Guy Peters, *Can Governments Go Bankrupt* (New York: Basic Books 1978); Henry Cavanna, ed., *Public Sector Deficits in OECD Countries: Causes, Consequences and Remedies* (London: Macmillan, 1988).

¹⁷ David R. Cameron, "Public expenditure and economic performance in international perspective," in *The Future of Welfare*, by Rudolf Klein and Michael O'Higgins, eds. (Oxford: Basil Blackwell, 1985): 8-21.

¹⁸ Jean-Pierre Dumont, *L'Impact de la Crise Economique sur les Systemes de Protection Sociale* (Paris: Economica, 1987); John Bristow and Declan McDonagh, eds., *Public Expenditure: the Key Issues* (Dublin: Institute of Public Administration 1986); and Leonardo Hakim and Christine Wallich, *Deficits, Debt, and Savings Structure of OECD Countries, with Trends from 1965 to 1981*, World Bank Staff Working Papers, No. 727 (Washington: World Bank, 1985).

¹⁹ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975); Richard Rubinson and Dan Quinlan, "The world economy and the distribution of incomes within states: A cross-national study," *American Sociological Review* 41(1976): 638-39; Richard Rubinson and Dan Quinlan, "Democracy and social inequality: A reanalysis," *American Sociological*

lower unemployment, lower inflation and growth. By using increased social benefits to counter demands for wage increases by trade unions, they may be more successful in controlling the wage bill of companies and improving profit margins. Of course, there may be little or no redistribution of wealth if the affluent segments of society succeed in re-circulating this income back into their own pockets.²⁰ There is no direct evidence, however, that health care expenditure leads to a displacement effect or that increased disposable income created by cutting health expenditure would lead to greater investment in productive activities. Finally, the willingness to pay taxes for the core programmes of social security (health and pensions) has not significantly declined despite high taxes.²¹

Public expenditure programmes lead to political backlashes with anti-tax, anti-welfare and anti-bureaucratic movements. The most significant cause of backlash is the 'painfully visible' progressive income and property taxes usually advocated by left wing political parties of the least corporatist oriented countries.²² A significant corollary of this observation is the possible inverse relation between universality and comprehensiveness of programmes and political backlash: "programmes that extend benefits over a broad income range will be less susceptible to politically motivated protest than programmes that target the poor."²³ Among the many social security provisions that have been introduced in the twentieth century, old age pension and health care are the most universal, most comprehensive and most popular. Means-tested public assistance for non-working, non-disabled and non-aged poor are the least popular.²⁴

Paradoxically, the high visibility of direct taxes and means-tested benefits are often associated with the lower-tax structures and lower spending capacity of left wing governments, due to political backlash. On the other hand, less visible but higher indirect taxes are sometimes associated with greater political acceptability and greater spending capacity of moderate centralist governments.

Review 42(1977): 611-23; and David Cameron, "The expansion of the public economy: A comparative analysis," *American Political Science Review* 72(4)(1978): 1243-361.

²⁰ Robert W. Jackman, *Politics and Social Equality: A Comparative Analysis* (New York: Wiley, 1975); and Robert W. Jackman, "Socialist parties and income inequality in Western industrial societies," *Journal of Politics* 43(1980): 135-49.

²¹ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 438.

²² Harold L. Wilensky, *The 'New Corporatism', Centralization and the Welfare State* (London and Beverly Hills: Sage, 1976).

²³ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 412.

²⁴ Richard M. Coughlin, *Ideology, Public Opinion, and Welfare Policy: Attitudes Towards Taxing and Spending in Industrialized Societies*, Monograph Series No. 42 (Berkeley: Institute of International Studies, University of California, 1980).

What is true at one level of socio-economic development may not be true at another. The impact of public expenditure for health care on economic performance may have both lower and upper thresholds in relation to GDP. In one large, cross-national study, the author demonstrated that public expenditure on the health sector appeared to have no correlation to economic development (GDP) for low income countries. For the mid-range countries, there was a weak correlation between health care expenditure and economic development. For the high income countries, the positive correlation disappears and may even become negative.²⁵ Most of the other stereotype tradeoffs that are debated in the social policy literature have not been validated in cross-national reviews of health policy: the welfare state and democratic participation versus capital investment and a healthy economy; social benefits versus labour supply, productivity and economic growth; and the seemingly unlimited demand for public services versus reluctance to pay.

Cross-national studies have been largely unsuccessful in clarifying these debates for several reasons.²⁶ Researchers are asked to match studies focussing on different theoretical issues, different methodologies and non-comparable issues. They therefore need to be on guard constantly against the pitfalls created by artifacts from a variety of directions. Finally, there is a temptation to conclude that a determinant relationships exist when statistical analysis reveals that there is the presence of strong correlations between different events: "To give a grotesque example, Esping-Andersen reports that the correlation between social spending levels and the number of miles a nation's capital is from Stockholm is stronger than with either economic level or left wing party power."

²⁵ Abdelmjid Tibouti, PhD thesis, Aix-en-Provence, 1982.

²⁶ Franz Kraus, "The historical development of income inequality in Western Europe and the United States," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 187-236; and Benjamin I. Page, *Who Gets What from Government* (Berkeley: University of California Press, 1983).

²⁷ Jens Alber, Gösta Esping-Andersen and Lee Rainwater, "Studying the welfare state: issues and queries," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 459.

E. POLICY PROCESSES

Cross-national studies have been used to investigate the theoretical validity of issues related to convergence, diffusion, interdependence, evolution processes in fields as diverse as history, social policy, economics, political science, etc. Phenomena observed in health policy have not been systematically related to these processes. Yet, such an extension follows naturally from their wide application to social policy.

1. Convergence

The proponents of convergence theories maintain that at the macro-aggregate level, countries have common collective responses to similar levels of socio-economic development such as industrialization, urbanization and accumulation of wealth, irrespective of differences in their historical, cultural, political or bureaucratic orientations.¹ This theory has been used to explain why social security systems of both democratic and communist countries appear to offer the same seven or eight basic programmes, extend coverage over time and experience rapid increases in expenditure (decelerating recently) at similar levels of socio-economic development.²

Opponents to this theory claim that convergence is an artifact of statistical data that does not reflect the qualitative realities of programme comprehensiveness, differentiation, entitlement, coverage, targeting, universality, accessibility and financial burden associated with benefits.³ Such criticism is partly valid in that convergence theories have been mainly validated through statistical studies. Detailed programme-by-programme cross-national comparisons have not been conducted on enough of an international level to arrive at a satisfactory resolution of this debate.

2. Diffusion

In industrial societies, policy-makers imitate the time-proven policies of more advanced countries regardless of their socio-economic, political or bureaucratic contexts. Some scholars claim that the spread of social policy to neighbouring countries, such as the spread of social security from Germany to its close neighbours, is due to geographic

¹ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975): 41; and Margaret Gordon, *The Economics of Welfare Policies* (New York: Columbia University Press 1963): 322-5.

² Frederick Pryor, *Public Expenditure in Capitalist and Communist Nations* (Homewood, I.L.: Irwin, 1968).

³ Jens Alber, "Government responses to the challenge of unemployment: the development of unemployment insurance in Western Europe," in *The Development of Welfare States in Europe and America*, by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 37-80.

proximity.⁴ Others maintain that it is a hierarchical transmission from leaders to followers, such as from Britain to its former colonies -- Canada, Australia, New Zealand - - despite geographic distance.⁵ Threats of force, physical and economic, influence this process. These variants in diffusion are not mutually exclusive since it is possible that policies and resources be spread along historical, social, cultural, economic, political and bureaucratic as well as geographic links.⁶ The vulgarisation of the pure sciences and their application to solving ordinary day-to-day problems can be regarded as a diffusion of information from higher to lower levels of knowledge. The health sector depends on a successful diffusion and filtering of information from the laboratory to the bed-side. "International organisations are established with the explicit mandate of coordinating economic policies of the member countries ... [with] no systematic attention to the impact of diffusion."⁷

Opponents of diffusion theories claim that countries which have reached the most advanced stage of socio-economic development are not always the first to introduce innovative reforms. Some scholars have demonstrated that lack of urbanization and low levels of industrialization preclude the introduction of social security programmes.⁸ Yet the United Kingdom, although more industrially developed, was later than Germany in introducing such reforms.⁹ Such ambiguities have led to the conclusion that diffusion forces are necessary but insufficient as a determinant factor of social reform: other socio-economic, political and bureaucratic factors must also be taken into consideration, since measures of the distance between societies are no longer valid as a proxy for their isolation in the present context of easy communication. Most of the studies that have examined diffusion processes have been limited to subjective observations, not statistical analysis.

⁴ Such diffusion may apply to human and physical resources as well as to social policy. Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces, in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and HIWED Project, 1981): 125-50; Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press 1974); and Koji Taira and Peter Kilby, "Differences in social security development in selected countries," *International Social Security Review* 22(2)(1969): 1939-53.

⁵ Reinhard Bendix, "Tradition and modernity reconsidered," *Comparative Studies in Society and History* 9(1967): 292-342.

⁶ David Collier and Richard Messick, "Prerequisites versus diffusion: Testing alternative explanations of social security adoption," *American Political Science Review* 69(1975): 1299-315.

⁷ Adam Przeworski and Henry Teune, *The Logic of Comparative Social Inquiry* (New York: Wiley-Interscience 1970): 44.

⁸ David Collier and Richard Messick, "Prerequisites versus diffusion: Testing alternative explanations of social security adoption," *American Political Science Review* 69(1975): 1299-315.

⁹ Flora and Alber, "Modernization, democratization and the development of Welfare States."

3. Interdependence

It is often difficult to make a clear distinction between functional interdependence and diffusion. "If a particular trait occurred within the culture of *A*, was it because *A* contained the conditions that cause this trait or because *A* learned from other cultures."¹⁰ Cross-sectional links may occur among different policies within the same country and there may be longitudinal influences on policies introduced at a later point in time. "Indeed, inadequate methodological attention to interdependence is the most damaging weakness of cross-national studies."¹¹ This neglect stems in part from the failure to operationalise methodologies for the analysis of this type of relationship. Although, statistical models can distinguish internal and external correlations between particular phenomenon, the increased number of variables that must be examined without changing the number of countries observed compounds the risk of overdetermination through which excessive attribution is accorded to a limited number of factors that occur in high correlation with the observed event. The intimate relationship between ability to spend and willingness to pay makes it extremely difficult to separate economic issues from political processes. Keynesian economic policies are one example of how these distinctions become obscured.

4. Evolution

Systems evolve over time due to convergence, diffusion and interdependence processes, or other independent factors. If there is any interdependence among economic growth, policy commitments and the welfare state, changes in one will have an impact on the others. The literature on historical, economic and political theory has multiple references to long-term cyclical or repeating patterns that may, in themselves, evolve in a precarious way over time. Investigation limited to short time-spans will overlook such effects, giving the false impression that processes always occur in a predictable progressive direction. If the resulting oscillations were predictable, forecasting future trends would be relatively simple. Much of the current debate on the evolution of the welfare state centres around trying to predict such trends in policy.¹² Does public policy eventually double up on its historical path or do new options become available just at the moment when a return to the starting point appears inevitable? Does the welfare state face an unavoidable impending crisis due to loss of momentum in historical commitments,

¹⁰ Adam Przeworski and Henry Teune, *The Logic of Comparative Social Inquiry* (New York: Wiley-Interscience 1970): 44.

¹¹ Adam Przeworski and Henry Teune, *The Logic of Comparative Social Inquiry* (New York: Wiley-Interscience 1970): 44.

¹² Robert Erikson and Rune Åberg *Welfare in Transition: A Survey of Living Conditions in Sweden 1968-81* (Oxford: Clarendon Press, 1987); Howard Glennerster, *The Future of the Welfare State: Remaking Social Policy* (London: Heinemann, 1983); John Creedy and Richard Disney, *Social Insurance in Transition: An Economic Analysis* (Oxford: Clarendon Press, 1985); M. A. Jones, *The Australian Welfare State: Growth, Crisis and Change* (Sydney: George Allen & Unwin, 1983).

or self-damaging tendencies due to a negative effect of public, social and health care spending on economic growth.

One school of thought maintains that long-term trends in social policy are marked by uncertainty and are therefore difficult to predict.¹³ According to these authors, the debate on the welfare state in crisis is largely written by alarmists who have a poor understanding of change and low tolerance for uncertainty. Policy inevitably evolves over time and not always in the same direction. Other authors have shown that it is possible to anticipate some trends, such as public expenditure on health care, if the forecasting time-period is kept short.¹⁴

Until recently, theoretical debate was almost completely absent from the comparative health policy literature. Most cross-national health care studies focussed on operational aspects of service delivery such as sources of revenue collection, allocation of resources, mode of remuneration of health care providers, expenditure trends, cost controls, administrative structures and performance (efficiency, effectiveness and quality).¹⁵ "The health literature is primarily written by and addressed to policy planners, who pay more attention to pragmatic goals: they aim to examine particular systems and abstract lessons for policy-makers rather than construct theory."¹⁶ The lack of a solid theoretical base has been attributed to non-comparable data, problems standardising terminologies and problems transferring policies cross-nationally.¹⁷ There is still a widespread conviction that health policy is so complex that no two systems are alike: "One of the most striking facts about the financing and organisation of medical care is the extent to which it varies among developed countries.... I think it is premature to talk about convergence."¹⁸

¹³ Rudolph Klein and Michael O'Higgins, eds., *The Future of the Welfare* (Oxford: Basil Blackwell, 1985).

¹⁴ Thomas E Getzen and Jean-Pierre Poullier, "International Health Spending Forecasts: Concepts and Evaluation, Second World Congress on Health Economics, University of Zurich, Switzerland, 13 September 1990.

¹⁵ Able-Smith, "World trends in health care financing and delivery," International Symposium on Health Care Systems, Taipei, Taiwan, Republic of China, December 18-19, 1989.

¹⁶ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 416-17; Brian Abel-Smith, *Value for Money in Health Services: A Comparative Study* (London: Heinemann, 1976); Brian Abel-Smith, *Cost Containment in Health Care*, Occasional Papers on Social Administration (London: Bedford Square Press, NCVO, 1984).

¹⁷ George J. Schieber and Jean-Pierre Poullier, "Overview of international comparisons of health care expenditures," Annual Supplement, *Health Care Financing Review* (1989): 1.

¹⁸ Jeremy W. Hurst in response to Alain C. Enthoven, "What can Europeans learn from Americans," Annual Supplement, *Health Care Financing Review* (1989): 65.

Authors who have raised the possibility that some of these phenomena exist in health policy generally ignore its relation to the broader sphere of public and social policy.¹⁹ "Systematic investigation is needed to establish the extent to which public commitments to the health sector reflect or diverge from commitments to other policy areas and to expansive social policy in general."²⁰ Only rarely are the proposed hypotheses subjected to rigorous empirical validation. Complex issues such as coverage, targeting, universality, access, equity, comprehensiveness and transferability, as well as the time sequence in which entitlement to health care was introduced in relation to other social benefits have not received rigorous treatment in the comparative literature: "The legislative initiatives as to which social groups in an industrialized society should be assured health care have been clearly the results of political choices, not merely the products of socio-economic development."²¹

¹⁹ Uwe E Reinhardt in response to Bengt Jönsson, "What can Americans learn from Europeans?" Annual Supplement, *Health Care Financing Review* (1989).

²⁰ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 417.

²¹ Arnold J. Heidenheimer, Hugh Hecl and Carolyn Teich Adams, *Comparative Public Policy: the Politics of Social Choice in Europe and America*, 2nd Edition (New York:St Martin's Press, 1983): 53.

CHAPTER 2. METHODOLOGY

A. HYBRID DISCIPLINE

Cross-state comparisons, "the study of *why, how and to what effect* different governments pursue a particular course of action or inaction," provided the underlying framework for the research.¹ Comparative studies attempt to identify the phenomena which are true of one society at any given one point in time that are true of all societies over time.² They may be cross-national, cross-time within single countries, cross-level between different tiers of government, cross-policy and so on. Such studies have been carried out for centuries, but their application to health care is a recent development. The early forerunners to today's investigations were used as tools of political theorising and analysis.³ During the second half of the twentieth century, investigators have tried to apply the knowledge gained through social science to refine the research technique used to study of public policy⁴ which has come to include cross-national comparisons of both social and health policy.⁵ The dominant focus in recent years has been to examine the contents, determinants and effects of policy on society. It helps researchers to identify theoretical issues, develop methodologies, carry out investigations, analyse data and formulate future policy options based on validated hypothesis.⁶ It helps planners, legislators and administrators to assess the acceptability, feasibility and appropriateness of policy options based on the real experiences of other national settings.

By necessity, the theoretical base for cross-national studies has become a complex hybrid that often crosses many traditional boundaries to respond to the multi-faceted dimensions of the issues and policy options that are being examined.⁷ It bridges fields as

¹ Arnold J. Heidenheimer, Hugh Heclo and Carolyn Teich Adams, *Comparative Public Policy: the Politics of Social Choice in Europe and America*, 2nd Edition (New York: St Martin's Press, 1983): 2-3. The expressions "comparative", "cross-national" and "international" are used interchangeably.

² Stein Rokkan, *Comparative Research Across Cultures and Nations* (Paris: Mouton, 1968).

³ The political analysis of early Greek philosophers such as Aristotle and Plato refers extensively to foreign experiences.

⁴ Douglas Ashford, ed. *Comparing Public Policies* (Beverly Hills: Sage, 1978); Thomas R. Dye, *Policy Analysis: What Governments Do, Why They Do It, and What Difference It Makes* (University of Alabama: University of Alabama Press, 1976); and Stuart Nagel, *Contemporary Public Policy Analysis* (University of Alabama: University of Alabama Press, 1984).

⁵ Peter Flora and Arnold J. Heidenheimer, eds., *The Development of Welfare States in Europe and America* (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981).

⁶ Jan Berting, Felix Geyer and Ray Jarkovich, eds. *Problems in International Comparative Research in the Social Sciences* (Oxford: Pergamon).

⁷ Karl W. Deutsch, "Prologue: achievements and challenges in 2000 years of comparative research," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 7.

diverse as philosophy, history, political science, sociology, public administration, mathematics, statistics, economics and so on. The occurrence of phenomena such as thresholds, historical breaks, conjunctures, shifts, contractions and reversals makes it impractical to adhere to the unidimensional techniques of any of these non-comparative disciplines.⁸ Instead, it is often necessary to go beyond the standard research design used in the pure and applied social sciences. This has left the discipline open to harsh criticism on lacking theoretical unity.⁹ Cross-disciplinary investigations have been accused of being "essentially non-comparative ... essentially descriptive ... essentially parochial ... essentially static ... [and] essentially monographic."¹⁰ Other social sciences are equally vulnerable to such admonishment. Yet note of discordance heard about cross-national studies reflect variations in the orientations of universities and university departments as much as it does shortcomings in the research itself: "many universities encompass greater theoretical heterogeneity than most multi-national research teams."¹¹

B. SCIENTIFIC METHOD

Although the controlled *in vitro* laboratory experiment cannot be used for most research conducted in the humanities, the same scientific principles apply to carefully planned field experiments: "cross-national research is needed and conducted because it is the closest approximation to the controlled laboratory experiment of the natural scientists which is available to social scientists..."¹² The application of the scientific method to social research is generally referred to as 'quasi-experimentation'.¹³

The research design for the study was therefore strategically underpinned by the scientific method of investigation. At first sight, much of the accumulated cross-national public and social policy literature gives the disheartening impression that its only communality is an inability to come to any conclusion. Many are flawed by haphazard and inappropriate methodologies: unclear objectives, incomplete reviews of the literature, badly formulated hypotheses, poorly designed methodologies, careless experimental

⁸ Adam Przeworski and Henry Teune, *The Logic of Comparative Social Inquiry* (New York: Wiley-Interscience 1970).

⁹ Elliot J. Feldman, "Comparative Public Policy: Field or Method?" *Comparative Politics* 10(1978): 287-305.

¹⁰ Roy C. Macridis, *The Study of Comparative Government* (New York: Doubleday, 1955): 7-12.

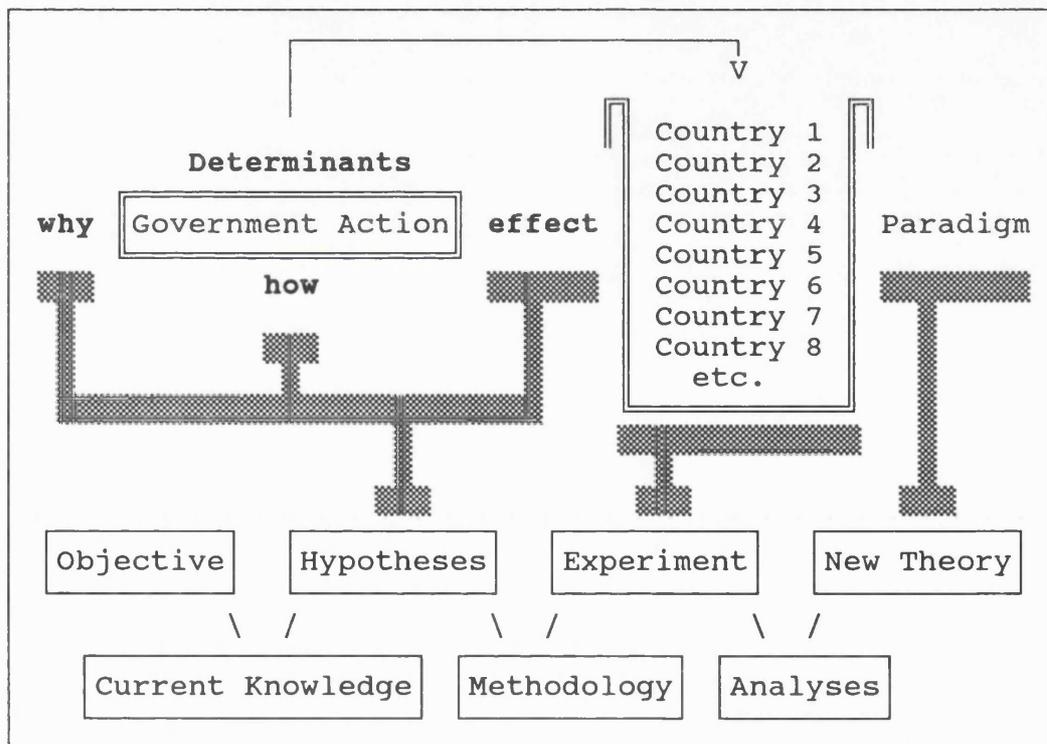
¹¹ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 44.

¹² Edmond Lisle, "Perspectives and challenges for cross-national research," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 475.

¹³ D.T. Campbell and J.T. Stanley, *Experimental and Quasi-Experimental Designs for Research* (Chicago: Rand McNally, 1966); T.D. Cook and D.T. Campbell, *Quasi Experimentation: Design and Analyses of Issues for Field Settings* (Chicago: Rand McNally, 1979).

techniques, inadequate analysis and construction of incorrect theories. Health policy has not remained immune to these faults. Instead, a thorough preliminary review of the literature should help the investigator to formulate a clear objective for the research, recognise the relevant key issues and identify existing hypotheses. Methodological rigour then provides the basis for a solid experiment, and the possibility of making a positive contribution to knowledge or the formulation of new theories.¹⁴ A pure experimental research design, in which the independent variable is fully controlled, is not possible in the case of the social sciences. A careful selection of countries with certain characteristics is the closest approximation. The following schematic representation of the research design tries to capture all of these elements.

Figure 2.1 Quasi-Experimental Method



Over-emphasis on rigid methodological purity can be counter-productive if it leads to the publication of time-sensitive results years after the research is relevant: "Methodologists can inform us that all we have done thus far is wrong and that we must begin again ... Like preachers, [they] are at times listened to, always acclaimed, but rarely

¹⁴ R. Dubin, *Theory Building* (New York: Free Press, 1969); and B.G. Glaser and A.L. Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (London: Weidenfeld and Nicholson, 1967).

followed."¹⁵ Mapping the dynamic flux of policies with no apparent fixed landmarks does not lend itself well to the randomised double-blind prospective trials of the clinical sciences. Using a carefully designed research strategy, many hypotheses can be rejected quickly on purely empirical grounds. One good study may influence research practice more than volumes of theoretical textbooks on methodological purity.¹⁶

Such criticism of methodological purity should not be misconstrued as an excuse for lack of rigour, but in recent years many of the significant contributions to the knowledge of cross-national phenomena have come from empirical validation or repudiation of hypotheses, and not from methodological breakthroughs.¹⁷ "In general, during the past decade epistemological discussions of cross-national research and the essence of the 'comparative method' have exhibited visibly diminishing returns."¹⁸ How to accumulate knowledge through cross-national research has ceased being an area of extensive esoteric debate. "Indeed, references to manuals on comparative methodology gradually disappear from articles presenting substantive studies.... Researchers now know how to do it and no longer need to legitimate [sic] their procedures by reference to textbooks."¹⁹ The component elements of the scientific method of investigation research as it was adopted for the study is tabulated below.

¹⁵ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 31.

¹⁶ D.T. Campbell, "'Degrees of Freedom' and the Case Study," *Comparative Political Studies* 8(1975): 179-93.

¹⁷ A. Etzioni and F.L. Dubow, eds., *Comparative Perspectives: Theories and Methods* (Boston: Little, Brown and Company); J.M. Armer and A.D. Grimshaw, eds., *Comparative Social Research: Methodological Problems and Strategies* (New York: Wiley); N.J. Smelser, *Comparative Methods in the Social Sciences* (Englewood Cliffs, NJ: Prentice-Hall 1975); M. Niessen and J. Peschar, eds., *International Comparative Research: Problems of Theory, Methodology and Organisation in Eastern and Western Europe* (Oxford: Pergamon Press 1982); A. Szalai and R. Petrella, eds., *Cross-National Comparative Survey Research: Theory and Practice* (Oxford: Pergamon Press 1977); D.P. Warwick and S. Osheron, eds., *Comparative Research Methods* (Englewood Cliffs, NJ: Prentice-Hall, 1973); J. Berting, F. Geyer and R. Jurkovich, eds., *Problems in International Comparative Research in the Social Sciences* (Oxford: Pergamon Press 1979).

¹⁸ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 34.

¹⁹ Idem.

Figure 2.2 Research Design

Objective:	Clarification of issues and policy options in health care financing
<i>Mechanisms</i>	Direct charges versus prepayment
<i>Participation</i>	Voluntary versus compulsory
<i>Entitlement</i>	Restricted versus universal
<i>Services</i>	Basic versus comprehensive
<i>Linkages</i>	Risk-rated versus open-ended
Hypotheses:	Government involvement in health care financing
<i>Why</i>	Socio-economic, political, bureaucratic, market failure
<i>How</i>	Allocation, redistribution and stabilisation
<i>Effects</i>	Growth, debt, opportunity, displacement, backlash, expenditure, equity
<i>Trends</i>	Historic, future
<i>Processes</i>	Convergence, diffusion, interdependence, evolution
Methodology:	Quasi-experimental research design
<i>Styles</i>	Descriptive, quantitative Case study, statistical Longitudinal, cross-sectional
<i>Elements</i>	Contextual, spatial, temporal
<i>Dimensions</i>	Content, terminology, scope, boundary, units-of-measurement
<i>Countries</i>	All, many, few, similar, different
<i>Time frames</i>	Historical, current, future, fixed, relative
Experiment:	Cross-national and national profiles
<i>Data Collection</i>	Written records, surveys, interviews
Analysis:	Conceptualisation, explanation and validation
<i>Descriptive</i>	Logic, positivist, linguistic, narrative, graphic scaling
<i>Quantitative</i>	Computer assisted, cluster, statistical, econometric
Theory:	New paradigms

C. OBJECTIVES

This study involved an in-depth cross-national analysis of statutory provisions for compulsory participation and universal entitlement to comprehensive health care services.²⁰ The objective of the research was to explore the process that led to the introduction of such legislative provisions, to deepen our understanding of associated health financing mechanisms, to test specific theories about some of their effects and to propose relevant paradigms about related health policies. As the contribution that research makes to the state of current knowledge increases according to the theoretical

²⁰ These were the founding principles of the Canadian health care system set forth in the *Health Charter for Canadians*: "The achievement of the highest possible health standards for all our people ... This objective can best be achieved through a comprehensive, universal Health Services Programme for the Canadian People, ... financed through prepayment arrangements." Canada, The Royal Commission on Health Services (RCHS), *Report* [Chairman Emmett M. Hall] (Ottawa: Queen's Printer, 1964): 11.

complexity of the issues under investigation, the last element is the most difficult, but potentially also the most rewarding: specific problem-solving, descriptions of the state of the art, validation of existing theories and formulation of new theories.²¹ Preferences between direct out-of-pocket charges versus prepayment through third-party financing mechanisms, voluntary versus compulsory participation, restricted versus universal entitlement, basic versus comprehensive services and various linkages between these dichotomies in health policy have significant implications in terms of equity and efficiency of both financing and delivery of services. An analysis of the choices that governments have made when faced with an option between such policies provides a powerful instrument for examining a number of empirical and theoretical questions related to the role of the state in health care financing.

Figure 2.3 Issues and Policy Options Examined in Study

Issues	Policy options
<i>Mechanisms</i>	Direct charges versus prepayment
<i>Participation</i>	Voluntary versus compulsory
<i>Entitlement</i>	Restricted versus universal
<i>Services</i>	Basic versus comprehensive
<i>Linkages</i>	Risk-rated versus open-ended

D. HYPOTHESES

The conceptualisation of clear hypotheses to be tested remains one of the most critical challenges in comparative studies because it influences all the other components of the research design ranging from experimental choices to data collection to analytical instruments, and ultimately to the conclusions that can be derived from the investigation. The process also influences its conceptualisation. Hypotheses can only be constructed after the formulation of clear objectives and a thorough review of the literature. A thorough exploration of the arguments for and against a particular hypothesis invariably leads to a need for revision in attitudes, objectives and research designs.²²

The final formulation of hypotheses for the study had to take place after "pilot" field trips to some of the countries that would be included. This trial-and-error process was unavoidable because a significant part of the literature review was not readily available in

²¹ P.H. Grinyer, 5th National Conference on Doctoral Research in Management and Industrial Relations, University of Aston Management Centre, 6-7th April 1981.

²² Preliminary notions about concepts were analysed further through cluster analysis and other techniques for the formulation of concepts described under the section on analysis.

any one country. Financing, participation, entitlement and services are only four of a constellation of characteristics that distinguish health systems. The importance of the dichotomies presented by the issues and policy options of direct out-of-pocket charges versus prepaid third-party financing, voluntary versus compulsory participation, restricted versus universal entitlements, basic versus comprehensive services and their various linkages was more evident in the literature of the Nordic countries than in the English language literature. In the Nordic countries, identification of the landmark legislative reforms took in-depth analysis of primary sources because even well informed scholars gave the initial impression that 'things have always been as they are today'.

A dominant focus of scholars in recent years has been to examine the socio-economic, political and bureaucratic determinants of public and social policy. Although much of this work is inconclusive because alleged causal correlations are at best aleatory, it has potentially important implications for health policy. Even unequivocal correlations between GDP per capita, health care expenditure per capita and health status ignore a constellation of potentially important political and bureaucratic variables. Furthermore, most past studies have focussed on the independent variable -- the possible determinants. Few scholars have examined the dependent variable or programme features such as legislative provisions, financial burden, participation, entitlement and services. To what extent does socio-economic level of development, political choice and bureaucratic infrastructure influence these variables? Are there other significant correlations that have not been explored in the past? There is a great need for such programme by programme and sub-programme by sub-programme validation of a number of unproven hypotheses about the determinants of health policy as well as its relation to observations in the public and social policy literature.

Theories on the state offer some clues as to *why*, *how* and *to what effect* different governments pursue a particular course of action or inaction. The often cited hypothesis in the health policy and health economics literature, which has escaped systematic cross-national validation, is that the governments involved in health care financing either for ideological reasons or because "market-failure" prevented individuals and private institutions from providing an adequate response to needs for health care. Although all western countries have some legislative provisions for prepayment of health care, several important questions remain unanswered. Why did some countries introduce compulsory participation while others continue to rely on voluntary participation? Why do some countries rely more on one type of prepayment, such as general revenues, social insurance or private insurance, than others? Why did some countries extend entitlement to their whole population while others still restrict it to a sub-group? Why did some countries expand benefits to include comprehensive care while others limit this to basic services?

Why did some abandon risk-rated contributions and membership-dependent access? Health policy has largely escaped systematic validation of convergence, diffusion, interdependence and evolution processes that are at the centre of the theoretical debate on social policy. The study tried to provide some of these missing links by answering these questions.

How governments get drawn into health care -- through regulations, subsidies and direct provision of services, or simply by doing nothing -- varies greatly from one state to another, but this may be as important as why they get involved. Style of governing may in itself shape the unfolding health policy. The process of policy-making has received much less attention in the cross-national health policy literature compared with the many hypotheses about possible determinants and effects.

In the absence of the ability to establish concrete causal relationships, falsifying popular myths has the advantage of exposing such distortions to policy-makers. Claims that definitive actions will lead to decisive outcomes remain at the centre of many of the debates on health care reforms today. The effect of health policy on society in terms of equity, efficiency, socio-economic development, political backlash and health status is extremely difficult to prove in concrete terms. Was government involvement in health care financing the first step on the road to socialism, as the medical profession has repeatedly warned over time? Do compulsory participation and universal entitlement to health care inevitably lead to problems in economic growth, escalating national debt and opportunity costs in terms of other publicly programmes. Does it displace revenues away from other social security benefits or lead to a political backlash as claimed by some critics? Did it have an impact on equity in financing? Does it lead to an explosion in public sector and health care expenditure? Is health care a luxury consumer good, public good or merit good?

Finally, to what extent do the theories on convergence and diffusion phenomena that are widely discussed in the public and social policy literature apply to health policy? Is there any evidence of less-debated interdependence and evolution processes in policies? There may be close links or an interdependence between the introduction of social security provisions and state involvement in health care. What is the relation between the two in terms of evolution? Few direct links have been made between observations in social policy and health policy. Even fewer have been systematically validated. What were the past trends? Is there any basis for future forecasting?

Figure 2.4 Government Involvement in Health Care

Hypothesis:

<i>Why</i>	Socio-economic, political, bureaucratic, market failure
<i>How</i>	Allocation, redistribution and stabilisation
<i>Effects</i>	Growth, debt, opportunity, displacement, backlash, expenditure, equity
<i>Trends</i>	Historic, future
<i>Processes</i>	Convergence, diffusion, interdependence, evolution

E. RESEARCH DESIGN

The study was designed to capture both complexities of individual policies and generalities of broad trends through a combination of research styles and elements of investigation. This made possible an exploration of constant and dynamic facets of health policies as they occurred over time and across national boundaries that would have been impossible through any single analytical framework.

Figure 2.5 Quasi-experimental Research Design

Methodology:

<i>Styles</i>	Descriptive, quantitative Case study, statistical Longitudinal, cross-sectional
<i>Elements</i>	Contextual, spatial, temporal
<i>Dimensions</i>	Contents, terminology, scope, boundary, units
<i>Countries</i>	All, many, few, similar, different
<i>Time frames</i>	Historical, current, future, fixed, relative

1. Styles

The study used two broad research styles that are common to most cross-national investigations -- descriptive and quantitative studies. A matrix of eight methodological variations can be constructed from these options. Not all provide useful information. Some should even be avoided because they will lead to distortions. There are four basic variations of descriptive studies: longitudinal case studies, longitudinal statistical studies, cross-sectional case studies and cross-sectional statistical studies. Likewise, there are four variants of quantitative studies. The possibility of combining these approaches places cross-national studies in a category by themselves, distinct from both non-experimental

case studies and experimental statistical studies.²³ Vastly different facets of similar issues may surface when studies that use mismatched methodologies are compared. Some of the contradictory conclusions observed in the literature are due to inappropriate research designs.

Figure 2.6 Descriptive and Quantitative Studies

\ Quantitative \	\ \	\ \
Descriptive	Case study	Statistical
Longitudinal		
Cross-sectional		

Descriptive studies often focus in great detail on qualitative aspects of terminology, content, scope, boundaries, units-of-measurement and transformation of policy issues. These types of studies should do not seek to establish causal relationships, but rather to examine the subtle nuances of the substantive issue and to validate hypotheses empirically about determinants that have already been established through quantitative analysis. The number of countries selected is therefore less important than in quantitative studies, although the choice remains crucial. These studies can be divided into several subgroups:²⁴

Descriptive studies where causal relationships are well established.²⁵

Descriptive studies that impose global structures on partial data.²⁶

Descriptive studies of innovative policies.

By contrast, quantitative studies focus on concrete units-of-measurements which have been assigned as proxies to reflect the realities of the policies being investigated. These

²³ N.J. Smelser, "The methodology of comparative analysis," in *Comparative Research Methods*, by D. Warwick and S. Osheron, eds. (Englewood Cliffs, N.J.: Prentice-Hall 1973); and E. Vedung, "The comparative method and its neighbours," in *Power and Political Theory: Some European Perspectives* (Chichester: Wiley 1976).

²⁴ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 3-36.

²⁵ B.P. Bosworth, "Capital formation and economic policy," in *Brookings Papers on Economic Activity 2(1982): 273-326*.

²⁶ M. Rein and L. Rainwater, *From Welfare State to Welfare Society: Some Unresolved Issues in Assessment*, IIVG-AP (Berlin: WZB 1981).

studies often seek to establish causal relationships through statistical analysis. The number of countries selected is crucial to the research design, and the more random the choice, the less biased the results. These studies can be divided into several subgroups:²⁷

Studies that ask whether X is responsible for Y ;

Studies that ask whether X is an effective measure for or against Y ;

Studies that ask whether X is producing a sufficient effect upon Y ;

Studies that compare the effectiveness of partial changes within complex systems.

Researchers who carry out descriptive analysis on case studies are able to explore the subtle qualitative aspects of core explanatory variables in much greater detail than is possible through statistical studies. "Comparative case histories uncover a myriad of details of social reforms, their administrative properties, coverage, financial agreements, distributive logic and so forth. In the correlational approach, the welfare state is often reduced to one or two highly aggregate indices."²⁸ This applies to both cross-sectional and longitudinal historical material from case studies. The reliance on the case study approach for comparative studies of health policy may reflect the conviction that the unique historical settings and the subject matter being treated is too complex to compare similarities, leaving only the contrast of differences as an option.

In-depth investigations using case studies are both time-consuming and costly. They are therefore often limited to an exploration of a few countries at a time. Although this permits a rich description of complex interacting policy issues, it also limits the possibilities for significant statistical analysis of causal relationships.²⁹ The fewer the countries, the greater the number of potentially competing determinant variables. The purported identification of causal relationships through statistical analysis of a large number of independent variables from a small cross-sectional or longitudinal database should be avoided because it leads to **overdeterminism**, and observations that have virtually no statistical significance.³⁰

²⁷ D.G. Taylor, "Analyzing Quantitative Data," in *Handbook of Social Research* (New York: Academic Press 1983); and Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 36-37.

²⁸ Jens Alber, Gösta Esping-Andersen and Lee Rainwater, "Studying the welfare state: issues and queries," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 462.

²⁹ Some causal relationships can be inferred from formal models of choice, contextual analysis, hierarchical models of organisations and intervention analysis, but their conclusions are all vulnerable to overdeterminism.

³⁰ J.J. Wiatr, "The role of theory and methodology in cross-national research," *Polish Roundtable* (1070-1): 4.

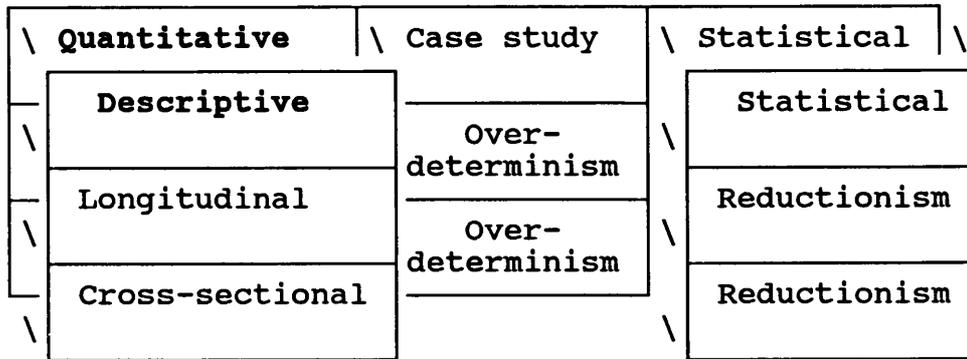
Researchers using statistical studies are faced with a totally different set of possibilities and constraints. Quantitative analysis of standard longitudinal time series and cross-sectional data, such as multi-variant regression analysis, allows the investigator to pinpoint the relative importance of each of a large number of possible correlated factors.³¹ Descriptive material in longitudinal time series and cross-sectional databases can also be quantified and analysed statistically. Path analysis, in which the sequence of events is carefully mapped may even suggest determinant relationships. The substantive issue becomes the dependent variable and the possible determinant factors, the independent or intermediate variables, but there is an excessive claim of causal relationships in the literature based on correlations that merely co-exist. The random selection of a large number of countries leads to the least biased conclusions about the determinants of social policies.

Statistical studies have their disadvantages, since the subtle nuances of the substantive issues lose some of their richness and complexity through the **reductionism** inherent in aggregates. Many policy issues are not readily quantifiable some are impossible to represent as precise uni-dimensional units-of-measurement. The terminology, boundaries, scope, units-of-measurement and transformation of policies vary greatly from one country to another. Sweeping generalisations and trends described in statistical studies at the national level do not necessarily reflect the realities of micro-systems at the state/regional/local levels, or the realities of the institutional features of their composing programmes and sub-programmes.

The investigator has recourse to one or more of four, rather than eight, effective research styles because those that lead to either overdeterminism or reductionism are best avoided. The best descriptive studies use longitudinal or cross-sectional historical material. This is characteristic of the case study approach. Descriptive analysis of statistical data is best avoided because it is vulnerable to reductionism. The best quantitative studies use longitudinal or cross-sectional statistical data. This is characteristic of economic approaches. Quantitative analysis on case study material is best avoided because it is vulnerable to overdeterminism. The policy issues that will be explored will largely determine the type of research style that is best suited for a given investigation. The research style will in turn determine the most appropriate group of countries and relevant time period.

³¹ S. Feinberg, *The Analysis of Cross-Classified Categorical Data* (Cambridge: MIT Press 1977).

Figure 2.7 Reductionism and Overdeterminism



Several of these research styles were combined to explore complex subjective and objective aspects of the policy issues that were being investigated in the study.³² Issues on why and how the state became involved in legislative reforms that lead to compulsory participation and universal entitlement to health care were best explored through longitudinal descriptive case study techniques. Hypotheses about their determinants and effects are best explored through cross-sectional quantitative statistical techniques. Empirical evidence for validating or disputing many hypotheses and trends, such as convergence, diffusion, interdependence and evolution processes, came from a mixture of techniques. Descriptive analyses of statistical data was avoided, as were quantitative analyses of case study material.

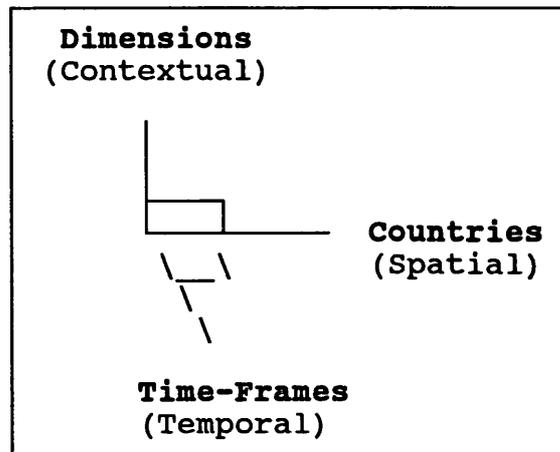
2. Elements

The study integrated different elements of cross-national comparisons that can be graphically represented along three separate axes: *dimensions* (content, terminology, scope, boundary and units-of-measurement), *countries* (all versus many versus few and similar versus different), and *time-frames* (current versus historical and fixed versus relative). Dimensions of issues and policy options that were true in one setting had to be carefully matched with other settings. Some were best examined through in-depth reviews of a few countries, while others best observed through broad overviews of larger numbers of countries. Finally, some were easily confined to narrow time frames, while others required much longer periods. The existing literature does little to put these methodological elements of cross-national research into a simple structured framework.³³

³² The specific techniques used are discussed under the section on analysis.

³³ The components of these axes could be quantified through multi-variant scaling.

Figure 2.8 Methodological Choices



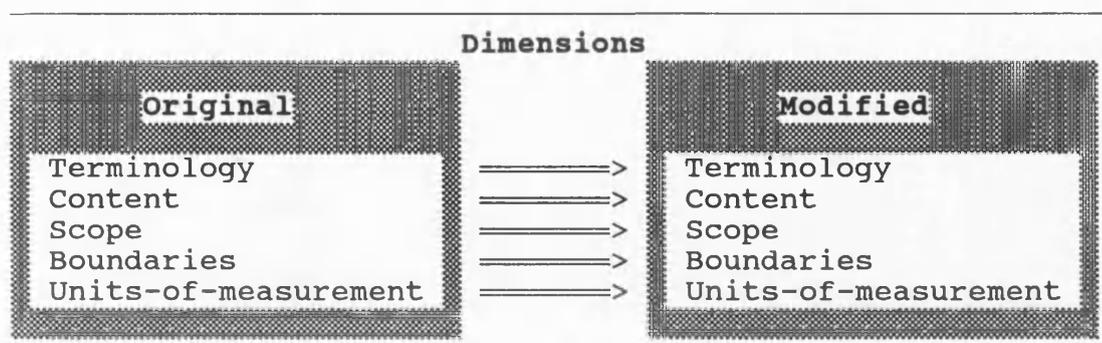
a) Dimensions (Contextual)

The comparative literature has given little attention to **transformations** such as historical breaks, thresholds, conjunctures, shifts, contractions and reversals that occur over time in issues and policy options. "The concepts which give rise to philosophical problems should be analysed and clarified noting their use in everyday life."³⁴ In longitudinal time series, static descriptions fail to capture the changes that occur over time in the terminology, content, scope, boundaries and units-of-measurement of each of the key issues that were examined in the study - compulsory participation and universal entitlement to health care. Likewise, cross-sectional analysis at any one point in time are vulnerable to mismatching transformations in meanings between disciplines. "Historically, welfare-state 'laggards' like the United States tend to be education leaders ... [occurring] well before the big expansion of the rest of the welfare state."³⁵ Even though some errors are unavoidable when aiming at moving targetes, awareness of the existence of such problems draws attention to the limits of cross-national comparability.

³⁴ One approach to analysing political ideas in this way is linguistic analysis which will be discussed under the methodology section on analysis. David Miller, *Social Justice* (Oxford: Clarendon Press, 1976).

³⁵ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 402; and Arnold J. Heidenheimer, "Education and social security entitlement in Europe and America," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 269-304.

Figure 2.9 Transformation in issues and policy options



Similar **terminology** can describe vastly incongruous concepts if their dimensions differ significantly. A classic example of this difficulty appears in the difference between the terms *policy* and *politics* in English language, which have only one equivalent in both German (*politik*) and French (*politique*). Debate about health care financing is often confused in the literature because at times it refers to activities involving revenues collection at other times, to the allocation of financial resources and at still other times, to the cost or expenditure on services. The terms direct payments, user charges, fees, out-of-pocket payments, co-payments, cost recovery and *ticket modérateur* are used in different ways in many countries. The notion of health insurance is extremely poorly differentiated. At times it refers to any collective prepayment, including general revenues. At other times, it refers only to earmarked social insurance or risk-related private insurance. Principles that apply to one of these aspects of health care financing do not apply to the others. The same term may have slightly different meanings in different cultural settings or when translated from one language into another. The study tried to clarify the ambiguities of such terminology through special analytical techniques that will be described later.

Comparative studies on the welfare state have often focussed on the **contents** of 'core programmes' without validating their composition or consistency. Health care represents vastly different things in different countries or at different points in time. Similar standard provisions for ambulatory care, institutional care and public health may differ significantly in a number of qualitative aspects. Each sub-component is the peak of a pyramid of its own. The minimum standards for social security advocated by the International Labour Organization (ILO) in 1952 included medical care, sickness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivors benefits, all of which have some impact on health.³⁶ Health care was initially meant to include treatment by

³⁶ International Labour Office (ILO), Social Security (Minimum Standards) Convention, No. 102 (Geneva: ILO, 1952).

generalists, specialists, essential medications, pre- and post-natal care, deliveries, hospitalisation, dental care and medical prosthesis. Today, most Western and Eastern European countries offer the same seven or eight basic programmes, but their content varies considerably. Some include dentistry, pharmaceutical products, prosthesis, ophthalmological equipment, social services, chronic care and health spas, while others provide none of them. These differences had to be clarified in the study. The core content of health care was much more limited in 1900 than in the 1950s and the 1980s.

The **scope** of health care has no clear demarcation within the broader sphere of social benefits. "The key term 'minimum standards' has proved unacceptable to some who insist on a definition based on 'adequate' or even 'optimal' standards. These questions are crucial to comparative research."³⁷ According to the World Health Organisation (WHO), which advocates a more comprehensive definition than the ILO, health care must reduce differences between individuals, allow full expression of individual potential, reduce diseases and disabilities, prevent premature deaths and care for those who cannot care for themselves through all stages of the life-cycle if it hopes to improve health status.³⁸ Without food, water, shelter, education, employment and useful participation in society, traditional health services probably have an insignificant impact on health status. At the extreme, the medicalisation of society is almost limitless since most activities can be construed to have some direct or indirect impact on health, well-being and the life-cycle.

The **boundaries** between different programmes, such as health care and social services, often obscure the complexity of the issues and policy options being examined. The cleavages made to delineate their content and scope are rarely natural. The public/private debate confuses financing, production (administration and ownership), and resource allocation issues.³⁹ Just as public expenditure on social services is not an accurate index of total welfare effort, so health care expenditure ignores important related sectors, such as education, pensions, social security, agriculture, defence and housing, as well as the informal sectors such as households.⁴⁰ At the same time, extensive disaggregation risks camouflaging phenomena such as the processes of convergence, diffusion,

³⁷ Jens Alber, Gösta Esping-Andersen and Lee Rainwater, "Studying the welfare state: Issues and queries," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 460.

³⁸ World Health Organization (WHO), Regional Office for Europe (ROE), *Targets for Health for All: Targets in Support of the European Regional Strategy for Health for All* (Copenhagen: WHO, ROE, 1985): 23.

³⁹ M. Rein and L. Rainwater, *The Private/Public Interplay in Social Protection* (New York: M.E. Sharpe, 1985); Gordon McLachlan and Alan Maynard, eds., *The Public/Private Mix for Health: The Relevance and Effects of Change* (London: Nuffield Provincial Hospitals Trust, 1982); A.J. Culyer and Bengt Jönsson, eds., *Public and Private Health Services: Complementarities and Conflicts* (Oxford: Basil Blackwell, 1986).

⁴⁰ George Crumper, *Health Sector Financing: Estimating Health Expenditure in Developing Countries*, A Discussion Paper, EPC Publication No. 9 (London: London School of Hygiene and Tropical Medicine, 1986).

interdependencies and evolution that may be more apparent at the macro-aggregate level of analysis.

The assignment of appropriate **units-of-measurement** that accurately reflect the realities of the policies also poses a difficult, sometimes impossible, challenge. Mortality and morbidity statistics do not accurately reflect degree of incapacity, suffering or quality of life.⁴¹ Macro-aggregates have the advantage of being easily available, readily quantifiable and the only statistical way to discriminate among a large number of possible determinant factors. Sweeping generalisations in macro-analyses at the national level, however, do not reflect the realities of their component programmes or sub-programmes at the state, regional and local levels. Traditional measures of social expenditure (social security expenditure/GDP) and health care expenditure (public expenditure/GDP) do not reflect the qualitative components such as financial burden, participation, entitlement and services. High spending may indicate unavoidable expenditure on a high incidence of social problems rather than political will. "The validity of any study depends on whether it explains what it purports to explain."⁴² For example, the notion of GDP did not exist before the 1950s. Indices were developed as proxies for measuring efficiency and outcome. Whenever possible, the study used the standard terminology, content, scope, boundaries and units-of-measurement for health care that have been developed by the OECD Health Data File.⁴³

b) Countries (Spatial)

Two opposing approaches have emerged in relation to the number of countries to include in cross-national comparisons. The best selection depends to a large extent on the hypotheses that will be tested and the research style that will be chosen to examine the issues and policy options under investigation. Selection criteria for cross-sectional statistical analysis should therefore be different from that for in-depth descriptive case study analysis because they look at different facets of health policy and use different analytical techniques.

One school of thought claims that there is no valid reason to limit countries to a specific subset.⁴⁴ On the contrary, limitations based on such constraints as the dictates of

⁴¹ G.W. Torrance, "Utility approach to measuring health-related quality of life," *Journal of Chronic Diseases* 40(6)(1987).

⁴² Jens Alber, Gösta Esping-Andersen and Lee Rainwater, "Studying the welfare state: issues and queries," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 462.

⁴³ This data base will be described in detail in the section on data collection.

⁴⁴ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 31-49.

funding agencies who may have a special interest in certain countries is as damaging as an arbitrary selection on the basis of socio-economic, geo-political or other characteristics. A second school of thought claims that irrelevant *noise* should be filtered out by carefully selecting a specific subset of countries to highlight the information that will be examined in detail. In reality, these two approaches are not at odds with each other, since the proponents of the random selection approach perform mainly macro-aggregate quantitative analyses on large groups while the proponents of the limited sub-group approach perform mainly descriptive case study analyses on small groups. Pre-selection limits the quality of the quantitative analysis of statistical studies as much as haphazard selection introduces a lot of irrelevant material into case studies.

The proponents of the quantitative statistical analytical method argue that random selection of a large cohort leads to the least biased results in establishing causal relationships through techniques such as multi-variant regression analysis. Although the distinction between descriptive and explanatory is often unclear, "in explanation or evaluation research, the choice of countries becomes a crucial decision in the design of a study."⁴⁵ The most comprehensive cross-national study would include all the countries in the world. These investigators favour enlarging the sample size until purportedly universal principles observed in a handful of countries are validated in a larger group. Increasing the sample size allows a randomisation of factors that will eventually uncover competing hypotheses. "A hypothesis which defends itself among 22 countries that happen to belong to the same data-collecting organisation while apparently more dubious elsewhere is suspect."⁴⁶

Unfortunately, the greater the number of countries the greater the chances that the data will involve the standardisation of terminology, content, scope and boundaries of the substantive issues and policy options. Although statistically significant, the results may be irrelevant because the quality of the data is unreliable -- garbage-in-garbage-out (GIGO). Most quantitative studies are, therefore, forced to select a sub-group of countries for which reliable data is available, the choice of which remains important to the outcome of the analysis.⁴⁷

The proponents of the descriptive case study method argue that detailed historical reviews force the investigator to limit studies to a sub-group of countries in order to explore the complex substantive issues and policy options in sufficient depth. A number of

⁴⁵ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987).

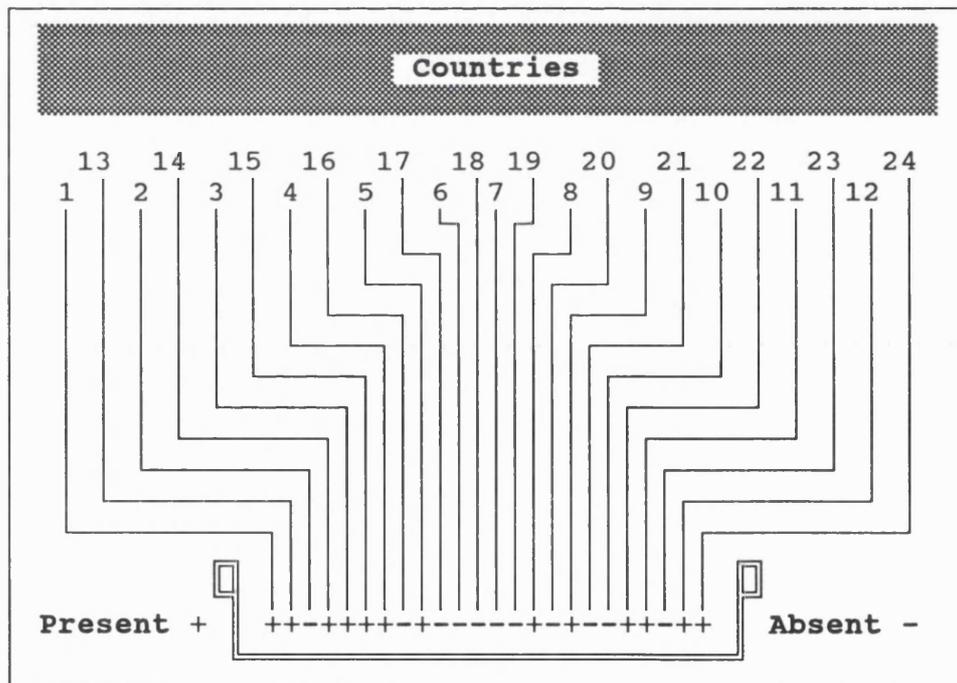
⁴⁶ Op. Cit., p. 36.

⁴⁷ George J. Schieber and Jean-Pierre Poullier, "Overview of international comparisons of health care expenditures," Annual Supplement, *Health Care Financing Review* (1989): 1-7.

well-known studies have demonstrated that precisely formulated hypotheses focussing on a small number of countries can give a richness of insight into specific issues that would have been impossible with the statistical approach.⁴⁸ The case study approach is best when reserved for exploration of qualitative issues, empirical validation of hypothesis or quantitative analyses of selected longitudinal historical trends, not for identifying causes and effects.

Investigators choosing the case study approach are faced with three additional choices: should the sub-group of countries be selected on the basis of a random sample, the presence of similar or contrasting characteristics? The arguments for selecting a random sample to enhance unbiased quantitative statistical analysis of macro-aggregates lose most of their power of persuasion because the potential cohort group is usually too small for significant statistical analysis from the outset. This leaves only two options -- the "most similar" approach and the "contrasting" approach.

Figure 2.10 Similar and Contrasting Characteristics



⁴⁸ Robert T. Kudrle and Theodore R. Marmor, "The development of welfare states in North America," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and HIWED Project, 1981): 81-121; Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and HIWED Project, 1981): 125-50.

Since certain policy issues are observed only within a specific context, detailed analysis should logically be limited to those countries for which such policies are relevant. For example, the legislative provisions for compulsory participation and universal entitlement to health care can only be observed in countries that have introduced or debated not to introduce such policies. The "most similar" comparative approach is most suitable in these studies.⁴⁹ This allows the investigator to focus on similarities, nuances and differences between the issues and policy options being examined without the distraction of irrelevant "noise" from countries that have neither introduced nor debated their introduction.⁵⁰ Added weight can be given to observations that bisect an otherwise homogeneous pre-selected group by using Bayesian analytical techniques. "Although over-determination is and will continue to be the central problem of cross-national research, some, perhaps a lot of it may be avoided by devoting more attention to research design, thinking in Bayesian terms, and overcoming institutional and cultural parochialism."⁵¹ Only a few authors have applied the "most similar" comparative approach to health policy analysis.⁵²

The debate in favour of the "contrasting" characteristics method is unconvincing. Those who criticise the "most similar approach" do so on the basis that limited sample size prevents significant statistical analysis. They often say "the most similar systems ...[design] ... is simply a bad idea ..." motivated by Eurocentrism and parochialism.⁵³ The choice of a few countries with contrasting features does not make the analysis statistically any more valid. It still leads to overdeterminism. Random selection or contrasting features of a small number of case studies increases "noise" without contributing to the analysis. Another reason for favouring the "contrasting" case study approach reflects the unsupported conviction that all health systems are unique. "By selecting only a few countries that differ greatly in the provisions they make for health care, analysts are biased toward this conclusion. A more systematic comparative approach would require an analysis of covariation: cross-national similarities (or differences) in health care systems need to be aligned with differences (or similarities) in political, economic or cultural

⁴⁹ Alex Inkeles, "Cross-national research confronts the needs of the policy-maker," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 50-55.

⁵⁰ The researcher is, nevertheless, obliged to examine some irrelevant "noise" to confirm that it does indeed lack the desired information.

⁵¹ G.E.P. Box and G.C. Tiao, *Bayesian Inference in Statistical Analysis* (San Francisco: Holden-Day, 1973).

⁵² Theodore R. Marmor, Wayne L. Hoffman and Thomas C. Heagy, "National health insurance: Some lessons from the Canadian experience," *Policy Sciences* 6(4)(1975): 447-66; Malcolm C. Brown, *National Health Insurance in Canada and Australia: A Comparative Political Economy Analysis*, Research Monograph No. 3 (Canberra: Health Economics Research Unit, 1983); and Robert T. Kudrle and Theodore R. Marmor, "The development of welfare states in North America," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and HIWED Project, 1981): 81-121.

⁵³ Adam Przeworski, "Methods of cross-national research, 1970-83: An overview," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 39.

contexts.⁵⁴ Authors of health policy have been especially prone to falling into this trap, limiting themselves to detailed case studies of a small number of countries selected purely on the basis of some contrasting policy feature, hoping to establish casual relationships in this way.⁵⁵

Although the investigator may feel forced to make an imperfect choice between seemingly mutually exclusive approaches, all the schools of thought stress the importance of choosing a theoretical framework and a systematic research design. Many of the pitfalls described in the literature could have been avoided if investigators had used the research style and selected countries on the basis of what they were intending to do rather than on the basis of a pre-determined bias for or against any particular methodology. In one study of 50 randomly selected countries and 158 political parties, the investigator realized that three of the most interesting Anglo-Saxon cases had been omitted -- the UK, US and Canada.⁵⁶

For the purpose of the study, different groups of countries were selected for the cross-sectional quantitative analysis and in-depth descriptive case study analysis to respond to the needs of each of these techniques. The part of the study that looked at causes and effects used a random selection of a large group of countries for which there was reliable standardised data. Most of the high-income countries in the world meet the reliable data criteria because of the OECD Health Data File.⁵⁷ There were two obvious, but unavoidable, weaknesses in the selection process used to choose this large group of countries. First, high-income but non-OECD member economies such as Saudi Arabia, Israel, Singapore, Hong Kong, Kuwait and United Arab Emirates were excluded from the group because their health care expenditure databases are not standardised with those of

⁵⁴ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 416.

⁵⁵ Christa Altenstetter, *Health Policy-making and Administration in West Germany and the United States* (Beverly Hills: Sage, 1974); Christa Altenstetter, *Innovations in Health Policy and Service Delivery: A Cross-National Perspective* (Cambridge, M.A.: Oelgeschlager, Gunn and Hain, 1981); Odin Anderson, *Health Care: Can There be Equity? The United States, Sweden, and England* (New York, Wiley, 1972); Howard Leichter, *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations* (Cambridge: Cambridge University Press, 1979); William Glaser, *Health Insurance Bargaining: Foreign Lessons for Americans* (New York: Halsted, 1978). J.W. Hurst, *Financing Health Services in the United States, Canada and Britain* (London: King's Fund, 1985). K. Henke, "What can Americans learn from the German health insurance system?" *Social Science* 55(1980): 134-137. In recent years, the literature is filled with studies on the contrasting features between the Canadian and American health care systems that try to postulate the causes and effects of these differences based on comparisons between the two countries.

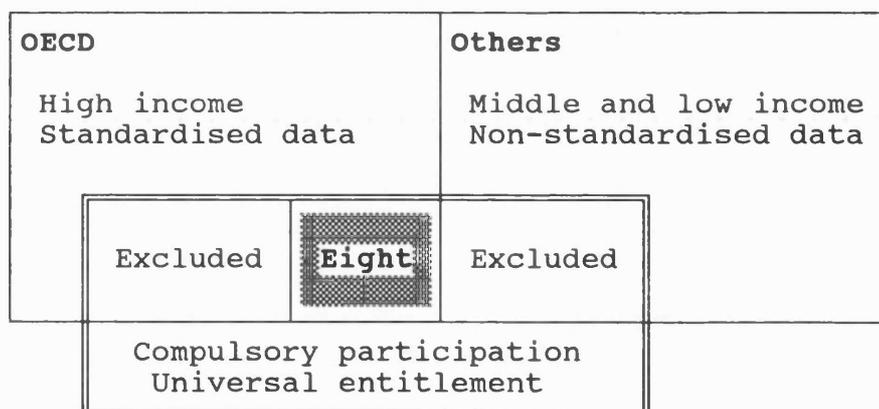
⁵⁶ Kenneth Janda, *A Conceptual Framework for the Comparative Analysis of Political Parties* (Sage: Beverly Hills, 1980).

⁵⁷ Australia, Austria, Belgium, Canada, Denmark, Federal Republic of Germany, France, Finland, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Switzerland, Portugal, Turkey, United Kingdom and United States. Yugoslavia participates with special status. John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 34.

the OECD. Second, middle-income countries such as Turkey, Portugal and Greece which belong to the OECD group were included because their data is standardised with that of the others.⁵⁸

For the in-depth descriptive case study analysis, the main selection criteria was that the country should have passed legislation to introduce compulsory participation and universal entitlement to health care, as well as belonging to the group for which meaningful cross-sectional quantitative analysis could also be carried out. Of the OECD group of countries, 13 had passed such legislation and eight had sufficient data to construct historical profiles of their health financing reforms.⁵⁹ Greece, Italy, Portugal and Spain were eliminated because insufficient historical data was available to construct meaningful profiles, and their recent reforms made post-reform analysis premature. Iceland, with its small population and remote location, was also omitted from detailed analysis. This left the four English-speaking countries (Australia, Canada, New Zealand and the United Kingdom) and four Nordic countries (Denmark, Finland, Norway, Sweden). National profiles were created from common socio-economic, political, bureaucratic and intrinsic programme features which developed over time.⁶⁰ Cross-national profiles were then created from comparable characteristics that evolved irrespective of spatial and temporal boundaries.

Figure 2.11 Selection Criteria for Eight Case Studies



The obvious, but unavoidable, weaknesses in the selection process used to choose this smaller sub-group of countries related to the countries that had to be omitted from the descriptive component of the study. Many of them have passed legislative reforms either

⁵⁸ The data for Turkey is still not reliable.

⁵⁹ Extensive preliminary review of all the OECD countries was needed to identify these countries and eliminate those that had not passed such legislation.

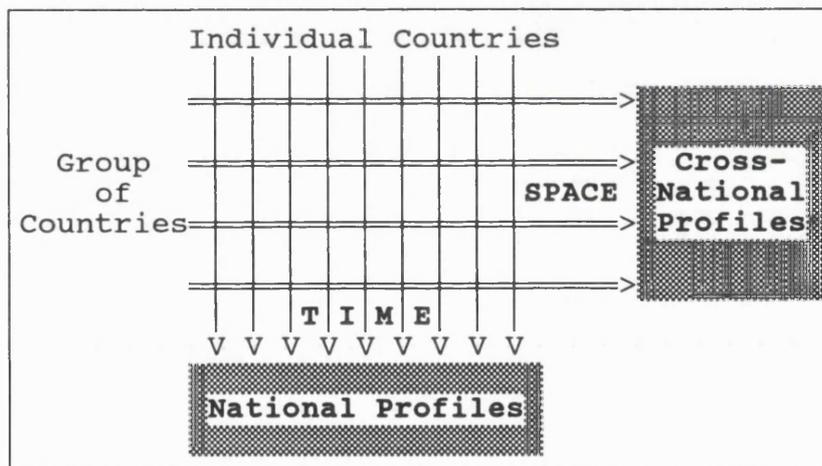
⁶⁰ Similar points in the evolution of the reforms under investigation were used as landmarks rather than chronological dates because the latter often differed for any given issue and policy option.

as part of their social security legislation or through services offered by their Ministries of Health (Welfare).⁶¹ They were primarily eliminated because they lacked comparable standardised data and therefore had to be excluded from the cross-national statistical analysis. The most notable omission was many of the COMECON member countries, most of which have universal entitlement to health care, although individuals make no direct contributions to pre-paid financing.⁶²

c) Time Period (Temporal)

Two different approaches have also emerged in relation to the time-frame examined in comparative studies. One focusses on cross-sectional data while the other focusses on longitudinal data. In both cases, the dependent and independent variables usually correspond to the substantive issue being examined and its determinants or effects, not the countries themselves nor the time-frame used for the investigation.

Figure 2.12 National and Cross-National Profiles



Most cross-sectional analysis uses a single chronological date as the fixed frame-of-reference, with the substantive issue being examined as the dependent variable and the possible determinant factors as the independent variables.⁶³ A few studies that have looked at the effects of social reform on society, its political system and the economy. In

⁶¹ United States, Department of Health and Human Services (DHHS), *Social Security Programs [sic] Throughout the World - 1983*, Research Report No. 59 (Washington: Government Printing Office, 1984); and World Health Organization (WHO), *Health Care Legislation of the World* (Geneva: WHO, yearly publication).

⁶² CMEA is the acronym for Council for Mutual Economic Assistance (COMECON). The six founding members, Bulgaria, Czechoslovakia, Hungary, Poland, Romania and USSR, were later joined by Albania (1949-61), German Democratic Republic (1950), Mongolia (1962), Cuba (1972), Vietnam (1978). Yugoslavia, Afghanistan, Angola, Ethiopia, Laos, Mexico, Mozambique, Nicaragua and the People's Democratic Republic of Yemen attend as observers. Paxton, *Statesman's Year-Book 1986-1987*, 48.

⁶³ See the section on substantive issues.

this case, the independent variable is the substantive issue and the dependent variables are the effects.⁶⁴ When using this approach, choosing a suitable time-frame becomes crucial because both the dependent and independent variables may be at different stages of evolution from one country to another at any one given point in time. Their terminology, content, scope, boundaries and transformations risk being different from one country to another, undermining the quality of any observed statistical or descriptive similarities or variations.

Instead of looking at the substantive policy issues for a fixed reference year in cross-sectional analysis, some investigators have tried to standardise the dependent variable by matching different stages of its development as the fixed frame of reference for their studies. For instance, the investigator might choose to compare programmes at different chronological times when programmes were first proposed, introduced in legislature, implemented or at a certain level of maturity. The extensive in-depth historical reviews needed to closely match the definitional boundaries of complex issues are extremely time-consuming and costly, which may explain why this approach is largely ignored in the literature. For pragmatic reasons, such studies tend to use the case study approach, limited to a small group of countries. This limits the possibility of subsequent significant statistical analysis.

Longitudinal historical reviews, because of their in-depth nature and the complexity of the subject matter, are also often restricted to a small group of countries focussing on a limited number of variables. Although their terminology, content, scope and boundaries can be defined much more precisely, transformations over time may easily be missed. Even when the sample group is too small for cross-sectional quantitative statistical analysis, statistically significant analysis of longitudinal historical data can still reveal important trends within any one country. Hypotheses about determinants and effects need to be empirically validated through larger, statistically valid cross-sectional analysis. "Descriptive studies merely placed side by side would not be considered a suitable end product, but would be defined as raw material for further analysis."⁶⁵

⁶⁴ Richard Rubinson and Dan Quinlan, "The world economy and the distribution of income within states: A cross-national study," *American Sociological Review* 41(1976): 638-59; Richard Rubinson and Dan Quinlan, "Democracy and social inequality: A reanalysis," *American Sociological Review* 42(1977): 611-23; David Cameron, "The expansion of the public economy: A comparative analysis," *American Political Science Review* 72(4)(1978): 1243-361; David Cameron, "On the limits of the public economy," *Annals of the American Academy of Political and Social Science* 459(1982): 46-62; Douglas Hibbs, "Political parties and macro-economic policy," *American Political Science Review* 71(1977): 1467-88; Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975); Richard Rose and Guy Peters, *Can Governments Go Bankrupt?* (New York: Basic Books, 1978).

⁶⁵ Alex Inkeles, "Cross-national research confronts the needs of the policy-maker," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 52.

F. DATA COLLECTION

Access to politically sensitive data and public figures often presents a special problem in comparative research. The researcher who has privileged entry through official channels will be more successful in obtaining the needed information than the researcher who has no such access. Research carried simultaneously for the Commission of Inquiry into the Health and Social Services of Quebec greatly facilitated data collection as well as field work for this study.¹ The research styles and three axes of the elements of investigation provided the rationale for the data that was collected for the different components of the study. Textual, and nominal or categorical data was gathered for the descriptive analysis. Ordinal or ranked, interval and ratio data was gathered for the quantitative analysis.

Figure 2.14 Data for Cross-national and National Profiles

Experiment:

Data Collection

Written records, surveys, interviews

1. Descriptive

The standard tools used by the social sciences to collect qualitative data -- review of written records, surveys and interviews -- remains central to cross-national research.² Descriptive data was gathered from an extensive review of written documents, visits to each country and interviews.³ Primary sources included working documents, official reports, green papers, white papers, legislative bills, statutes and regulations, as well as journal articles and conference proceedings.⁴ The work done by Commissions prior to introducing important legislation provided an invaluable source of information.⁵ This data

¹ Alexander S. Preker, "Public finance and provision of health care services in Québec: An international perspective," *Brief*, presented to the Commission of Inquiry into the Health and Social Services of Quebec [Chairman Jean Rochon] (London: IIHS, December 1986).

² R.K. Som, *A Manual of Sampling Techniques* (London: Heinemann, 1973).

³ The survey technique was limited to guidelines used during open-ended interviews with selected individuals in each of the countries chosen for the case studies. It was not intended for statistical analysis.

⁴ Martin Bulmer, ed., *Social Research and Royal Commissions* (London: George Allen & Unwin, 1980). Original documents were also examined in for the Nordic countries with the exception of a few key documents for Finland, which were translated into English by Helle Satälä of the Finnish Embassy in London.

⁵ R.A. Chapman, ed., *The Role of Commissions in Policy-Making* (London: George Allen & Unwin, 1973); G. Rhodes, *Committees of Inquiry* (London: George Allen & Unwin, 1975); T.J. Cartwright, *Royal Commissions and Departmental Committees in Britain* (London: George Allen & Unwin, 1975); M. Komarovsky, ed., *Sociology*

was supplemented by a review of secondary and tertiary sources such as monographs, handbooks, textbooks, statistical series, journals and so on.⁶ Whenever possible, interviews were carried out with the people who had been directly responsible for bringing about the reforms: politicians, civil servants, administrators, health professionals, economists and social scientists.⁷ Finally, during visits to each country, the existing health care systems were examined directly. For the reasons described above, detailed descriptive data was collected from primary sources for eight in-depth case studies. This covered a time frame of almost a century. Less detailed descriptive data was collected on other OECD and COMECON countries through secondary sources.

Data on social protection such as entitlement and services is more difficult to compile and interpret. Most of the documentation is description, making language barriers a significant obstacle. Legal and constitutional provisions may differ significantly from customary practices. Translating either of these into indicators that can be used in time series or cross-sectional analysis bears many risks. All-or-nothing classifications are the most reliable indicators, but these were of limited use in the project because they fail to capture the gradations that occurred in the introduction of compulsive prepayment and universal entitlement to health care.

Several key questions were asked for each of the historical time periods:

- Why did infrastructures for collective financing of health care develop? What were the key determining factors leading to a growth in these financial infrastructures? Why did the public sector get involved? What percentage of the population remained without protection prior to the introduction of legislative provisions for universal access to comprehensive health care? Who were those without protection? Who were the key health care reformers?
- Why were legislative provisions introduced to provide universal access to comprehensive health care? What were the anticipated secondary gains from the reform? Why did the public sector get involved? How developed was each country's financial infrastructure prior to the reform? What was society's sense of civic responsibility for financing social programmes through the public sector before the reform? Who were the key health care reformers?
- What were the persistent barriers to universal access following the reform? Who were the key health care reformers?

and *Public Policy: The Case of the Presidential Commissions* (New York: Elsevier, 1975); and Martin Bulmer, *Social Research and Royal Commissions* (London: George Allen & Unwin, 1980).

⁶ Martin Bulmer, *The Uses of Social Research: Social Investigation in Public Policy-Making* (London: George Allen & Unwin, 1982). For more comprehensive reviews, see references in Charles Lindblom and David Cohen, *Usable Knowledge: Social Science and Social Problem Solving* (New Haven: Yale University Press, 1979): 102-26.

⁷ In the Nordic countries, Australia and Canada, many of the key people involved in earlier reforms were still alive and willing to grant interviews.

2. Quantitative

The collection of quantitative statistical data on health care expenditure presents a different set of problems. The scope of work done by early researchers was limited because of the problems in data compatibility. To overcome some of these obstacles, authors went through a laborious and costly processes to compile their own data sets.⁸ Later, as guidelines were established for the recording of health expenditure data,⁹ some countries began to standardise their national account records. Three approaches have evolved to compile official statistical data at the international level:

A single agency finances and conducts surveys in different countries based on controlled questions, concepts, definitions and processing.

A single compilation unit gathers the data provided by different agencies that work in close collaboration to provide standardised information.

A single analyst adjusts readily accessible data from different countries to comparable standards.

The first method is the most reliable way to obtain full cross-national comparability. Because of the high cost of this type of investigation, it is only conducted on rare occasions and in an episodic way which limits its usefulness as way to compile ongoing data. The second method will lead to a more solid database. It also requires extensive cooperation between many agencies, which is rarely possible and involves long studies, which is unsuitable in time-sensitive investigations. The third method is the least costly and most expedient way to collect a useful body of information for cross-national comparisons. Conveniences offset the disadvantages of having to depend on the judgement of a single compiler and the obvious limits to extracting useful data from sometimes vastly different sources. However it also limit the possibility of verification and validation of the data. This is the method that the OECD uses to collect its comprehensive Health Care Data File which, since 1985, has triggered an extensive reevaluation of accepted national accounting standards for health care.¹¹ The researcher must decide when the need for timely accessibility to data for cross-national comparisons

⁸ Abel-Smith and Richard M. Titmuss, *The Cost of the National Health Service in England and Wales* (Cambridge: Cambridge University Press, 1956).

⁹ Brian Abel-Smith, "Paying for health services: A study of the costs and sources of finance in six countries," *World Health Organization Public Health Papers* 17(1963); and Brian Abel-Smith, "An international study of health expenditure, and its relevance for health planning," *World Health Organization Public Health Papers* 32(1967).

¹⁰ Jean-Pierre Poullier, "Health data file: Overview and methodology," Annual Supplement, *Health Care Financing Review* (1989): 111-118.

¹¹ OECD, *Measuring Health Care 1960-1983: Expenditure, Costs and Performance*, OECD Social Policy Studies. (Paris: OECD, 1985).

justifies accepting the concomitant compromises that must be made when national data is manipulated to reflect international standards.

The OECD health care expenditure data is based on a national accounting concept that has become an international standard.¹² It presents a comprehensive series which adheres to rigorous economic classification principles in an attempt to ensure that all costs incurred are added up. Private consumption includes hospital care, physician services, pharmaceuticals, therapeutic appliances and other insurable health care related benefits. Public consumption includes public health services, administration, regulation, education and biomedical research. Sickness benefits paid in cash, which belong to income maintenance functions, are excluded from both public and private health care expenditure. Total health care expenditure (HCE) is the arithmetic sum of public expenditure, private expenditure, expenditure on health care in non-related fields such as education, research and other ministries, and informal expenditure by households.¹³ Data becomes increasingly unreliable and unavailable towards the bottom of this list.¹⁴ The OECD and most other statistical sources on health care expenditure ignore the fourth category, give an incomplete account of the third and base the second on estimates.

In principle,

$$\text{Total HCE} = \Sigma \text{Public} + \Sigma \text{Private} + \Sigma \text{Other} + \Sigma \text{Informal}$$

But in practice,

$$\text{Total HCE} = \Sigma \text{Public} + \Sigma \text{Private}$$

The impressive statistical health care database and accounting standards established in the OECD countries continues to expand with time. The most recent OECD health care publication includes a compendium of 67 tables from more than 400 tables presently being compiled as part of the Health Data File.¹⁵ It includes detailed data on health care expenditure trends, prices and incomes, social protection, medical care use and personnel, medical practice variations, health status indicators, and demographic and economic

¹² Quantitative differences among classification systems are discussed in *Structural Problems of Social Security Today and Tomorrow*, Proceedings of the European Institute of Social Security, Leuven, Belgium, ACCO, 1988, Table A-1.

¹³ George Crumper, *Health Sector Financing: Estimating Health Expenditure in Developing Countries*, A Discussion Paper, EPC Publication No. 9 (London: London School of Hygiene and Tropical Medicine, 1986).

¹⁴ Likewise, Gross Domestic Product (GDP) underestimates real national wealth because it excludes the productivity of informal sectors such as households and "black markets".

¹⁵ OECD, *Health Care Systems in Transition: The Search for Efficiency*, Social Policy Studies No. 7 (Paris: OECD, 1989).

background data. Similar information is being compiled for developing countries by the World Bank's technical assistance division, but collection of this information is much more episodic and it is carried out by a team of researchers rather than a single individual.

The national accounting concept of health care expenditures used by the OECD is not without inconveniences. National aggregates fail to represent provincial, regional, local and individual realities. There are gaps in the comprehensiveness of the data series of some countries. Not all activities that contribute to health status are classified under health expenditure, especially those made by other ministries. Health expenditure made by enterprises is treated as an "intermediate" outlay rather than final consumption. Gross capital expenditures are added to the aggregate outlay. Even among OECD countries, some national accounting systems are rudimentary, leading to underreporting. Information on public sector activity is more reliable than that for private sector activity, which may be splintered and even deliberately falsified for fiscal reasons. Information on public expenditure on health care is more reliable than information on total expenditure, which relies on estimates of private expenditure. Furthermore, statistics on utilisation, practice styles, health status and outcome indicators are essential to investigations that look at health care performance in terms of efficiency, effectiveness and quality of care. Even within individual countries, such data is still fragmented and at an infancy stage of development. Cross-national comparisons using the limited available standardised data remains precarious. Furthermore, OECD data dates back only to 1960.

The OECD Health Data File and the UN statistical records provided an important source of information for quantitative analysis that required cross-sectional comparability for comparisons of financing mechanisms, expenditure levels, coverage, efficiency and outcomes. For quantitative analysis of time series, data was required from before 1960. National statistical series were used for this purpose because internal consistency was considered more important than cross-national comparability for this phase of the study.¹⁶ A single sources was used rather than multiple time series whenever possible to minimise the introduction of artifacts. These were then compared with other sources to check for inconsistencies. Original statistical sources were preferred over secondary sources. The use of raw data from national statistical sources posed many unavoidable inconveniences. There were changes in classifications used to gather data by national authorities,¹⁷ devaluation of currencies,¹⁸ omitted or added data,¹⁹ revised estimates in

¹⁶ See the Select Bibliography for references for the statistical time series used for the Nordic countries, New Zealand and the United Kingdom whose time series preceded the beginning of the OECD Health Data File.

¹⁷ This happened in most countries during the late 1960s and early 1970s.

¹⁸ This happened in Finland during its time series.

¹⁹ This was a major problem in the case of New Zealand and the United Kingdom prior the 1950s. The Nordic statistical series is issued only once every two or three years.

later volumes of statistical yearbooks,²⁰ and data sources with conflicting information.²¹ All the problems of transformation in terminology, content, scope, boundaries and units-of-measurements posed a serious problem for the use of non-standardised data. When possible, corrections were made for such inconsistencies.

Information on the sources of revenue for financing health care is much less readily available than expenditure data.²² Total health care revenues (HCR) is the arithmetic sum of several sources: budgetary revenues (BR) may include both general revenues (GR) and social insurance (SI); extra-budgetary revenues (ER) may include public funds available to other ministries for health care, special funds, cash intake by institutions, other private sources and foreign aid in the case of many developing countries; private revenues (PR) in the form of health insurance (HI) and out-of-pocket spending (OOP). Double counting often occurs between cash intake by institutions and OOP spending. Data once again becomes increasingly unreliable and unavailable further down this list. Most official statistical reports limit their treatment of revenue collection for health care to general revenues, social insurance and estimates of private revenues.

In principle,

$$\text{Total HCR} = \Sigma \text{Prepayment} + \Sigma \text{Direct Charges}$$

But in practice,

$$\text{Total HCR} = \Sigma \text{GR} + \Sigma \text{SI} + \Sigma \text{PR}$$

G. ANALYTICAL TECHNIQUES

The key issues and policy options examined in the study were analysed using both descriptive and quantitative techniques. The purpose of the descriptive phase of the study was to identify, clarify and analyse some of the subjective aspects of the concepts being explored. Many of these relate to questions on *why* and *how* governments introduced compulsory participation and universal entitlement to health care. The purpose of the quantitative phase of the study was to recognise patterns, analyse existing hypotheses and provide an objective basis for constructing new theories. Many of these relate to explanations and predictions about the *determinants* and *effects* of government

²⁰ The most recent revision was considered the most reliable.

²¹ In recent years, national time series differ significantly from the OECD Health Data File because the latter is standardised for international comparability.

²² The OECD Health Data File includes no information on the sources of revenue.

on the policies being examined. Both techniques were useful for empirical validation of existing hypotheses.

Figure 2.15 Analytical Techniques

Analysis:	Techniques
<i>Descriptive</i> <i>Quantitative</i>	Logic, positivist, linguistic, narrative, graphic scaling Computer assisted, cluster, statistical, econometric

1. Descriptive

Many aspects of health policy would lose their richness if reduced to quantifiable representations. Deductive and inductive reasoning were the most powerful analytical techniques used in the descriptive phase of the study.²³ The countries selected for the case studies²⁴ were submitted to *positivist analysis* of their constitutional provisions, health and social legislations, regulations, conventions, administrative infrastructures and health policies,²⁵ and *linguistic analysis* of relevant issues and policy options.²⁶ These two techniques, which formed the cornerstone of the descriptive analysis, are described in greater detail in the sections below. *Multi-dimensional graphic scaling* made possible the design of a perceptual map from the three axes of the elements of investigation (contextual, spatial and temporal.)²⁷ *Narrative accounts* of historical data were used to explore the validity of rival theories and construct national and cross-national profiles.²⁸ *Discriminate analysis* made possible a weighted classification of other countries according to variables that had been assigned to the key issues investigated in the case studies.²⁹

The following technical developments in descriptive analysis were not applied to the eight case studies, because statistical analysis of limited cross-sectional samples leads to

²³ K. Popper, *The Logic of Scientific Discovery* (London: Hutchinson, 1959); Arnold J. Heidenheimer, Hugh Hecllo and Carolyn Teich Adams, *Comparative Public Policy: The Politics of Social Choice in Europe and America*, 2nd Edition (New York: St. Martin's Press, 1983); Peter Flora, *State, Economy, and Society in Western Europe, 1815-1975: A Data Handbook in Two Volumes* (Chicago: St James, 1983); and Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., *Comparative Policy Research: Learning from Experience*, WZB-Publications (Hants: Gower, 1987).

²⁴ See the section on selection of countries for the rationale behind those selected for detailed case studies: Australia, Denmark, Canada, Finland, Norway, New Zealand, Sweden and the United Kingdom.

²⁵ H.L.A. Hart, *The Concept of Law* (Oxford: Clarendon Press, 1961).

²⁶ David Miller, *Social Justice* (Oxford: Clarendon Press, 1976).

²⁷ R.N. Shepard, A.K. Romney and S.B. Nerlov, *Multidimensional Scaling: Theory and Applications in the Behavioural Sciences*, Volume 1 and 2 (New York: Seminar Press, 1972); and A.H.G.S. van der Ven, *Introduction to Scaling* (New York: Wiley, 1980).

²⁸ J. Carrier and I. Kendall "The development of welfare states: The production of plausible accounts," *Journal of Social Policy* 6(1977): 271-290.

²⁹ P.A. Lachenbruch, *Discriminate Analysis* (London: Collier Macmillan, 1975); and M. Goldstein and W.R. Dillon, *Discrete Discriminate Analysis* (New York: Wiley, 1978).

overdeterminism. *Formal models of choice* provide for an assessment of the impact of changes in institutional structures and strategic policies on the behaviour of individuals within the system being examined.³⁰ *Hierarchical models of organisations* provides a measure of the impact of constraints on individual units within an organisation.³¹ *Contextual analysis* provides an appraisal of the impact of system-level characteristics on the behavior of individuals within organisations.³² *Factor analysis* takes a number of measurements of a particular issue and attempts to explain differences.³³ *Statistical techniques* provide a more sophisticated treatment of qualitative variables that has previously been limited to quantitative variables.³⁴ *Intervention analysis* provides an evaluation of the effects of policy changes, regulations and dynamic behaviour on systems.³⁵ *Meta-analysis* makes it possible to re-evaluate a body of otherwise contradictory literature.³⁶

a) Positivist Analysis

The classic position of the positivist theory of analysis, which has come to dominate legal jurisprudence in the nineteenth and twentieth centuries, is to deny any *a priori* source of natural laws, and to recognise only positive facts or observable phenomena.³⁷ Interpretation of policies based on the authority of existing legal systems and established social infrastructures offers advantages over value-laden distortions of what things ought to be or might be under ideal circumstances. Public debate on the philosophical or ethical aspects of health care as an important subset of the welfare state is very different from political commitment to preparing, passing and implementing a law that offers such provisions.

Several factors made this rigorous approach possible. Legislative reforms provided useful landmarks for many of the transitions that occurred in health policy such compulsory participation and universal entitlement to health care. Both constitutional

³⁰ D.C. Mueller, *Public Choice* (Cambridge: Cambridge University Press, 1979).

³¹ J.F. Padgett, "Hierarchy and ecological control in federal budgetary decision making," *American Journal of Sociology* 87(1981): 75-129.

³² L.H. Boyd, Jr. and G.R. Iversen, *Contextual Analysis: Concepts and Statistical Techniques* (Belmont, CA: Wadsworth Publishing Company 1979).

³³ H.H. Harman, *Modern Factor Analysis* (Chicago: University of Chicago, 1967); and R.J. Rummell, *Applied Factor Analysis* (Evanston: North Western Press, 1970).

³⁴ S. Fienberg, *The Analysis of Cross-Classified Categorical Data* (Cambridge: MIT Press 1977).

³⁵ McLeary and Hay, *Time Series Analysis* (Beverly Hills: Sage 1978).

³⁶ Editorial, "Meta-analysis: Controlled Clinical Trial," *Journal of Rheumatology* 16(4)(1989).

³⁷ Jeremy Bentham, "An introduction to the principles of morals and legislation," in *A Fragment of Government and an Introduction to the Principles of Morals and Legislation*, by Wilfrid Harrison, ed. (Oxford: Blackwell, 1948): 78. See also H.L.A. Hart, *The Concept of Law* (Oxford: Clarendon Press, 1961); Kelsen, *General Theory of Law and State*, 1945; and Austin, *The Province of Jurisprudence Defined* in *Library of Ideas*, 1921.

provisions³⁸ and legislative amendments related to health care³⁹ are well documented. These legislative landmarks provided the reference citation that allowed other important related works to be identified: early public debates, commissions of enquiry, related legislations and so on. This orientation was adopted as the cornerstone during the descriptive analysis of the eight case studies selected for the study, and to establish chronological reference points for many of the quantitative analyses.

The positivist approach has its disadvantages. Reliable information on legislative reforms and official documents requires extensive field work. Many of the parliamentary papers that were consulted for the study were only available in the archives of the host countries. Most were not translated into English, and therefore required a working knowledge of Scandinavian languages. Taken in isolation, legislative landmarks fail to capture the long preparatory time period that often precedes a new law. There may also be delays before the law is implemented and short-falls in realising its objectives. Legal authority is sometimes rejected by vested interest groups. The medical profession systematically tried to frustrate legal provisions with which it did not agree by refusing to implement the reforms. Transformations in issues and policies occur despite legal provision. Terms used in the laws of one country may not represent the same concepts in other countries. To overcome these problems, the positivist approach had to be supplemented by other techniques of descriptive analysis.

b) Linguistic Analysis

The central thesis of linguistic theory of analysis is that concepts that give rise to ambiguities can be clarified by noting their everyday use.⁴⁰ Its application to the analysis of political phenomena that is heavily influenced by the logical positivism described above.⁴¹ The theory rejects the belief that policies have specific intrinsic philosophical meanings because this depends on abstract speculation rather than empirical analysis of facts. It is a powerful adjunct to other techniques used for concept formulation.⁴²

This approach had a clear applicability to the descriptive component of the study. As an example, in recent times, health needs/demands/desires have come to be regarded as conferring certain rights/entitlement/claims to cure/rehabilitation/care which in turn confers a notion of duties/obligation/responsibility on the part of society/state/systems to provide rewards/benefits/privileges. This relatively short statement contains several

³⁸ A.P. Blaustein and G. Flanz, *Constitutions of the Countries of the World*, Continuous Update.

³⁹ World Health Organization, *World Health Legislation Review Journal*, Continuous Update and Statutes of individual countries.

⁴⁰ Thomas D. Weldon, *The Vocabulary of Politics* (Harmondsworth: Pelican, 1953).

⁴¹ David Miller, *Social Justice* (Oxford: Clarendon Press, 1976).

⁴² N. Bolton, *Concept Formation* (Oxford: Pergamon, 1977).

extremely complex concepts necessary to fully understand the issues and policy options in the relationship between the state, health care systems and populations.

Case studies made it possible for constituent words such as compulsory, universal and comprehensive to be observed in a variety of contexts. Does compulsory mean mandatory or unavoidable? For whom? When does compulsory become coercive rather than protective? Can compulsory participation be enforced? If not does the obligatory nature lose some of its authority? Does universal mean that a particular thing is everywhere or that everyone is affected similarly by it, or are some social classes different?⁴³ If access is limited for example in rural settings does universal entitlement become a "paper right"? Does comprehensive mean availability of a heart-lung machine for everyone or humane nursing homes when people become old, weak and disabled? Answers to these questions had to be clarified to make subsequent quantitative analysis meaningful.

The initial phase was to examine the range and limits of the concept by an exploration of its uses by different populations in different countries at different times. The second step was to discriminate and distinguish characteristics of the concepts from one another. The third step was to reduce the concept to broad categories of significant basic meanings. Because it is difficult to conceive of totally value-neutral concepts, an attempt was made to identify evaluative overtones. To completely dissociate interpretation from evaluation is probably impossible because judgements are themselves a reflection of the views of the society being observed. Universal and comprehensive connotes one notion, while compulsory connotes another. Universality and comprehensive could be perceived to be good because they confer equity. This could be contrasted with the cynical view that they are bad because health care is useless,⁴⁴ or worse, harmful.⁴⁵ Likewise compulsory might be seen by subgroups such as the medical profession as a threat to power and independence when juxtaposed with government control.⁴⁶ The final step was to place the resulting interpretations in their normal social setting and explain why a particular interpretation emerged at a particular point in time. These can be summarised as an exploration of the range, limits, differentiation and interpretation, followed by a reduction and valuation of the concepts under examination.

Linguistic analysis is not without criticism. Even rigorous analysis leaves some gaps in the detection of the complex dimensions of policy such as transformation in terminology, content, scope, boundaries and units-of-measurement over time and across national

⁴³ Peter Townsend and Nick Davidson, eds., *Inequalities in Health: The Black Report* (Harmondsworth: Penguin Books, 1982).

⁴⁴ Tom McKeown, *The Role of Medicine* (Oxford: Blackwell, 1979).

⁴⁵ Ivan Illich, *Limits to Medicine: Medical Nemesis, The Expropriation of Health* (Harmondsworth: Pelican, 1976).

⁴⁶ For a discussion of the battle between the AMA and the US federal government during the 50's and 60's. See Chapman, *Physicians, Law, & Ethics*, 1984: 103-124.

boundaries. First, terms are used differently in a historical context than today. The technique is susceptible to "temporal parochialism"⁴⁷ because subtle nuances evolve over time. Second, some terms such as medical or technical jargon have ambiguous usage between two segments of the same society. Finally, the same term may have different meanings in different political and cultural settings. These three limitations - historical variation, interpretive divergences and natural context - suggest that linguistic analysis is necessary but not sufficient in itself to fully understanding all the issues and health policy options. The positivist legal approach helped to fill in some of the gaps. Field work and interviews clarified others.

2. Quantitative

Just as some aspects of health policy are best analysed by descriptive techniques, others are impossible to unravel without quantitative methods. Computer-assisted cluster analysis, statistical techniques and econometric modeling were the standard analytical tools used during the quantitative phase of the study.⁴⁸ Many early works on comparative health policy limited their treatment to a small number of descriptive case studies, making it impossible to carry out statistically significant cross-sectional analysis.⁴⁹ Time series were usually limited to reporting of unadjusted health expenditure trends. In recent years, the accumulation of detailed case studies of many individual countries has allowed a closer matching of comparable issues and more accurate mapping of similarities and differences among countries for cross-sectional analysis. The standardisation of health care expenditure reporting,⁵⁰ and the accumulation of a detailed Health Data File by the OECD,⁵¹ is permitting new and more rigorous treatment of both longitudinal and cross-

⁴⁷ David Miller, *Social Justice*, 1976: 3.

⁴⁸ SPSS, *SPSS/PC + Advanced Statistics*, IBM PC Computer Module, Version 4.0 (Chicago: SPSS, 1990).

⁴⁹ Christa Altenstetter, *Health Policy-making and Administration in West Germany and the United States* (Beverly Hills: Sage, 1974); Christa Altenstetter, *Innovations in Health Policy and Service Delivery: A Cross-National Perspective* (Cambridge, M.A.: Oelgeschlager, Gunn and Hain, 1981); Odin Anderson, *Health Care: Can There be Equity? The United States, Sweden, and England* (New York, Wiley, 1972); Brian Abel-Smith, "The history of medical care," in *Comparative Development in Social Welfare* by E.W. Martin, ed. (London: Allen & Unwin, 1972); Howard Leichter, *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations* (Cambridge: Cambridge University Press, 1979); William Glaser, *Health Insurance Bargaining: Foreign Lessons for Americans* (New York: Halsted, 1978); Milton Irwin Roemer, *Comparative National Policies on Health Care* (New Haven: Yale University Press, 1977); Milton I. Roemer, *Health Care Systems in World Perspective* (Ann Arbor: Health Administration Press, 1976).

⁵⁰ Brian Abel-Smith, "Paying for health services: A study of the costs and sources of finance in six countries," *World Health Organization Public Health Papers* 17(1963); and Brian Abel-Smith, "An international study of health expenditure, and its relevance for health planning," *World Health Organization Public Health Papers* 32(1967); Jean-Pierre Poulhier, "Health data file: Overview and methodology," *Annual Supplement, Health Care Financing Review* (1989): 111-118.

⁵¹ OECD, *Measuring Health Care 1960-1983: Expenditure, Costs and Performance, OECD Social Policy Studies* (Paris: OECD, 1985); OECD, *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries, OECD Social Policy Studies No. 2.* (Paris: OECD, 1987); OECD, *Social Expenditure 1960-1990: Problems of Growth and Control, OECD Social Policy Studies* (Paris: OECD, 1985); and US Department of Health and Human Services, *Annual Supplement, Health Care Financing Review* (1989).

sectional macro-aggregate data.⁵² Comparative micro-analysis is less advanced than macro-analysis, but many authors are now looking at disaggregates indicators in an attempt to analyse complex policies.

Each country has its own unique historical setting and health care system. Among the countries that have health care systems characterised by compulsory participation and universal entitlement to health care, only some introduced all three aspects at the same time. Many had other potentially significant features such as salaried medical services, nationalised ownership, co-existence of private or para-public health insurance, and so on. Computer-assisted *cluster analyses* and *pattern recognition* proved useful for classifying issues, grouping similar countries and distinguishing those that were different.⁵³ This analysis was carried out as part of the pre-selection for determining both the issues and countries that would be included in the case study phase of the study.

a) Time series

Detailed analysis of longitudinal trends are best carried out through quantitative techniques performed on *time series*.⁵⁴ Such longitudinal analysis was used to examine health care expenditure trends, opportunity costs and displacement effects. Governments often express alarm at what they describe as an explosion in public expenditure on health care. The social policy literature is full of apprehension about the opportunity cost of health care expenditure and the danger that it might draw funds away from other social programmes that have equal or greater effects on health through a displacement effect.

The identification of an appropriate chronological time frame posed a difficult methodological problem at this phase of the analysis. There was often a lag between when legislative reforms were passed, when resulting laws were implemented and when expenditures reflected the resulting impact. Positivist, linguistic and narrative analysis of the case histories was indispensable to identifying the starting point of the time series which differed from country to country.

⁵² Thomas E. Getzen and Jean-Pierre Poullier, "International health spending forecasts: Concepts and evaluation"; U.G. Gerdtham, B. Jönsson, F. Andersson, J. Sögaard, "The determinants of health expenditures: An econometrical analysis across the OECD countries"; Alexander S. Preker, "Expenditure control through public financing in the OECD"; and François Champagne, André-Pierre Contandriopoulos, Anne Lemay and Alexander S. Preker, "Evaluation of health care performance in the OECD," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁵³ M.R. Anderberg, *Cluster Analysis for Applications* (New York: Academic Press, 1973); B. Everitt, *Graphical Techniques for Multivariate Data* (London: Heinemann, 1978); and B.G. Batchelor, *Pattern Recognition* (New York: Plenum Press, 1978).

⁵⁴ G.E.P. Box and G.M. Jenkins, *Time Series Analysis: Forecasting and Control*, Revised ed. (San Francisco: Holden-Day, 1976).

Nominal changes in health care expenditure ($dHCE_{\text{nominal}}$) at a given point in time (t+1) compared with expenditure during the previous year (t) are sometimes used to observe changes:⁵⁵

Simple Macro-aggregate Approach

$$dHCE_{\text{nominal}} = (HCE_{t+1} - HCE_t)/HCE_t$$

This simplified approach is misleading because it ignores a number important interacting factors that influence expenditure trends such as demographic growth (dD), health care price increases (dP_H) and changes in utilisation patterns (dQ) per capita ($d(Q/D) = dQ_D$), as well as associated growth in GDP and public sector expenditures. Changes in health care prices can be disaggregated even further into a component that is due to general consumer price increases (dP_C). The implicit GDP deflator (dP_{GDP}) has been used by some authors as an indicator of overall inflation. There are several other options such as the implicit expenditure deflator, the consumer price index and the wholesale price index. None are satisfactory substitutes for a health sector specific price index. Nominal health care expenditure can be broken down into its component parts to provide a more complex representation of annual trends:⁵⁶

Complex Disaggregate Approach

$$dHCE = dD \times dP_H \times dP_{\text{GDP}} \times dQ_D$$

A clear advantage of this approach is that it identifies some of the factors that influence nominal health spending. From 1975 to 1987, an analysis of the annual compound rate of growth in spending among the seven richest countries in the world indicates general inflation to be the most important extrinsic factor driving up overall health care expenditure.⁵⁷ Health care specific inflation was the most important intrinsic factor, followed by increases in volume-intensity activities and population growth.

Such complex decomposition of health care expenditure also has some significant shortcomings. First, the identification of relationships does not impute causality, capacity or appropriateness.⁵⁸ Second, even countries with extremely well-developed data systems

⁵⁵ Nominal = Current Values.

⁵⁶ Four factors were used in this model. George J. Schieber and Jean-Pierre Poullier, "Overview of international comparisons of health care expenditures," Annual Supplement, *Health Care Financing Review* (1989): 1-9. Others have tried to include factors such as demand/need, economic resources, substitution of care, supplier induced demand, public/private mix in financing and relative price on health care. U. Gerdtham, F. Anderson, J. Sogaard and B. Jönsson, "Economic analysis of health care expenditures: A cross-sectional study of the OECD countries" *GMT Report 1988-9* (Linköping: Centre for Medical Technology Assessment, 1988).

⁵⁷ Based on composite values of Canada, France, Germany, Italy, Japan, United Kingdom and United States.

⁵⁸ E. Kleiman, "The determinants of national outlay on health," in *The Economics of Health and Medical Care* by M. Perlman (London: Macmillan, 1974).

have difficulty measuring utilisation rates and health specific prices indices. Most derive utilisation-intensive activities from other components ($dQ_D = dHCE / (dD \times dP_H \times dP_{GDP})$). In those instances where this kind of information is slowly becoming available due to computerised record keeping, different components are difficult to re-combine into indices that have cross-national comparability. Practice styles vary, the behaviour of different age groups vary, the use of technology varies and so on. Third, health care specific price indices are still in an embryonic stage of development. They are often derived from GDP deflators and health care expenditure trends, ignoring demographic and volume-intensive factors ($dP_H = dHCE / dP_{GDP}$). Furthermore, price indices that have been developed for overall medical consumption do not capture the differences in in-patient care, ambulatory care, pharmaceutical production and therapeutic appliances. Wage and supply components are usually mixed; so are public and private components.⁵⁹ Because almost all of this work ignores cost data, it fails to adjust performance for efficiency and cost-effectiveness.⁶⁰

Although this technique offers promise for the future analyses, it was of limited value in the historical analysis of expenditure trends date back to the 1950s and earlier. Utilisation statistics and price deflators were even more unreliable during this time period than they are today. Disaggregates of complex relationships was therefore not used to follow health care expenditure trends in the study. Health care expenditure trends can be represented in two other ways.⁶¹ Some authors have tried to adjust all values ($t+1$) in the simple macro-aggregate approach by a price deflator (P) to arrive at a representation of expenditure trends in real terms⁶² ($dHCE_{real} = dHCE_{nominal} \times P$). Attractive as this may seem at first sight, it still leads to distortions because the health care specific price deflators are unreliable. Both national and cross-national trends described in constant values are vulnerable to these distortions. An alternative approach is to represent health care expenditure as a ratio relative to other expenditures such as

⁵⁹ R.R. Leu "The public-private mix and international health care costs," in *Public and Private Health Services: Complementarities and Conflicts* by A. J. Culyer and B. Jönsson (Oxford: Basil Blackwell, 1986).

⁶⁰ Andrew F. Long and Stephen Harrison, eds., *Health Services Performance: Effectiveness and Efficiency* (London: Crom Helm, 1985).

⁶¹ Brian-Able Smith and Richard M. Titmuss, *The Cost of the National Health Service in England and Wales* (Cambridge: Cambridge University Press, 1956.)

⁶² Real = Constant Values.

GDP, government total expenditure (GTE), government consumption expenditure (GCE) and government social expenditure (GSE).⁶³

Ratio Approach

$$\begin{aligned}
 R_{GDP} &= \text{HCE}/\text{GDP} \\
 R_{GTE} &= \text{HCE}/\text{Government total expenditure} \\
 R_{GCE} &= \text{HCE}/\text{Government consumption expenditure} \\
 R_{GSE} &= \text{HCE}/\text{Government social expenditure}
 \end{aligned}$$

This approach has several technical advantages over other methods of analysing macro-aggregate expenditure trends. It avoids the problems associated with health specific price indices and assessments of volume-intensive activities. At the same time, it broadens the scope of issues that can be examined by incorporating notions of national wealth (GDP), as well as political willingness and capacity to pay (GTE), competing demands for funds to finance public services (GCE) and various forms of cash transfer payments or social security benefits ($GSE \approx GTE - GCE$).

These factors can then be re-combined in different ways to track expenditure trends within any given country, or to provide standardised indicators for cross-sectional analysis of determinants and effects. The GTE/GDP ratio can be used as an indirect measure of government involvement in the economic activities of a country, and the GSE/GDP ratio can be used as an indirect indicator of the financial resources devoted to public services and their infrastructures. Finally, HCE/GDP ratio can be used as an indirect indicator of the financial resources devoted to the health sector and its infrastructures. Changes in the R_{GTE} over time can be used as an indicator of fiscal responsibility for health care. Changes in the R_{GCE} over time can be used as an indicator of opportunity costs. Changes in the R_{GSE} over time can be used as an indicator of the extent which public funds are channeled away from social security cash benefits.

This technique is not without disadvantages. Straight ratios hide distortions created by disproportionate growth in GDP or government expenditure. The R_{GDP} ratio will remain stable when health care expenditure and GDP both increase or decrease at the same rate. When health care expenditure grows more quickly than GDP, the ratio will rise rapidly. Conversely, when health care expenditure grows more slowly than GDP, the ratio will fall even though there may still be some growth in real terms. Similar distortions occur in the R_{GTE} , R_{GCE} and R_{GSE} ratios because of differential growth rates. The straight ratio approach was therefore weakened to the marked differences in rates of economic growth during the 1940s, 1950s, 1960s and 1970s. This problem was partly overcome by validating

⁶³ Government transfer payments (payments made through social security programmes) comprise the main difference between government total expenditure and government consumption expenditure ($GSE \approx GTE - GCE$).

the observed trends against health care expenditure per capita growth rates ($dHCE_{capita}$) relative to the per capita growth rates of the other variables ($dGDP_{capita}$, $dGTE_{capita}$, $dGCE_{capita}$ and $dGSE_{capita}$). This calculation was carried out by using a double logarithmic regression on HCE and the variable in the denominator of the equation during a specific time-period (10 years) following the introduction of compulsory participation and universal entitlement to health care.⁶⁴

Elasticity Approach

$$\begin{aligned} E_{HCE/GDP} &= dHCE_{capita}/dGDP_{capita} \\ E_{HCE/GTE} &= dHCE_{capita}/dGTE_{capita} \\ E_{HCE/GCE} &= dHCE_{capita}/dGCE_{capita} \\ E_{HCE/GSE} &= dHCE_{capita}/dGSE_{capita} \end{aligned}$$

b) Cross-sectional analysis

Validation or falsification of hypotheses about determinants and effects are carried out more effectively through *multi-variant regression* techniques than through quantitative analysis of trends in time series.⁶⁵

Two methodological problems were confronted at this point in the study. First, the key issue being investigated was not readily quantifiable. Cluster analysis was performed on scaling ratios for direct/prepaid financing mechanisms, voluntary/compulsory participation, restricted/universal entitlement and basic/comprehensive services in the OECD for data from the early 1980s. Detailed information on these variables was however episodic, and could therefore not be used to provide a tracer over time. The most reliable historical marker was the introduction of legislative reforms for compulsory participation and universal entitlement to health care. This was used as a chronological landmark and as a way to dichotomise countries into two groups. Those that had passed and implemented such legislation were assigned a "dummy" variable $\tau = 1$, while those that had not taken these steps were assigned $\tau = 0$. This statistical trick provided a framework for carrying out further quantitative analysis of determinants and effects. Second, there were no ideal quantitative indicators to measure many of the trends, determinants and effects. Some were based on the work of past authors, while others were developed specifically for the study. The extent to which macro-aggregates succeed in describing reality perfectly or imperfectly varies greatly. They can never capture the full

⁶⁴ GDP elasticity of health care expenditure is defined as the percentage change in per capita health care expenditure divided by the percentage change in per capita GDP. Similar elasticities can be developed relative to different aspects of government expenditure per capita.

⁶⁵ N.R. Draper and H. Smith, *Applied Regression Analysis*, 2nd ed. (New York: Wiley, 1980); R.J. Freund and P.D. Minton, *Regression Methods* (New York: Dekker, 1979).

richness of most complex policy issues and therefore need to be supplemented by other, more descriptive techniques.

Socio-economic level of development, political processes and administrative infrastructures are the most frequently postulated determinants of public expenditure on in a welfare state. They have not been examined for their impact on health policy. Other authors have proposed quantitative indicators that can be used as measures for many of these determinants. National wealth per capita (GDP_{cap}) is often used as a standard indicator of level of socio-economic development.⁶⁶ The ratio approach was once again seen as a more reliable standard than absolute expenditures. General government total expenditure can be used as an indirect indicator of the extent of government involvement in the economic activities of a country (economic effect of political ideology).⁶⁷ Government consumption expenditure can be used as an indirect indicator of the financial resources devoted to public services and their infrastructures, while government social expenditure can be used as an indirect indicator of the financial resources devoted to social security transfer payment and their infrastructures.⁶⁸ Health care expenditure can be used as a direct indicator of the financial resources devoted to the health sector and its infrastructures.⁶⁹

Because the countries that had introduced legislative reforms for the policies being examined did so at different chronological points in time and countries that had not introduced such legislation had no marker date at all, cross-sectional regression analysis on possible determinants was impossible. Serious errors would also have been introduced into the analysis if absolute values had been deflated over a fifty-year time period and converted into a single currency for cross-sectional comparison. Analysis of determinants was therefore limited to a descriptive empirical validation of different hypothesis. The ratio approach did, however, allow some comparison of trends in GTE/GDP, GCE/GDP, and GSE/GDP among the countries that had introduced the policies in question.

⁶⁶ Other indicators that have been tried include levels of energy consumption, urbanization and literacy rates. Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975).

⁶⁷ Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press 1974); and Francis Castles, *The Social Democratic Image of Society* (London: Routledge and Kegan Paul, 1978). Most other authors have used more descriptive analysis to look at the impact of ideology, democracy and political parties. Peter Flora and Arnold J. Heidenheimer, eds. *The Development of Welfare States in Europe and America* (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981); Francis Castles, "The impact of parties on public expenditure," in *The Impact of Parties: Politics and Policies in Democratic Capitalist States*, by Francis Castles, ed., (Beverly Hills: Sage 1982).

⁶⁸ Social security spending is the standard indicator for the evolution of administrative infrastructures. Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press 1974); and Gerhard Lembruch and Philippe C. Schmitter, eds., *Patterns of Corporatist Policy-making* (Beverly Hills: Sage, 1982).

⁶⁹ This is the standard indicator used in most of the health economics literature, but there have been few attempts to relate health care expenditure to specific programme features of health policy.

A cut-off date (1987) was chosen because more recent dates would have led to gaps in data. Indicators were developed to quantify a number of possible long term effects of the reforms.⁷⁰ First, in the case of socio-economic development, GDP per capita (GDP_{cap}) and average real GDP growth rates (GDP_{gwt}) were used for economic performance; accumulated general government debt relative to GDP (GGD/GDP) for national debt; and government consumption expenditure relative to GDP (GCE/GDP) for opportunity costs. Second, in the case of political processes, government social expenditure relative to GDP (GSE/GDP) was used for displacement effects on social security; and GDP elasticity of health care expenditure (HCE_{ela}) and policy reversals for backlash. Third, in the case of administrative structures, general government total expenditure relative to GDP (GTE/GDP) was used for public sector activity or the extent of government involvement in economic affairs of the state; and purchase-power-parity-adjusted health care expenditure relative to GDP per capita (HCE_{ppp}/GDP_{cap}) for total expenditure on health care. Finally, in the case of state responses to market failure, the ratio of public to total health care expenditure (Pub/Tot) was used for equity. It was felt that health status indicators were not sufficiently standardised or refined to be useful in detailed cross-national comparisons of outcome. Analysis of life expectancy and infant mortality rates would be more misleading than informative.

The standard regression equation is a straight line ($y = a + bx$), where x and y represent the independent and the dependent variable. When the principle of least squares is applied to linear regressions, the exercise is to minimise the expression $\Sigma (y - a - bx)^2$ for the **constant** a (intercept on the y -axis) and **X coefficient** b (slope of the line). Because it is tedious to carry out the calculations that are needed to find the "best fit" of a line through a "scatter plot", they are best performed by computer-assisted techniques. The **degrees of freedom** are the number of observations minus the number of constants. The smaller the number of observations, the less statistically significant the analysis. The **standard error co-efficient** gives an indication of the reliability of the slope b . The **standard error** (σ) of the slope b and intercept a is usually unknown. It is based on the Standard Deviation (SD) of the observed points about the fitted line ($S_{xy} = \sqrt{\Sigma(y-Y)^2}/(n-2)$). Finally, **R squared**, which ranges from 0 to 1, indicates the predictive value or correlation between x and y ; if the correlation is perfect, R Squared is 1 and if there is no correlation, R Squared is 0.

The equation is easily adapted to more than one explanation ($y = a + b_1x_1 + b_2x_2 + b_3x_3$). The greater the number of correlating factors ($x_1, x_2, x_3 \dots x_n$), the greater the R Squared and the greater the combined predictive power of the hypothesis being tested. Occasionally it is difficult to find a linear fit for complex mathematical forms ($y = ac^{bx}$).

⁷⁰ The impact of the "dummy" variable T was checked against these outcome indicators.

In these cases, some manipulation of the data will help achieve a linear fit ($\log y = \log a + b \log x$). By redefining the values ($y' = \log y$, $a' = \log a$; $b' = b \log c$) this equation becomes a linear relationship ($y' = a' + b'x$). The calculation of elasticities, where relationships were complex, required this technique.

When it is impossible to designate at least one independent variable, the relationship is more correctly described as a correlation between two mutually dependent variables. In this case, the **coefficient of the correlation** describes the extent of the relationship between x and y , also known as the **product moment correlation** or **Pearson's coefficient of correlation**. Furthermore, without concomitant *path analysis*,⁷¹ even strong correlations fail to give unequivocal evidence of causal relationships or proof of the existence of determinants:

$$r = \frac{\Sigma(x-\bar{x})(Y-\bar{y})}{\sqrt{\Sigma(x-\bar{x})^2 \Sigma(y-\bar{y})^2}}$$

Many authors claim that there is a high correlation between a country's level of socio-economic development or capacity to spend and expenditure on health care, based on statistical regression analysis of income trends and health care expenditure.⁷² Like other techniques, statistical regression analysis in health care is not without flaws. First, in cross-national comparisons of absolute values rather than ratios of expenditure data, exchange rates cannot be used because they are too sensitive to short-term fluctuations in capital flows and international capital markets. Researchers are still in the early stages of developing purchasing power parities (PPP) that represent average prices in specific countries relative to average international prices ($HCE_{PPP} = HCE \times PPP$).⁷³ Second, for cross-sectional regression analysis of income to be valid, income elasticity must be constant; in reality, it rises with income. Third, public choice or preference may vary

⁷¹ H.M. Blalock, *Causal Models in the Social Sciences* (London: Macmillan, 1971); and K.G. Lockyer, *An Introduction to Critical Path Analysis*, 3rd ed. (London: Pitman, 1969).

⁷² L.I. Leviatan, *Consumption Patterns in Israel*, (Jerusalem: Falk Project for Economic Research in Israel, 1964); E. Kleiman, "The determinants of national outlay on health," in *The Economics of Health and Medical Care* by M. Perlman (London: Macmillan, 1974); J.P. Newhouse, "Development and allocation of medical care resources: Medico-economic approach," in *Development and Allocation of Medical Care Resources*, Proceedings of the 29th World Medical Assembly, Tokyo, Japan Medical Association, 1975; J.P. Newhouse, "Medical care expenditure: A cross-national survey," *Journal of Human Resources* 12(1)(Winter 1977): 115-125; Robert J. Maxwell, *Health and Wealth: An International Study of Health-Care Spending* (Lexington, Massachusetts: Lexington Books, 1981); OECD, *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*, OECD Social Policy Studies No. 2 (Paris: OECD, 1987); D. Parkin, A. McGuire and B. Yule, "Aggregate health care expenditures and national income: Is health care a luxury good?" *Journal of Health Economics* 6(2)(June 1987): 109-128; George J. Schieber and Jean-Pierre Poullier, "International health spending and utilization trends," *Health Affairs* 7(4)(1988): 105-112; and Antony J. Culyer, "Cost Containment in Europe," Annual Supplement, *Health Care Financing Review* (1989): 31.

⁷³ M. Ward, *Purchasing Power Parities and Real Expenditures in the OECD* (Paris: OECD, 1985).

considerably within a country. This is especially true in the case of highly decentralised systems and federations of states. National macro-aggregate indicators cannot represent such differences. Some reductionism of complex policy issues is unavoidable. Fourth, health care is not homogeneous. Similar expenditure may represent vastly different standards of health care depending on the structure, policy orientation and quality of the service delivery system. Finally, some things are simply not quantifiable. These are important areas for future research which this study did not attempt to address.

Figure 2.16 Questions, techniques and indicators

Question:	Techniques and Indicators
<i>Why</i>	Linguistic, case studies
<i>How</i>	Positivist policy analysis, constitutions, laws, regulations
<i>Processes</i>	Path analysis, national, cross-national profiles
<i>Effects</i>	
National wealth	Econometric, regression, ranking, GDP_{cap}
Growth	Econometric, regression, ranking, GDP_{gwt}
Debt	Econometric, regression, ranking, GGD/GDP
Opportunity cost	Econometric, regression, GCE/GDP
Displacement	Econometric, regression, GSE/GDP
Backlash	Positivist policy analysis, econometric, elasticity HCE_{ela}
Expenditure	Econometric, regression, GTE/GDP and HCE_{ppp}/GDP_{cap}
Equity	Econometric, regression, ranking, Pub/Tot health expenditure ratios
<i>Trends</i>	
Historic	Linguistic, case studies, econometric, statistical
Future	Positivist policy analysis, econometric, forecasting

PART II. NATIONAL PROFILES

CHAPTER 3. NEW ZEALAND

Our New Zealand National Health Service must be 'free', it must be complete, it must meet all the needs of all the people.¹

D.G. McMillan, 1935

A. FINANCIAL INFRASTRUCTURES

1. Colonial Military Outposts

Western settlers in New Zealand were young and energetic people, largely from England and Scotland, who had left the old world to better themselves. Their working-class background quickly set the pattern for the financing of health care which developed through social-democratic ideals.² Unlike other English colonies where the native populations were largely exterminated, New Zealand integrated its Maori population into the health care system at an early stage.

British military outposts provided the colony with its first rudimentary medical facilities. New Zealand therefore began its colonial history with a 'nationalised' health service, financed through the British treasury. As the population grew, such facilities became inappropriate for civilian needs. Since the young colony had no landed gentry and few wealthy business elite to finance charitable and voluntary organizations, the sick and needy remained largely the responsibility of the colonial government.³

Four agencies evolved to provide health care for the early settlers: central government institutions, private institutions, voluntary organizations and self-help groups. The sick, the socially needy and the poor were considered liabilities by most of these organizations. Although in theory the voluntary hospitals were financed through members' subscriptions, these institutions depended on public subsidies to pay their running costs.⁴ The incurable, infectious, mentally ill, elderly and poor, as well as pregnant mothers and alcoholics were often denied admission.

¹ D.G. McMillan, *A National Health Service in the New Zealand of Tomorrow* (Wellington: New Zealand Labour Party, 1935): 7.

² J.B. Condliffe, *The Welfare State in New Zealand* (London: George Allen & Unwin, 1959): 323; and Warwick Brunton, "Hostages to history," *New Zealand Health Review* (1983): 3; and William Ball Sutch, *The Quest for Security in New Zealand: 1800 to 1966* (London: Oxford University Press, 1966).

³ These included the infirm, sick, old, widowed, displaced peasants, ex-soldiers, servants without masters, abandoned children and beggars.

⁴ *New Zealand Medical Journal*, "Editorial," *New Zealand Medical Journal* (December 1932); and J.B. Lovell-Smith, *The New Zealand Doctor and the Welfare State* (Auckland: Blackwood & Janet Paul, 1966): 16.

The civilian population soon began using the public hospitals, originally established to treat the Maori people. Even those who could afford the luxury of private care at home found that such care was unavailable because of the scarcity of doctors. Furthermore, medical science remained primitive during the nineteenth century; those who could, did without health care.

2. National Insurance Plan of 1882

Britain initially tried to establish a strong central government in most of its overseas colonies. The Crown Colony of New Zealand, nevertheless, decentralised its Government between 1840 and 1876. Its first constitution of 1846 established two provinces. This was increased to six by 1852, and later to nine. By 1876, when a policy of 'colonial governmentality' returned authority to the central government, considerable damage had been done: public services, including health care, had become fragmented leaving a 'hybrid system' of 'residualism', 'parochialism' and 'ad hococracy'.⁵

A spirit of renewed commitment to a strong central government led Harry Atkinson, the Colonial Treasurer, to propose a compulsory national health insurance plan in 1882. His proposal called for cash support during illness, old age and infirmity due to accidents, as well as for widows and orphans. A flat-rate compulsory national insurance contribution of £40 per year from workers would finance most of the programme, while a consolidated fund would finance old age benefits, and rates on property would finance widows' and orphans' benefits.⁶

Atkinson was an unusual politician. He was the 'mainstay' of the Conservative Party, but his political views were 'quasi-socialistic'.⁷ In a passionate speech, he defended his plan:

In accordance with the ideas of equality which we hold in this part of the world, then everybody would pay to the fund and everybody would have the right to draw from it.⁸

He maintained that this was the only way that New Zealand could "strike a fatal blow at pauperism.... [and the] inadequate remedy of the poor laws.... [which he felt were a] blight upon the social scene" in Great Britain during the nineteenth century.⁹

⁵ Brunton, "Hostages," 3.

⁶ Lovell-Smith, *New Zealand Doctor*, 11.

⁷ J. Rutherford, *Sir George Grey, K.C.B., 1812-1898: A Study in Colonial Government* (London: Cassell & Company, 1961): ix.

⁸ New Zealand, "Atkinson," *Parliamentary Debates* 41(Wellington: King's Printer 10 July 1882): 191. Lovell-Smith, *New Zealand Doctor*, 11.

⁹ From Harry Atkinson's National Insurance Proposal of 1882. New Zealand, "Atkinson," 191.

George Grey of the Liberal Opposition maintained that subtle evils lurked behind Atkinson's plan:

It will sap the independence of the people so relieved, it will sap the relations between different members of a family ... it will sap the feelings of children to their parents.¹⁰

The ensuing conflict between Atkinson and Grey foreshadowed events that would occur in New Zealand fifty years later. Similar conflicts would also arise in other countries that would later try to introduce public financing for universal entitlement of health care.

Although Atkinson's motion was defeated, he persisted and re-submitted his proposal a year later when he became Prime Minister. The political price was high; the Atkinson Government suffered a serious defeat in the next election, and the national insurance plan collapsed.

Over the following years, public sector involvement in the financing of health care increased slowly. The Hospitals and Charitable Aid Act of 1885 drew a reluctant Government into a compromise arrangement of joint financing for the few existing private hospitals, voluntary hospitals and public hospitals. The Government agreed to meet 'a reasonable' proportion of the running costs through general revenues.¹¹ By 1905, forty-eight hospitals were operating under this Act, serving a growing proportion of the population which had no other options for affordable health care. Despite these provisions, the isolation of New Zealand from the rest of the world and the inhospitable terrain of mountains and inlets made access to existing facilities difficult.

By the late nineteenth century, public hospitals were serving patients of all classes and had long ceased to be regarded as charitable institutions. In 1900, a fear of plague led to the creation of the Department of Public Health, the first of its kind in the world. The Department of Mental Hospitals and Department of Hospitals and Charitable Institutions were established in 1907. In an attempt to regionalise care, the Department of Hospitals and Department of Public Health merged, and the number of hospital districts was reduced in 1909. Through this process, public hospitals developed a broad base of popular support, although during the early years they continued using a means-test to determine who would receive free care.¹²

Despite such efforts, institutional care continued to be fragmented, and there were virtually no collective provisions for financing ambulatory care. Not many doctors could

¹⁰ New Zealand, "Atkinson," 112. Lovell-Smith, *New Zealand Doctor*, 11.

¹¹ New Zealand, Governmental Investigation Committee into National Health Insurance (GICNHI), "Report," *Parliamentary Papers* (Wellington: King's Printer, 1935).

¹² New Zealand, National Health Insurance and Superannuation Committee (NHISC), "Report [Chairman Rev. A.H. Nordmeyer]," *Parliamentary Papers* (Wellington: King's Printer, 1938): 7.

survive on the limited income they earned in private practice. At the turn of the century, health care outside an institutional setting failed to provide adequate coverage for New Zealand's population of 815,853 spread over the country's 268,103 square kilometers of mountains, inlets and islands.¹³

3. Friendly Societies

Over the next forty years, public financing for social security and health care increased slowly in New Zealand as it did in most European countries. Specific measures were introduced to satisfy both idealistic and pragmatic objectives.

First, Governments hoped to use public financing for social security to indirectly redistribute the wealth of society to the aged, the disabled, widows, orphans and other needy sectors of the population.¹⁴ Miners' pensions, workers' compensation and unemployment payments offered support to victims of economic and employment hazards. Sickness, accident and disability insurance offered hope of improving the quality of life and of sharing the cost of illness.

Collective measures that bridged moments of hardship in the life-cycle were also intended to prevent social unrest and improve productivity of the work-force. Local authorities, rate-payers, and doctors who in the past had complained that it was they who carried the financial burden of charity, welcomed initiatives by the central government which offered them some relief from this legacy.

The introduction of social security in New Zealand was, however, a fragmented and incomplete process. Old-age pension, financed through general revenues, was introduced in 1898, widows' pension in 1911, pension for the blind in 1924, family allowance in 1926, and invalidity pension and pension for deserted wives in 1936. New Zealand did not use means-tested social insurance but rather general revenues to finance these programmes. Membership with friendly societies, on the other hand, remained low. By the late 1930s, such societies included only 20 per cent of the population.¹⁵

During the Great Depression of the 1930s, only the independently wealthy and better-paid workers could afford the luxury of paying fee-for-service. Using a 'Robin Hood' principle, doctors often overcharged the rich, claiming that this allowed them to

¹³ The population for 1901 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962), 283 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 879.

¹⁴ William Ball Sutch, *The Responsible Society in New Zealand* (Christchurch: Whitcombe & Tombs, 1971): 33.

¹⁵ W.H. Oliver, "The origins and growth of the welfare state," in *Social Welfare and New Zealand Society*, edited by A.D. Trlin (New Zealand: Methuen, 1977): 13.

offer cheaper and sometimes free treatment to the poor. Doctors in their private offices and public hospitals absorbed the cost for those who could not afford to pay. Both groups were anxious to explore alternative modes of financing.

The Department of Health reviewed the official proposals for national health insurance in Australia (1927), in South Africa (1928), in Canada (1932) and those of the British Medical Association (1930).¹⁶ On several occasions, the Department debated the merits of introducing a national health insurance programme similar to the Lloyd George Plan in Great Britain. New Zealand's Annual Conference of the Hospital Boards supported a proposal of this kind in 1924 and 1929.¹⁷ The New Zealand branch of the British Medical Association proposed its own plan during the late 1920s, anticipating the financial advantages for its members.¹⁸

However, since the rural population would receive few benefits from a Lloyd George industrial-type plan, popular support for such a programme was lacking. "Conditions in New Zealand, and the outlook of our people are so different from those in overseas countries that no existing programme could be adopted in toto."¹⁹

Instead, a fragmented system of financing of health care was maintained well into the twentieth century in New Zealand, at a time when Great Britain and other European countries were offering extensive protection through social insurance. Major social upheavals and political reforms were necessary to change the course of history. The Great Depression and the election of New Zealand's Labour Government triggered these changes.

B. LANDMARK LEGISLATIVE REFORMS

1. General Election of 1935

The Social Democratic Party, forerunner to New Zealand's Labour Party, had called for free hospital treatment, sickness insurance and pension for orphans, the blind and the disabled in 1914.²⁰ The Labour Party continued this commitment to free health care,

¹⁶ British Medical Journal, "British Medical Association's proposals for a general medical service for the nation," Supplement, *British Medical Journal* (26 April 1930). The *British Medical Journal* published a similar proposal in 1938.

¹⁷ Lovell-Smith, *New Zealand Doctor*, 19; and Combined Hospital Boards Association, "Report," *Annual Reports* (Wellington: Combined Hospital Boards Association, 1929).

¹⁸ New Zealand Medical Journal, "National health insurance," *New Zealand Medical Journal* 34(1935): 291.

¹⁹ New Zealand, National Health Insurance Investigation Committee (NHIIC), "Report [Chairman D.G. McMillan]," *Parliamentary Papers* (Wellington: Parliament, 1937): 11.

²⁰ The Labour Party was formed from the Social Democratic Party.

pensions and unemployment benefits. In 1921, the party slogan, created as a response to the economic hardships of the 1920s, included 'free' medical attention.

By 1934, a rise in the price of wool had improved economic conditions in New Zealand.²¹ Many people, however, continued to harbour a fear that the cost of health care and hospitalisation would impoverish them. The poor resented their lot as recipients of handouts from doctors; the medical profession likewise begrudged the burden of involuntary charity imposed on them. Rate-payers wished to be relieved of subsidies that they paid for public hospital beds and social assistance.

Not surprisingly every political party in the country, sensitive to an issue with immense popular support, developed proposals for some form of national health plan in anticipation of the 1935 elections. The Coalition Government of Prime Minister Joseph Gordon Coates called for a state health service as part of its election platform. The programme would include a general practitioner service, specialists, dentists and maternity benefits.

Before the election, the Government established an Interdepartmental Committee on Compulsory National Superannuation and Health Insurance.²² The committee called for a major reform and consolidation of the splintered social security system. The existing system was deemed disorganised and costly.²³ Contributions based on actuarial calculations from workers and employers as well as state subsidies would finance the proposed national programme. A means-test would exclude the rich and self-employed from collecting benefits.

The Labour Party's election platform likewise called for major social reforms. If elected, the party promised to introduce guaranteed prices, a minimum wage, improved educational services and a national health and superannuation plan. Health care would include free family doctors, specialists and hospitals. The state would provide "non-contributory, universal, comprehensive and adequate" services as a civil right to all inhabitants.²⁴ Although the radicals in the party wanted to 'soak the rich' by forcing employers to finance the whole programme, the final official platform called for financing through general revenues.

²¹ James Thorn, *Peter Fraser: New Zealand's Wartime Prime Minister* (London: Odham's Press, 1952): 106.

²² The report was compiled by senior civil servants from the Public Service Commission, Treasury, the National Provident Fund and the Pensions, Actuary's and Health Departments.

²³ Under the existing system, cash benefits for superannuation, sickness, invalidity, widows, orphans, children and pregnant women were all separate. New Zealand, Appendices H-30, *Journals of the House* (September 1935) quoted in Sutch, *Responsible Society*, 45.

²⁴ Elizabeth A. Hanson, "The social security story: A study of the political origins of the 1938 Social Security Act," *Master's thesis* (Auckland: University of Auckland, 1975): 49.

In 1935, New Zealand elected its first Labour Government. The personal popularity of Michael Joseph Savage, the new Prime Minister, had secured massive support for the party.²⁵ In contrast to more radical forms of socialism that had swept across Europe, Savage believed in a humanitarian socialism which rejected bloody revolution.

Peter Fraser became the Minister of Health and Education (later war-time Prime Minister), Walter Nash became the Minister of Finance and Dr. D.G. McMillan became the spokesman on health. The Labour Caucus was split between those who supported acceptance of continued colonial economic status and those advocating freedom from such dependence.²⁶ Savage, Fraser and Nash, known as the 'Savage Trinity', believed in maintaining historical links with Britain and continuing international payments.²⁷ H.T. Armstrong, J.A. Lee and McMillan, members of the left wing of the Caucus, wanted to introduce a more radical socialist economy.

McMillan's social views were formed while he worked in contract practice for various unions. His ideas on a national health programme were first outlined at the Labour Party Conference of 1935. The blueprint of his plan was later published in a pamphlet entitled *A National Health Service*.²⁸ It called for universal entitlement, free access, comprehensive services, local clinics, prevention, and income replacement during illness. Prevention would include good housing, adequate nutrition, and healthy physical and emotional surroundings. A "non-contributory insurance" would finance the programme.²⁹

Several of McMillan's ideas were revolutionary for their time. His convictions and skill as a public speaker provided the Government's opponents with a formidable adversary. But his failure to design his plan in collaboration with the medical profession and his attachment to the Labour Party made him increasingly unpopular with the New Zealand of the British Medical Association, even though the Prime Minister and the left wing of the Caucus supported his proposals.³⁰

Peter Fraser, Minister of Health and Education, had a gentler manner and was more compromising in nature. He shunned the more controversial debates over health care during the early years in government, letting McMillan push the party line with his

²⁵ Keith Sinclair, *Walter Nash* (Auckland: Auckland University Press, 1976): 161.

²⁶ Sutch, *Responsible Society*, 41.

²⁷ Peter Fraser, Walter Nash and Paddy Webb formed the pre-election 'Trinity'. John A. Lee, *Simple on a Soap-Box* (Auckland: Collins, 1963): 32.

²⁸ McMillan, *National Health Service*.

²⁹ Funds for the non-contributory insurance used to finance the various social security programmes derived from general revenues. Oliver, "Origins and growth," 19.

³⁰ Sinclair, *Walter Nash*, 160; and Lovell-Smith, *New Zealand Doctor*, 38. McMillan and Dr. Douglass Robb believed in the public health approach, rare at the time. Douglass Robb, *Medicine and Health in New Zealand: A Retrospect and A Prospect* (Christchurch: Whitcombe & Tombs, 1941); and Douglass Robb, *Health Reform in New Zealand* (Christchurch: Whitcombe & Tombs, 1947).

colleagues. This allowed Fraser to devote his attention to improving education, particularly among the Maori people.³¹ He also acted as Prime Minister during the frequent periods when Savage was indisposed due to terminal bowel cancer.

Walter Nash, Minister of Finance, believed that society had "obligations towards the old and infirm because of their work ... [and] obligations towards the young ... to make a still better world tomorrow."³² He also supported McMillan's call for universal entitlement and free access to a national health service. Nash, however, deeply distrusted doctors. He was aggressive, "at times leaning on the doctors none too lightly" during negotiations.³³ This abrasive approach unfortunately stirred much unnecessary resentment and did little to secure the cooperation of the medical profession during later stages of negotiations.³⁴

2. International Communist and Socialist Influence

Critics of the Labour Party's health platform were quick to accuse the Government of trying to introduce a communist system of socialized medicine in New Zealand.³⁵ The medical profession quickly jumped on this bandwagon. Even radical socialists wanted to distance themselves from the great social upheavals occurring in eastern Europe during the early twentieth century and were horrified by the rumors of Stalin's purges during the mid-1930s.

In reality, the health care policies of the seven European countries of the communist bloc were less progressive than those proposed in New Zealand. As was described in the introduction, a well-developed system of social insurance provided health care for urban workers long before the onset of communist rule in eastern Europe.³⁶ Financing universal access through general revenues, early developments in health care in these countries following the Bolshevik revolution focussed on strengthening the existing social insurance systems, transferring the administrative responsibilities to trade unions and improving services for industrial workers, thereby redistributing the existing scarce resources. Initially, those on either side of the working age, as well as farmers, housewives and the unemployed, remained without protection.

³¹ Thorn, *Peter Fraser*, 147.

³² Walter Nash, *New Zealand: A Working Democracy* (London: Dent & Sons, 1943): 176.

³³ Sinclair, *Walter Nash*, 163.

³⁴ In his personal life he "never said anything harsher than 'dash'." Lee, *Soap-Box*, 23.

³⁵ Lovell-Smith, *New Zealand Doctor*, 49, 55 and 74.

³⁶ COMECON is the unofficial abbreviation for CMEA (Council for Mutual Economic Assistance). The founding members were USSR, Bulgaria, Czechoslovakia, Hungary, Poland and Romania. Later admissions were Albania (1949-61), German Democratic Republic (1950), Mongolia (1962), Cuba (1972), Vietnam (1978). Yugoslavia, Afghanistan, Angola, Ethiopia, Laos, Mexico, Mozambique, Nicaragua and the People's Democratic Republic of Yemen attend as observers. John Paxton, *Statesman's Year-Book 1986-87*, 48.

Even when free health care became recognised as a civic right in many of the communist bloc countries, limited resources prevented universal access, especially to rural populations. In practice, tipping continued and black markets thrived. None therefore offered a functioning universal entitlement that New Zealand could use as a model for its ambitious plans in 1938, although New Zealand's Minister of Finance, Walter Nash, may not have been aware of this subtlety during his visit to Moscow in 1937.

3. National Health Insurance Committee of 1935

The New Zealand branch of the British Medical Association kept in close communication with its British parent body. During the early years, most of New Zealand's doctors were trained in England and Scotland; during later years most went to Britain for advanced education. In this context, it was not surprising that the New Zealand branch quickly turned to Britain for guidance on how to deal with the Labour Government's planned legislation for creating a National Health Service.

As an early strategy, the New Zealand Association established a National Health Insurance Committee in 1935 to conduct an extensive assessment of the health needs of the country. Dr. J.P.S. Jamieson, its Chairman, was a Shetland Islander and surgeon of modest means. The personal financial price which he endured during subsequent years proved his commitment to his appointment. His 'pertinacious personality' and leadership would soon pose a serious challenge to the Government.³⁷

Dr. H. Guy Dain, the Chairman of the British Medical Association, visited New Zealand shortly after negotiations started between the Government and the medical profession. Dain was known as an advocate of the British panel system and was described as an 'encyclopedia' of health insurance knowledge.³⁸ Dr. G.F. McCleary, Chief Medical Officer for Health Insurance in the British Ministry of Health and author of a book on Britain's national health insurance, was an advocate of the Lloyd George Plan. He also visited New Zealand to advise its doctors.³⁹ During more difficult stages of negotiation in 1937, Henry Brackenbury, Vice-President of the British Medical Association (later Chairman), was asked to come to New Zealand to offer his advise.

Brackenbury had played a significant role in the Lloyd George Plan in England and had worked with the old 'fourpenny club', 'sixpenny club' and 'panel systems'. As a result,

³⁷ Lovell-Smith, *New Zealand Doctor*, 26; Sinclair, *Walter Nash*, 161.

³⁸ New Zealand branch of British Medical Association, National Health Insurance Committee (NHIC), "Interview with members of the British delegation to the Melbourne conference," Supplement, *New Zealand Medical Journal* (October 1935): 10-15. Dain would later play a major part in the negotiations between the British Medical Association and the Government during the creation of the British National Health Service.

³⁹ G.F. McCleary, "Report of an address on 14 February 1936," Supplement, *New Zealand Medical Journal* (June 1936): 18.

he advocated a contributory national health insurance programme with remuneration on a capitation basis. He regarded this as "payment proportional to the responsibility undertaken," while he accused the fee-for-service system of "reducing practice to the status of selling packets of goods over the counter."⁴⁰ The New Zealand Association, however, preferred fees-for-service. The medical profession was, therefore, unhappy about Brackenbury's recommendations and at times "had to discipline old 'Brack' a bit ... to emphasise and what not to say, even if he thought it."⁴¹

In June 1937, the New Zealand Association published its proposal which called for a contributory plan with a means-test dividing the population into four different groups based on income.⁴² The profession wanted to introduce a system whereby those with reasonable financial means would pay while the poor and disabled would receive free treatment, financed through public funds: "To expect the medical profession to treat the unemployed and their dependents free of cost is an unjust tax upon one section of the community."⁴³ Their proposal sparked immediate indignation from both the population and the Labour Government: "Anything more out of touch with public opinion than a scheme of charity, when the public wanted social security, is hard to imagine."⁴⁴

Jamieson, however, also called upon the Government to direct its efforts toward preventive medicine: "You have huge institutions which aren't necessary, huge staffs which aren't necessary, and if there was a system by which these people could secure treatment which could be given to them in their homes, it would be of benefit to everybody."⁴⁵

The Government and the medical profession had by this time become so hostile to each other that even constructive proposals fell on deaf ears. As a result of these events, the Government, in formulating its plan, ignored both the Zealand Medical Association's self-serving demands and Jamieson's constructive recommendations for greater emphasis on ambulatory care and prevention.

⁴⁰ New Zealand branch of the British Medical Association, National Health Insurance Committee (NHIC), "Report," *New Zealand Medical Journal* (December 1937): 42-48; and Lovell-Smith, *New Zealand Doctor*, 60.

⁴¹ Lovell-Smith, *New Zealand Doctor*, 61.

⁴² New Zealand branch of British Medical Association, National Health Insurance Committee (NHIC) "Suggested scheme of payment for services rendered," Supplement, *New Zealand Medical Journal* (June 1937): 21-24.

⁴³ C.E. Hercus, "Health insurance in New Zealand," *New Zealand Medical Journal* 34(1935): 90.

⁴⁴ Sinclair, *Walter Nash*, 161.

⁴⁵ Jamieson addressing the Napier to Hawkes Bay Division of the New Zealand branch of the British Medical Association on 14 March 1937 quoted in Lovell-Smith, *New Zealand Doctor*, 36.

4. Parliamentary Investigation Committee of 1937

In keeping with the Labour Party's 1935 election promises, Fraser appointed McMillan as Chairman of a Parliamentary Investigation Committee on National Health and Superannuation. The committee was charged with drafting the proposal for such a plan, although its terms of reference did not include a mandate to establish a national health service. Through its work, it consulted hospital boards, friendly societies, health insurance groups, doctors, medical schools, other health professionals and anyone who wanted to express an opinion on the future health plan.⁴⁶

In September 1937, B.C. Ashwin and J.S. Reid from the Treasury Department prepared a separate inter-departmental report before Nash's Cabinet Committee had finished its work. Ashwin and Reid estimated that universal superannuation, other pensions and a non-means-tested health service would cost the country £30 million. Income from general revenues, however, added only £20 million to the Treasury in 1937.⁴⁷ Nash kept these sobering estimates confidential while looking for other options for financing the Labour Government's social security reform.

As the Government prepared the plans for the future national health service, its silence on the matter was interpreted by the doctors as a lack of consultation. This became yet another point of conflict that soured the relationship between the two parties. Negotiations were characterised by Jamieson's intransigence, McMillan's hostile campaigning and Nash's paranoid distrust for the profession. Fraser's conciliatory efforts were to no avail as relations between the medical profession and the Government deteriorated. By 1937, negotiations had all but come to a standstill.

Interest groups other than the medical profession also opposed the Government's plans. The friendly societies and the private hospitals rightfully feared that a national health service would put them out of business. Although the latter two groups were in themselves too weak and poorly organised to pose a direct challenge to the Government, they joined with the medical profession to form a powerful conservative right wing-lobby, opposing anything that could be perceived as socialised medicine.⁴⁸

With the help of W.H. Watt, Director General of Health, McMillan submitted his Parliamentary Committee Report on 4 September 1937. His report called for universal entitlement and free access to a national health service: "Any scheme which ... divides the

⁴⁶ The doctors were coached by the New Zealand Medical Association on how to respond to a questionnaire that was distributed by the Government.

⁴⁷ Hanson, "Social security," 57-58; and Sinclair, *Walter Nash*, 132 and 160.

⁴⁸ Sinclair, *Walter Nash*, 162.

people into two groups, those able to pay private fees and those unable to do so ... would be foreign to ... the people of New Zealand in general."⁴⁹

According to McMillan's proposal, the programme would be introduced in two phases. During the first phase, the plan would offer general practitioner services, maternity care, anaesthetics, laboratories, pharmaceutical benefits, hospital treatment, dental care, and research and medical education. During the second phase, the plan would add specialist consultations, home care, physiotherapy, pre-hospital transport, additional dental care and optical benefits. A central administration would run the programme through local branches.

The committee recommended that insurance contributions from those who could afford to pay should finance the future programme. It upheld the principle that everyone should be eligible for full benefits regardless of their ability to contribute and that the new programme should pay doctors a capitation fee for their services.⁵⁰ Many of these recommendations were in direct conflict with those made by the Medical Association's National Health Insurance Committee which earlier had released its report in June 1937.

5. Select Committee on National Health and Superannuation of 1937

Shortly after McMillan released his report, the House of Representatives established a Select Committee on National Health and Superannuation to prepare the Social Security Bill. Rev. A.H. Nordmeyer, a close friend of McMillan, became Chairman of the committee, while R.S. Wogan was nominated as Secretary.⁵¹ During the early phases of its work, the committee gathered evidence from various interest groups such as the British Medical Association, the Farmers' Union, the Federation of Labour, the Associated Chambers of Commerce, the Life Offices' Association of New Zealand and municipal associations.

The committee explored three options for the future national health service: a general practitioner services with universal entitlement; a comprehensive service with a means-tested target group; and a comprehensive service with universal entitlement, financed through general revenues. Both Nash and Fraser supported the third option. Fraser agreed, believing that such a programme would be easier to finance and

⁴⁹ New Zealand, NHIIC, "D.G. McMillan," 13.

⁵⁰ The term 'contributory' referred to a special tax in New Zealand.

⁵¹ New Zealand, Select Committee on National Health and Superannuation (SCNHS), "Report," *Parliamentary Papers* (Wellington: King's Printer, 1938). Members included the following: Atmore and Cobbe (United Party), Kyle (Reform Party), Holland (Reform Party), Nash and Savage (Labour), and others. B.C. Ashwin and J.S. Reid from Treasury Department (Conservatives), and G.H. Maddex from England joined as experts; Dr. M.H. Watt, A.O. Keisenberg and C.E. Wynne represented the Department of Health.

administer than a limited plan. It would also be consistent with the Labour Party's political platform.

The New Zealand Medical Association, however, continued to demand that the Government limit public funding to a means-tested target population which could not afford to pay for health care. Such a plan would free doctors and hospitals of their charity function to the poor, while encouraging those who could afford to pay for their own health care to do so. Although Fraser was prepared to negotiate with the doctors, Nash refused to compromise. Since Nash had the support of the Prime Minister and the left wing of the Caucus, negotiations between the Government and the medical profession reached an impasse by December 1937.

Although Nash had originally wanted to finance the full social security plan through general revenues, he had to satisfy the London financiers who controlled New Zealand's foreign borrowing as well as and the critics in his own treasury department.⁵² Ashwin and Reid of the Treasury Department, who earlier had submitted their pessimistic inter-departmental report on the projected cost of the future social security programme, felt that contributory financing based on actuarial principles would be easier to control than a programme financed exclusively through general revenues.

As early as 1936, Nash had made a diplomatic gesture by consulting Walter Kinnear, Controller of Health and Unemployment Insurance at the British Ministry of Health. He also sought the advice of Godfrey Ince, Chief Insurance Officer at the Ministry of Labour. When the British Actuary, George Maddex, was asked how the plan should be financed, Nash declined to give a direct answer: "With all respect, I think that is an unfair question to address to the actuary."⁵³ All three influenced the Labour Government's final choice for financing the future New Zealand social security reform.⁵⁴

As a compromise, the National Health and Superannuation Committee suggested that the health benefits, which would cost £17,850,000, could be financed through a combined 1 per cent levy on income yielding £7,500,000, a flat membership contribution of £1 per head per annum yielding £500,000 and a Consolidated Fund contribution of £9,850,000. This would represent a £2,355,000 increase in outlay to the Social Assistance Consolidated Fund above the outlay in the previous financial year 1938-39. The committee concluded that the purpose of the "scheme [was] simply to provide a more

⁵² Sutch, *Responsible Society*, 41.

⁵³ New Zealand, SCNHS, "Report," Minutes, Volume 2; and Sutch, *Responsible Society*, 61.

⁵⁴ Sinclair, *Walter Nash*, 164; Hanson, "Social security," 102. The misnomer 'social insurance' to describe financing originating from general revenues in New Zealand may have been an attempt to appease critics in London.

equitable distribution of the national income."⁵⁵ The self-employed, such as farmers and owners of small businesses, would be covered under the plan, but the details of how to collect contributions from such groups were not specified.⁵⁶

The left wing of the Caucus, which included Armstrong, Lee and McMillan, rejected the proposal: "We were prepared to make concessions regarding the levy on incomes but we were not prepared to limit our pension scheme to the interest on accumulated funds."⁵⁷ They therefore rejected Nash's 'complex tables' and 'beautiful material'.⁵⁸ As a result of this internal conflict, the provisions for financing the programme had to be modified before drafting the final Social Security Bill.

6. Social Security Act of 1938

Despite protests from the medical profession, the Government presented its White Paper in April 1938. The Social Security Bill was introduced on 11 August 1938 and the Social Security Act passed in the House of Representatives on 8 September 1938. The Pensions Department and the Employment Promotion branch of the Department of Labour would join to form a new Department of Social Security which would administer the consolidated and simplified social security programme.

Part III of the Act, which dealt with the medical provisions, was revolutionary for its day. It called for public financing for universal entitlement to health care which would be introduced in two stages.⁵⁹ Phase I would be introduced on 1 April 1939, providing free access to general practitioner services, hospitals, sanatoriums, pharmaceuticals and maternity benefits for the whole population. Phase II, designed to follow when public financing became available, would provide free access to anaesthetic services, laboratories, diagnostic radiology services, consultation by specialists, pre-hospital transport and dental care. The programme also called for health promotion, prevention, home nursing and domestic help for the ill.⁶⁰

Individual registration fees, charges on individual income and contributions from the newly established Social Security Fund, would finance the plan.⁶¹ The Commissioner of Taxes would assess and collect the social security charges according to the rates applicable

⁵⁵ New Zealand, SCNHS, "Report," 18.

⁵⁶ New Zealand, SCNHS, "Report," Minutes, Volume 2.

⁵⁷ Lee, *Soap-Box*, 98.

⁵⁸ Lee minute, Lee MSS, 441/22 quoted in Sinclair, *Walter Nash*, 164.

⁵⁹ New Zealand, SCNHS, "Report," 5.

⁶⁰ New Zealand, "Social Security Act," *Statutes* (Wellington: Parliament, 1938): Part III, pt. 77-104.

⁶¹ Although the radicals in the Caucus tried to block funding superannuation through a consolidated fund, such financing was maintained as a partial source of financing for health care. The assets of the Employment Promotion Fund would be transferred to the Social Security Fund.

to those liable for payment.⁶² All persons over sixteen years of age were required to register, and a penalty was set for evaders. Exemptions were defined precisely, and it became an offence to employ unregistered persons.⁶³ Charges on salaries, wages and other income would finance the contributory part of the programme.

New Zealand's social security reform captured the imagination of both the local population and people in other countries whose memories of the personal hardships suffered during the Depression were still fresh. British playwright Bernard Shaw wrote: "[New Zealand legislators] struck me as men who knew the nature of the task that confronted them and had the ability to see it through."⁶⁴ British Labour Party MP, Ernest Bevin, praised the reform when he visited New Zealand in 1938 and was outraged that British doctors had helped the New Zealand Association in their propaganda campaign against the reform.⁶⁵

Believing that their reforms were popular, the Labour Government called a general election eight days after passing the Social Security Act. On 15 October 1938, the Labour Party was returned with an increased majority.⁶⁶ The Opposition National Party did not challenge any major aspects of the act during the election.⁶⁷

The medical profession, however, was determined to fight the health care reforms: "It is our duty to oppose to the uttermost this ill-conceived measure so strongly tainted by party politics."⁶⁸ Despite the doctors' lack of cooperation, wide application of the institutional benefits became possible immediately because general hospitals and mental hospitals were already financed through public funds before when the reform took place. Free treatment in mental hospital was introduced in April 1939, free maternity services in May 1939 and free in-patient treatment in public hospital in July 1939. Doctors in these hospitals became salaried workers rather than honorary appointees, a development which few found objectionable since it allowed them a stable additional income.

The Government, however, remained unsuccessful in its negotiations. The Medical Association's National Health Insurance Committee argued that the health and welfare of the population, and the welfare of doctors were inseparable. It claimed that it was in the interest of the patient to pay his doctor because "satisfactory attendance to the sick

⁶² Collection would include the issuing of a Social Security Stamp.

⁶³ New Zealand, "Social Security Act," pt. 102-135.

⁶⁴ Letter by Bernard Shaw quoted in Thorn, *Peter Fraser*, 159.

⁶⁵ William Beveridge would later formulate a similar comprehensive social security reform for Great Britain.

⁶⁶ Elections in 1943 and 1946 returned the Labour Party with a reduced majority compared with the 1938 election results.

⁶⁷ The Opposition did not challenge the act in two later general elections. Robb, *Health Reform*, 25; and Sutch, *Responsible Society*, 60.

⁶⁸ British Medical Journal, "General medical service," 242.

depends upon the private and personal relationship between the patient and his doctor."⁶⁹ The medical profession, therefore, remained intransigent: "Evolution, not revolution, was what was required."⁷⁰

Fraser warned the Medical Association that unless it cooperated the Government would create a state medical service.⁷¹ With 25 per cent of doctors on overseas military duty, however, no one took this threat seriously; it would have been impossible for the overworked doctors who remained in New Zealand to staff such a service. Later, protracted negotiations met with failure and the general practitioner service, called for under the Social Security Act of 1938, was never established.⁷²

7. Social Security Amendment Bill of 1941

In 1940, Fraser became acting Prime Minister, replacing Savage whose health had deteriorated. The social and economic hardships created at this time by World War II were putting the Labour Government under considerable political pressure to implement the remaining provisions called for under the Social Security Act of 1938, including its health care benefits. Fraser at this point appointed H.T. Armstrong as the new Minister of Health and Education, hoping to utilise his new Minister's talents as a negotiator in dealing with the medical profession.⁷³

Despite protest from McMillan, Nash, Nordmeyer and most of the Cabinet, Fraser and Armstrong proposed a general practitioner service which would allow five different options for paying doctors. The programme offered the following payment choices: salaries, capitation, direct fee-for-service, refunds to patients following direct fee-for-service payments to doctors, refunds to doctors following bulk-billing for services rendered to patients, and 'tokens' and 'tips' under the latter two.

The pressures imposed by World War II and the conciliatory approach of Fraser and Armstrong finally broke the previously deadlocked negotiations. Under these terms, the medical profession agreed to participate in the national programme, and in September 1941 the Social Security Amendment Bill containing these options was introduced.⁷⁴ It passed in the House of Representatives on 1 November 1941.⁷⁵ The reform made New

⁶⁹ New Zealand branch of British Medical Association, National Health Insurance Committee (NHIC), "Minutes, 11 March 1935," Supplement, *New Zealand Medical Journal* (April 1936): 12.

⁷⁰ Sinclair, *Walter Nash*, 162.

⁷¹ *Dominion* (31 May 1939) quoted in Lovell-Smith, *New Zealand Doctor*, 103.

⁷² Reports opposing the reform issued by the Medical Association's National Health Insurance Committee appeared at regular intervals in the *New Zealand Medical Journal* from 1938 to 1940.

⁷³ While Minister of Labour, Armstrong had been known as a skillful conciliator.

⁷⁴ Thorn, *Peter Fraser*, 158; and Sinclair, *Walter Nash*, 196.

⁷⁵ New Zealand, "Social Security Amendment Act," *Statutes* (Wellington: Parliament, 1 November 1941).

Zealand the first western developed country with a market economy to offer public financing for universal entitlement to comprehensive health care.

C. BARRIERS TO UNIVERSAL ENTITLEMENT

1. Hostages to History

New Zealand's Social Security Act of 1938 and Social Security Amendment Act of 1941 eliminated reliance on charity for the financing of health care. The provisions of the reform, however, were introduced in a piecemeal fashion. Hospital out-patient benefits, pharmaceutical benefits and partial general medical services were introduced in 1941. Physiotherapy was introduced in 1942, district nursing and domestic help in 1944, laboratory services in 1946, dental benefits and prosthesis in 1947, specialists' consultations in 1969, and accident benefits and nurse practitioner services in 1974.

The varied and complex modes of paying for the General Practitioner Services led to chaos. During the initial period of trying to implement the refund system, thirty per cent of claims were inaccurately completed by patients, leading to incorrect refunds.⁷⁶ Erosion in coverage occurred because doctors charged more than the Government was willing to refund, and because they supplemented their official income with extra charges.⁷⁷ The principles behind public financing, universal entitlement and comprehensive services were quickly lost. Patients who could not afford the various 'tokens', 'tips' and 'incomplete refunds' free access to hospitals health care.

The New Zealand branch of the British Medical Association gave the unfortunate impression that doctors "were concerned solely with their own financial interests and not with the health of the community."⁷⁸ The thousand members of the medical profession blocked what the electorate had emphatically endorsed in 1938, thereby creating a class-structured health care system.⁷⁹ Only a few rebels broke ranks with the profession: "A cynic amongst us once said 'We are not the doctors, we are the disease.'⁸⁰ The long-term dangers of a refund system with its inevitable erosion in coverage were not recognised in 1941.⁸¹

⁷⁶ Lovell-Smith, *New Zealand Doctor*, 151; and Robb, *Health Reform*, 20.

⁷⁷ They would charge 3s from the patient and claim 7s 6d from the Social Security Fund thereby resulting in a total payment of 10s 6d.

⁷⁸ D. Stark Murray, *Health For All* (London: Victor Gallancz, 1942): 44.

⁷⁹ Brian Easton, *Social Policy and the Welfare State in New Zealand* (Sydney: George Allen & Unwin, 1979): 139.

⁸⁰ Robb, *Medicine*, viii; and William Ball Sutch, "Introduction," in *The Future of New Zealand Medicine: A Progressive Viewpoint*, edited by D.W. Beaven and B.H. Easton (Christchurch: N.M. Peryer, 1974): 6.

⁸¹ Had the Labour Government examined the problems which the refund system had created for sickness funds in the Nordic countries, especially in Norway during the 1920s, Fraser and Armstrong might have been more reluctant to introduce to such a system in New Zealand in 1941.

CHAPTER 4. UNITED KINGDOM

If someone discovered a universal panacea which would guarantee health for everyone throughout their lives, he would be hailed as the greatest man on earth.¹

D. Stark Murray, 1942

A. FINANCIAL INFRASTRUCTURES

1. Elizabethan Poor Laws

From the Middle Ages to the nineteenth century, care for the sick and the poor in England was largely the business of the church. Poverty, malnutrition, long hours of labour and insanitary living conditions led to "crippled and distorted forms ... widespread [accumulation] of human excreta, ... and terrifying dangers of epidemic disease."² The high mortality rates from recurring scourges of cholera, typhus and smallpox were recorded in the first report of the Registrar General in 1836.³

Two types of institutional care were available during the nineteenth century. Under the Elizabethan Poor Laws, the sick, disabled and elderly were housed either in mixed or separate workhouses.⁴ The criteria for relief was "less concerned with the alleviation of poverty than with preventing public subsidy of the idle."⁵ The philosophy of the Poor Laws was that able-bodied paupers would find it preferable to work than to obtain outdoor relief under the 'rigor' of the workhouse, a fate more unpleasant than the worst-paid job.

The second type of institutional care was the voluntary hospitals and venerable institutions. Their progenitors and patrons were members of the social elite who had founded them after King Henry VIII dissolved the monasteries in the sixteenth century. 'Worthy' patients in the voluntary hospitals excluded the incurable, hopeless and

¹ D. Stark Murray, *Health For All* (London: Victor Gallancz, 1942): 1.

² A. Gibbins, *Industrial History of England*, quoted in James Stirling Ross, *The National Health Service in Great Britain: An Historical and Descriptive Study* (London: Oxford University Press, 1952): 26.

³ The office of the Registrar General was established in 1836. Pat Thane, *Foundations of the Welfare State, Social Policy in Modern Britain*, series editor Jo Campling (London: Longman, 1982): 4-47.

⁴ Unification of the Poor Laws took place in 1602. The Poor Law Amendment Act was passed in 1834 and the Poor Law Outdoor Relief Regulation Order passed in 1852.

⁵ A.W. Dilnot, J.A. Kay and C.N. Morris, *The Reform of Social Security*, The Institute of Fiscal Studies London (Oxford: Clarendon Press, 1984): 6.

contagious; their families had to guarantee funeral expenses before hospitals would accept them as patients.⁶

The primitive state of medical science, shortage of trained nurses and inadequate physical facilities of institutions limited the quality and effectiveness of care offered through hospitals.⁷ The middle and upper classes, therefore, considered home a far healthier place to recover from illness.⁸

Doctors staffed hospitals on an honorary basis, using such appointments to make professional connections. They earned their main income from private practice where they charged wealthy clients a fee-for-service. During the period before financing of health care was introduced by the friendly societies, patients who could not afford general practitioner services relied on the out-patient departments of voluntary hospitals, charitable dispensaries, family care, local healers, natural remedies, apothecaries and quacks.⁹

Nurses and other salaried hospital workers were often domestic servants of a 'rough and coarse type', employed on a salaried basis.¹⁰ The nursing profession later gained some respectability as "an outlet for the social conscience and frustrated energies of the Victorian spinster."¹¹ When matrons and nurses realised the value of their work, their demand for higher salaries became a financial burden to the under-financed hospitals. As a result, many hospitals established nursing schools whose trainees paid a fee for their education even though they provided a pair of free hands on the wards during their training.

Lack of adequate ambulatory care led to an overuse of hospitals which were always short of funds.¹² Poor Law infirmaries, public hospitals and fever hospitals were financed through local rate, levies, central grants-in-aid and loans.¹³ Venerable institutions were financed through income from their endowments. Newer voluntary and teaching hospitals

⁶ Brian Abel-Smith, *The Hospitals 1800-1948*, Heineman Books on Sociology, series editor Donald Gunn MacRae (London: Heinemann, 1964): 1-15 and 64.

⁷ Ross, *National Health Service*, 32.

⁸ Abel-Smith, *Hospitals*, 2.

⁹ Conflicts between out-patient clinics and general practitioners were reduced following introduction of the referral system. Abel-Smith, *Hospitals*, 116.

¹⁰ Brian Abel-Smith, *A History of the Nursing Profession*, Heineman Books on Sociology, series editor Donald Gunn MacRae (London: Heineman, 1960): 1-16; and Abel-Smith, *Hospitals*, 8.

¹¹ Florence Nightingale, who founded the Training School and Nurses Home at St. Thomas Hospital, helped the nursing profession gain respectability. Abel-Smith, *Hospitals*, 66.

¹² The underfinancing of the hospital sector and the problem of out-patient abuses were explored in detail by the Lords' Committee in 1890-93. The work of the committee led to the establishment of the King Edward's Hospital Fund. United Kingdom, Select Committee on Metropolitan Hospitals (SCMH), "Report of Lords Committee 1890-93," *Accounts and Papers* (London: HMSO, 1893); and Abel-Smith, *Hospitals*, 135.

¹³ Abel-Smith, *Hospitals*, 4-5, 39 and 101.

depended on a combination of current subscriptions, donations, bazaars, dinners and balls for their financing. Finally, cottage hospitals, popular among general practitioners, were financed through a mixture of contributions and charges.¹⁴ Except for a few provincial hospitals, special hospitals and nursing homes, direct payment for beds in the voluntary hospitals was very uncommon until after World War I.¹⁵

When Edwin Chadwick became the first Secretary of the Poor Law Commission, established in 1834, he emphasised the inability of the existing institutions and current medical practice to deal effectively with the epidemics of infectious diseases.¹⁶ Poor health, he claimed, was due to problems of bad drainage, inadequate water and poor ventilation.¹⁷ Reflecting Chadwick's concern, the Municipal Corporations Act of 1835 called for public action. Under the Act, the municipalities appointed Medical Officers of Health to survey sanitary conditions.¹⁸

As antiseptic techniques improved, the Poor Law infirmaries built from 1867 onwards became safer and more acceptable to the ordinary working class. This acceptance was advanced by the Medical Relief Disqualifications Removal Act of 1885 which eliminated the label of 'pauper' from those who used these institutions. Previously, sick paupers had been disenfranchised, losing both the right of citizenship and the right to vote.¹⁹

At the turn of the twentieth century, poverty with its associated illnesses, still remained widespread throughout the 151,118 square kilometers of England and Wales with its population of 32,527,843.²⁰ "The interests of human life, except against willful violence, are almost uncared-for by the law.... I do not hesitate to say, [this] constitute[s] a national

¹⁴ Abel-Smith, *Hospitals*, 107.

¹⁵ Abel-Smith, *Hospitals*, 103 and 189.

¹⁶ Edwin Chadwick, *Report on the sanitary condition of the labouring population of Great Britain [1842]*, edited by M.W. Flynn (Edinburgh: Edinburgh University Press, 1965). Others have since supported this view: Ivan Illich, *Limits to Medicine, Medical Nemesis: The Expropriation of Health* (Harmondsworth: Penguin, 1976); Thomas McKeown, *The Role of Medicine: Dream, Mirage or Nemesis?* (Oxford: Basil Blackwell, 1979); and Scott B. Halstead, Julia A. Walsh and Kenneth S. Warren, *Good Health at Low Cost*, Proceedings of a Conference held at the Bellagio Conference Center, Bellagio, Italy, 29 April to 3 May 1985 (New York: Rockefeller Foundation, 1985).

¹⁷ Clauses Consolidation and Town Improvement Acts of 1846; Nuisances Removal and Diseases Prevention Acts of 1846; Public Health Act of 1848; Health of Towns Commission in 1848; and the Report of Lancet Commission. Commissioners included Charles Dickens and John Stuart Mill.

¹⁸ Medical Officers of Health were often general practitioners who also performed clinical duties. United Kingdom, "Local Government Act," *Statutes* (London: HMSO, 1929); and United Kingdom "Local Government Act," *Statutes* (London: HMSO, 1933).

¹⁹ Abel-Smith, *Hospitals*, 130.

²⁰ Charles Booth, *The Life and Labour of the People in London* (London: Mcmillan, 1902-4); and B.S. Rowntree, *Poverty: A Study of Town Life* (London: Mcmillan, 1902). The population for 1901 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962): 281 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 1281.

scandal, and perhaps in respect of their consequences, something not far removed from a national sin."²¹

Hoping to find solutions to the burdens placed on local rate-payers by the Poor Laws, the Conservative Government of Prime Minister G.W. Balfour appointed a Royal Commission on the Poor Laws and the Relief of Distress in 1905. Its majority report called for greater co-operation in the hospital sector but was opposed to a free national health service which it feared the growing middle-class would make too expensive.²² Its minority report, drafted by Beatrice Webb (formerly Potter) and her husband Sidney Webb, however, called for a unified service run by health committees of the local authorities. The Webbs felt that their proposed means-tested service should aim at prevention and should be financed through general revenues.²³ Although the medical profession as a whole rejected the Webb's recommendations, a small group of doctors supported the call for a nationalized medical profession.²⁴

These two reports raised most of the controversial issues which would later be the subjects of heated debates between the Government and doctors. Should there be a universal, comprehensive and free national service or a limited, means-tested and selective service? Should doctors receive a salary, capitation fees or fees-for-service? Should the administrative structure be central or local? Should the administration of the service include or exclude medical representation? Should it have an elected or an appointed membership? Should voluntary hospitals be incorporated into a unified system or should they be allowed to maintain their independence? Finally, should the financing of the service be through general revenues, insurance, local rates or charges?

2. Lloyd George's National Insurance Plan of 1911

The 1906 election, which gave a sizable majority to the Liberal Party led by Prime Minister Herbert Henry Asquith, determined the outcome of the debate. Lloyd George, Chancellor of the Exchequer, and Winston Churchill, President of the Board of Trade, both supported a Bismarkian social insurance plan for health care.²⁵ This was consistent with the traditional Liberal Party *laissez-faire* philosophy.

²¹ John Simon, quoted in Ross, *National Health Service*, 29. He was the architect of the 'Magna Carta' of public health, the Public Health Act of 1875, drawn up after the Royal Commission of 1871.

²² United Kingdom, Royal Commission on the Poor Laws (RCPL), "Report [Chairman G. Hamilton]," Cd. 4499, *Accounts and Papers* (London: HMSO, 1909).

²³ The Webbs who were members of the Fabian Society, a forum for social reform, advocated a socialised state.

²⁴ *British Medical Journal*, 1906, 1732 and *British Medical Journal*, 1913, 529-30 discussed in Abel-Smith, *Hospitals*, 249.

²⁵ H. Levy, *National Health Insurance: A Critical Study* (Cambridge: Cambridge University Press, 1944): 3; and John E. Pater, *The Making of the National Health Service*, King's Fund Historical Series No. 1 (London: King Edward's Hospital Fund, 1981): 4. Lloyd George had studied Bismark's plan during a visit to Germany in 1908.

The National Insurance Bill, introduced on 4 May 1911, called for national contributory and compulsory insurance. The preamble to the legislation described it as "an Act to provide for insurance against loss of health and the prevention and care of sickness, and for purposes incidental thereto."²⁶ The plan would cover all manual workers and other employed persons between sixteen and sixty-five whose income was below £160 per year. Membership would also be available on a voluntary basis for those excluded from compulsory membership and members of five years' standing.

Benefits would include diagnostic services, treatment by general practitioners, sanatoria, sickness pay and maternity benefits. Of the 13.5 million who would be compulsorily insured, the friendly societies would cover 6.5 million, large insurance companies would cover 5.5 million and trade unions would cover the remainder. These 'approved societies', would offer a 'panel' of doctors who would provide care for members.²⁷ The plan would be financed through workers' and employers' contributions as well as a general revenues subsidy.

Most medical practitioners in private practice earned their income from contracts with friendly societies and private clubs. These contracts were drawn up by the doctor for his poorer patients at a small annual subscription fee. Fearing a continuation of the conflicts that doctors had experienced in their relationship with the friendly societies, the British Medical Association (BMA) demanded the following 'six cardinal points' before agreeing to participate in the national insurance plan: means-testing for memberships, free choice of doctor, administrative committees, expert medical representation on these committees, increased levels of remuneration and a range of choice in the mode of remuneration. The medical profession pledged not to support the plan unless their demands were met.

The National Insurance Act was nevertheless passed on 16 December 1911, coming into effect on 15 July 1912 just before the beginning of World War I in January 1913. The Government won the cooperation of the medical profession by proposing an increase in the capitation fee, limiting the range of services offered under the programme and excluding those who could not afford to pay contributions. Under these terms, most of doctors quickly joined the plan fearing they would to be left without patients if they 'opted-out'. The basic terms of the plan remained in force for the next forty years. During this time the friendly societies slowly ceased offering health care benefits, eventually providing only cash benefits.

²⁶ United Kingdom, "National Health Insurance Act," *Statutes* (London: HMSO, 1911).

²⁷ Levy, *National Health Insurance*, 6. Institutional care, consultants, women and children were all excluded.

3. World War I to the Great Depression

Elements of a national hospital service were introduced during World War I to treat casualties and to stem the spread of venereal disease.²⁸ When this system was disbanded following the war, enquiries and official reports continued to examine many of the issues that had already been raised by the earlier Royal Commission on the Poor Laws and the Relief of Distress in 1905. These enquiries nearly all called for reforms in the uncoordinated hospital system and extension of the health care provisions of the friendly societies.

The Report of the Local Government Committee felt that local Boards of Guardians for the Poor Law infirmaries should be abolished and their functions transferred to the county councils and county borough councils.²⁹ The Haldane Committee led to the creation of the Ministry of Health in 1919.³⁰ The Minister of Health, Dr. Christopher Addison, established a Consultative Council to review Britain's health care needs.³¹ Later, the Dawson Report, stated that the current organization of medicine in Britain was not serving the public well and outlined the first official proposal for a national health service.³²

The Cave Committee on the Voluntary Hospitals recommended the establishment of a Hospital Commission to improve co-ordination between the hospitals which were all in need of financial support.³³ The Onslow Commission also stressed the need for a central body to co-ordinate hospitals.³⁴ The Royal Commission on National Health Insurance recommended that national insurance should be extended to cover more of the population and that insurance should be used in the financing of hospitals.³⁵ The Royal Commission on Local Government once again recommended that the Poor Laws'

²⁸ The Venereal Disease Act provided for free treatment for every citizen with a 75 per cent grant to co-operating local authorities. Richard M. Titmuss, *Problems of Social Policy*, in *History of the Second World War*, edited by W. K. Hancock, United Kingdom Civil Series [London: HMSO, 1950] revised edition (Nendeln: Kraus Reprint, 1976): 2-5; and Abel-Smith, *Hospitals*, 252-283.

²⁹ United Kingdom, Local Government Committee (LGC), "Report [Chairman Donald Maclean]," *Accounts and Papers* (London: HMSO, 1917).

³⁰ United Kingdom, "Ministry of Health Bill," *Accounts and Papers* (London: HMSO, 1918); and United Kingdom, Ministry of Reconstruction (MR), Machinery of Government Committee (MGC), "Report, [Chairman Viscount Haldane]," Cd. 9230, *Accounts and Papers* (London: HMSO, 1918).

³¹ The Ministry of Health, which was established in 1919, became responsible for both health and local government.

³² United Kingdom, Ministry of Health (MH), Consultative Council on Medical and Allied Services (CCMAS), "Interim Report on the future provision of medical and allied services [Chairman Lord Dawson]," Cmd. 693, *Accounts and Papers* (London: HMSO, 1920).

³³ United Kingdom, Ministry of Health (MH), Voluntary Hospitals Committee (VHC), "Final Report [Chairman Viscount Cave]," Cmd. 1335, *Accounts and Papers* (London: HMSO, 1921).

³⁴ United Kingdom, "Report on voluntary hospitals accommodation in England and Wales [Chairman Earl of Onslow]," Cm. 2486, *Accounts and Papers* (London: HMSO, 1923).

³⁵ United Kingdom, Royal Commission on the National Health Insurance (RCNHI), "Report [Chairman Lord Lawrence]," Cmd. 2596, *Accounts and Papers* (London: HMSO, 1926).

jurisdiction over hospitals should be handed over to local authorities.³⁶ This reform was implemented in 1929 by Neville Chamberlain, then Minister of Health, (later Prime Minister).³⁷ Following the recommendations of the Report of the Voluntary Hospitals Commission in 1937 the country was divided into hospital regions,³⁸ and the Nuffield Provincial Hospitals Trust was established.³⁹

By the 1930s, voluntary insurance provided an increasing share of the revenues for both doctors and hospitals.⁴⁰ Not surprisingly, the BMA called for an extension of such insurance in their proposals for a national medical service in 1930.⁴¹ "The system of medical provision which the Ministry of Health should seek to establish is one which would give to all who need it every kind of treatment necessary for the cure or alleviation of disease and would utilise for this purpose every class of medical practitioner."⁴²

The medical profession saw the family doctor as a coordinator and a unified public authority who would be responsible for the administration and financing of their programme. Despite their objections to government intervention, over ninety per cent of general practitioners had joined the panel system by 1938. Only 50 per cent of the population, however, were covered through these provisions.⁴³

Restraints in public expenditure, brought on by World War I and the early years of the Great Depression (1929-31), hampered the implementation of previous recommendations. As World War II approached, the incomplete coverage offered by the friendly societies forced a significant portion of the population to seek medical attention through hospitals. These institutions in turn became increasingly dependent on Government funds for financing their running costs. Charitable donations, subscriptions, contributions, charges, pay beds and central block grants were no longer sufficient.⁴⁴ The call for reform came from all directions.

³⁶ United Kingdom, Royal Commission on Local Government (RCLG), "Second Report," Cmd. 343, *Accounts and Papers* (London: HMSO, 1928).

³⁷ Chamberlain wanted to reform local governments, hospitals and services offered by general practitioners.

³⁸ The Commission included Dr. Henry Brackenbury from the BMA and representatives from the Royal Colleges. British Hospital Association, "Report of the Voluntary Hospitals Commission [Chairman Lord Sankey]," *Monograph* (London: British Hospital Association, 1937).

³⁹ Lord Nuffield created the trust with a gift of one million shares (yielding £115,000 per year) in Morris Motors.

⁴⁰ Abel-Smith, *Hospitals*, 404.

⁴¹ Dr. H. Guy Dain and Dr. Henry Brackenbury had been closely involved in the New Zealand experience, and the BMA's proposal was studied carefully overseas in New Zealand, Canada and Australia.

⁴² British Medical Journal, "British Medical Association's proposals for a general medical service for the nation," Supplement, *British Medical Journal* (26 April 1930): 1. An almost identical draft was presented in 1938.

⁴³ Jan Blanpain, Luc Delesie and Herman Nys, *National Health Insurance and Health Resources: The European Experience* (Cambridge, Mass: Harvard University Press, 1978): 59.

⁴⁴ Central block grants, based on demographic, geographic, income and other epidemiological characteristics, were started in 1929.

4. World War II

Just as World War I had led to a trial run for a national hospital service, so did World War II. The medical services of 1939 were judged unable to handle the projected massive civilian casualties resulting from German air raids, gas warfare, increased infections and neurosis.⁴⁵ The Emergency Medical Services, Public Health Laboratory Service, Hospital Laboratory Services and Civilian Blood Transfusion Services were all established to cope with potential casualties.⁴⁶ "Because war means the organization of killing and wounding it must also mean the organization of services to repair and heal."⁴⁷ Proper care of casualties was seen as a crucial means of maintaining high morale and an effective fighting force.

"The frame and pattern of the hospital services at the end of the war were due as much -- if not more -- to the kind of war expected as to the kind of war that happened."⁴⁸ Forced for the first time to come into contact with the average poorly equipped local hospital, which would handle the wounded, the influential members of the medical profession reacted in horror to existing physical and manpower deficiencies, calling for a large-scale reorganization of the hospital sector.⁴⁹ "The Ministry of Health then became the department responsible for base hospitals, the cost falling entirely upon the Exchequer."⁵⁰

At this point, all political parties were demanding increased financing for existing health care services to benefit the population on a more permanent basis. The Liberal Party developed a programme based on local authority health centres offering universal entitlement, free access and comprehensive services.⁵¹ The Communist Party published a memorandum early in 1943 which gave tacit support to an improved service, but without describing the details. Finally, the Labour Party drew up a plan for a National Health Service in 1943 in close collaboration with the Socialist Medical Association. Their plan included regional services, unified central administration, salaried doctors, subcontracted voluntary hospitals and financing through general revenues.⁵²

⁴⁵ Titmuss, *Problems of Social Policy*, 6.

⁴⁶ Abel-Smith, *Hospitals*, 431; Ross, *National Health Service*, 77-8; and Pater, *National Health Service*, 20.

⁴⁷ Titmuss, *Problems of Social Policy*, 54.

⁴⁸ Titmuss, *Problems of Social Policy*, 54.

⁴⁹ The most talented doctors worked in the teaching hospitals which were all within a mile or two of Harley Street.

⁵⁰ Titmuss, *Problems of Social Policy*, 56-57. By 1 June 1938 the Government abolished the distinction between base and casualty hospitals. *Annual Report of Chief Medical Officer of the Ministry of Health, 1938*, p. 58, quoted in Titmuss, *Problems of Social Policy*, 58. The Government later took over responsibility for the ambulatory health services. *Ibid.*, pp. 216-32.

⁵¹ Liberal Party, "Health for the people: Proposals for a positive and active health policy for the nation," *Monograph* (London: Liberal Publications Department, 1942). The Beveridge Report appeared in late 1942.

⁵² Labour Party, "National service for health: The Labour Party's post-war policy," *Monograph* (London: Labour Party, 1943); Abel-Smith, *Hospitals*, 321; and Pater, *National Health Service*, 106.

Preparing for what appeared to be the inevitable, the Ministry of Health considered various plans for separate hospital and general practitioner services. John Maude, the permanent secretary from 1940 to 1945, resisted these efforts. Instead, he hoped to develop a national health service which would be integrated into a comprehensive social security programme. "It [was] the objective of the Government ... to ensure that by means of a comprehensive hospital service appropriate treatment [would] be readily available to every person in need of it."⁵³ Each of three successive Ministers of Health drew up a different proposal -- Brown, Willink and Bevan.

B. LANDMARK LEGISLATIVE REFORMS

1. Beveridge's Report

The first concrete official proposal for a national health service was issued under the auspices of a social security plan: "The Health Departments soon found that they could not limit their interests and activities to the emergency sector of the hospital services as they had originally intended."⁵⁴ On 10 June 1941, The war-time Conservative Coalition Government, led by Prime Minister Winston Churchill, appointed William Beveridge as Chairman of an Inter-Departmental Committee on Social Security and Allied Services.⁵⁵ Its terms of reference were as follows: "To undertake, with special reference to the inter-relation of the existing national schemes for social insurance and allied services, a survey of the existing national schemes for social insurance and allied services, including workmen's compensation."⁵⁶

Although, critical of existing health care provisions, Beveridge felt that the British social security system was "not surpassed and hardly rivaled in any other country of the world."⁵⁷ Its medical service on the other hand was inadequate, "both in the range of treatment which [it] provided as a right and the classes of persons for whom it [was] provided."⁵⁸ Beveridge concluded: "Want is only one of five giants on the road of reconstruction ... The others are Disease, Ignorance, Squalor, and Idleness."⁵⁹

⁵³ United Kingdom, House of Commons, *Parliamentary Debates* (London: HMSO, 9 October 1941): vol. 374, col. 1116 quoted in Titmuss, *Problems of Social Policy*, 504.

⁵⁴ Titmuss, *Problems of Social Policy*, 502.

⁵⁵ Arthur Greenwood, Minister without Portfolio, acted as Chairman of a committee on reconstruction problems. Committee members included various senior civil servants from the Government departments previously involved in the administration of cash benefits and pensions.

⁵⁶ United Kingdom, Inter-departmental Committee on Social Insurance and Allied Services (ICSIAS) "Report [Chairman Lord William Beveridge]," Cmd. 6404, *Accounts and Papers* (London: HMSO, 1942): 2.

⁵⁷ United Kingdom, ICSIAS, "Lord William Beveridge," 3.

⁵⁸ United Kingdom, ICSIAS, "Lord William Beveridge," 3.

⁵⁹ United Kingdom, ICSIAS, "Lord William Beveridge," 7.

The report went on to state that a comprehensive national health service would "ensure that for every citizen there [was] available whatever medical treatment he [required] ... for prevention and cure of disease and restoration of capacity for work."⁶⁰ He hoped that an effective programme of prevention, early diagnosis and treatment would reduce the number of people qualifying for sickness benefits and that a controlled general practitioner service would verify claims.

The Government's actuary, G.S.W. Epps, estimated the breakdown of public financing for the social security plan as follows: 28 per cent from workers, 20 per cent from employers, 2 per cent from interest on existing funds, 25 per cent from Exchequer revenues and 25 per cent from local rates.⁶¹ Under the new plan, he estimated an income to the treasury of £697 million, while previous arrangements would have yielded only £432 million.

Public expenditure on health care was estimated at £249 million. Treatment would account for £170 million and cash benefits for £79 million. Adjusting for other incomes and expenditures, the health care provisions were estimated to involve an additional public expenditure of £70 million or an increase of 28 per cent compared with previous arrangements.

Reactions to Beveridge's National Insurance plan varied. Some acclaimed it for having invented the National Health Service (NHS). It was a war-time 'best seller', capturing the public imagination.⁶² "Beveridge himself promoted the plan with almost messianic fervour, addressing gatherings of all kinds all over the country."⁶³

The health care provisions of the plan were, however, branded as an uninspired extension of the existing National Health Insurance programme. Others described it as a "Trojan horse which the Ministry of Health [was] attempting to introduce into the camp of the medical profession."⁶⁴ Kinglsey Wood, the Chancellor of the Exchequer, worried about the eventual cost of the plan. The Beveridge Report, nevertheless, introduced two great principles which would later form the cornerstone for the National Health Service: universal entitlement and comprehensive services financed through the public sector.⁶⁵

⁶⁰ United Kingdom, ICSIAS, "Lord William Beveridge," 158.

⁶¹ United Kingdom, ICSIAS, "Lord William Beveridge," Appendix A.

⁶² Arthur J. Willcocks, *The Creation of the National Health Service: A Study of Pressure Groups and a Major Social Policy Decision* (London: Routledge and Kegan Paul, 1967): 23.

⁶³ Pater, *National Health Service*, 45.

⁶⁴ United Kingdom, "Lord Derwet," House of Lords, *Parliamentary Debates* (London: HMSO, 1 June 1943): col. 729-767.

⁶⁵ United Kingdom, ICSIAS, "Lord William Beveridge," 201.

2. Vested-Interest Groups

A number of groups tried to protect their own interests against the threats introduced by the proposal. These included pressure groups with skills to offer (doctors, dentists, pharmacists, opticians, physiotherapists, nurses and many others), pressure groups of administrative organizations (county councils, non-county boroughs, districts, insurance organizations and others) and pressure groups with property at stake (local government and voluntary hospitals).⁶⁶ The dentists wanted independence from the medical profession. The pharmacists resented having to sell cosmetics to make a living. Finally, the opticians claimed the right to test eyes and prescribe glasses, domains which doctors claimed as their own. The general practitioners wanted independence from the friendly societies and local authorities.

Three contentious issues divided the medical profession. Some members wanted a central ministerial administration, while others wanted local control.⁶⁷ Some wanted a salaried service, citing examples from the judiciary, episcopate, civil service, teaching profession and business world to support their stance.⁶⁸ Others feared a loss of clinical freedom, loss of individual initiative and freedom of choice under salaries.⁶⁹ Group practice was desired by many, but others feared competition from health centres.

The British Medical Association, representing general practitioners, wanted a comprehensive public programme with the right to private practice and remuneration on a fee-for-service or capitation basis.⁷⁰ The Medical Officers of Health wanted universal entitlement under local authority control but financing through the Exchequer. The Royal College of Physicians wanted a salaried service run by an independent central board such as the BBC.⁷¹ The Royal College of Surgeons preferred ministerial control with a preservation of the voluntary hospital system.⁷² The Socialist Medical Association wanted a service based on universal entitlement, comprehensive benefits and free access using salaried doctors working in health centres.⁷³ All wanted reform, but as Lord Moran

⁶⁶ Willcocks, *Health Service*, 32-3.

⁶⁷ The general practitioners fought against control by both local governments and specialists.

⁶⁸ Pater, *National Health Service*, 35.

⁶⁹ The general practitioners refused to accept salaries.

⁷⁰ Dr. Guy Dain would replace Dr. Henry Souttar as Chairman.

⁷¹ Lord Moran (Churchill's doctor) represented them both as President of the Royal College of Physicians and as a member of the House of Lords. He strongly advocated a regional hospital plan, opposing local government control.

⁷² Lord Webb-Johnson was their President.

⁷³ The members of the association were accused by Henry Brackenbury of working 'logically and assiduously' to produce a salaried health service. Abel-Smith, *Hospitals*, 422; and Murray, *Health*, 77-78.

explained, "it [was] difficult for a doctor who [was] nurtured in the voluntary system to speak of its extinction with detachment."⁷⁴

In August 1940, the BMA established a Medical Planning Commission in collaboration with the Royal Colleges, the Royal Scottish Corporations and the Society of Medical Officers of Health.⁷⁵ Its only report, an interim report, called for a limited service covering the poorer 90 ninety per cent of the population. Their proposal included the following recommendations: central government control with local administrations, means-tested general practice services based on health centres (group practice), regional hospital services, free choice of doctor, basic salary supplemented by fee-for-service, prohibition of the sale of practices, extension of contributory insurance to cover treatment by consultants, laboratory services for the poorer 90 per cent of the population, acceptance of generalist-specialist divisions and financing through general Exchequer funds.

The report stressed that a national plan should give equal emphasis to health promotion, prevention of disease and treatment of illness. When the general membership opposed the official BMA line by rejecting the salary option, the younger doctors formed their own Medical Planning Research Association. Their association advocated universal access to free services as part of a comprehensive social security package.⁷⁶

During the war, however, "those who suffered ... were not air raid casualties, nor were they men in uniform. They were the sick, the diseased, the old, the very young and mothers."⁷⁷ Most of the vested-interest groups reacted favourably to the call for reform. But there was considerable disagreement on how to achieve this reform. If the doctors had formed a united front, they would have been a formidable adversary; instead, their divided ranks prevented a serious challenge to the Government's plans.

3. Brown's Plan

Social reforms "do not come down inscribed on sacred tablets from some political party's research centre, ... they are, rather, built up in discussion and negotiations."⁷⁸ When Ernest Brown became the Coalition Government's Minister of Health on 9 October 1941, he immediately had his Permanent Secretary, John Maude, and Deputy

⁷⁴ United Kingdom, "Lord Moran," House of Lords, *Parliamentary Debates* (London: HMSO, 16 April 1946): col. 824.

⁷⁵ Notable members were Lord Dawson, Lord Moran (Royal College of Physicians) and Lord Webb-Johnson (Royal College of Physicians).

⁷⁶ British Medical Journal, "Medical Planning Commission," Supplement, *British Medical Journal* (20 June 1942): 93.

⁷⁷ Titmuss, *Problems of Social Policy*, 193.

⁷⁸ Willcocks, *Health Service*, 104-5.

Secretary, John Wrigley, conduct a survey of existing hospital facilities and draft a plan for a comprehensive post-hospital service. Contributions and central subsidies would finance the plan.⁷⁹

In a conciliatory tone, largely intended to ease the concerns of doctors, Brown stated that private arrangements would still be allowed and that patients would retain the freedom to visit the doctor of their choice. His directives, however, contained many conflicting concepts. "What was really meant by such words as safeguard, collaboration, co-operation, unification, comprehensive and ... ultimate responsibility?"⁸⁰

In February 1943, the Lord President of the Council, John Anderson, announced that the Coalition Government had adopted a formal policy to create a National Health Service. The legislation would be introduced in three stages. First, there would be confidential and tentative negotiations with the medical profession, voluntary hospitals and local government authorities. Next, a general plan would be published as a White Paper for public discussion. Finally, the legislation would be presented to Parliament.

By March 1943, Brown's plan started to take form. It called for a unified administration with the Minister of Health advised by a Medical Advisory Committee. Medical committees, joint boards of local authorities and voluntary hospitals would together delegate administrative responsibility to Area Committees. These, in turn, would administer all services on a regional basis. A Central Medical Board would be responsible for the terms of service, appointments, inspection and discipline. Salaried comprehensive general practitioners in health centres would offer a comprehensive range of free services "Here in simple terms was the full-time salaried local government service: it included almost everything that the BMA hated most."⁸¹

The plan resembled earlier plans produced by the National Association of Local Government Officers and the Society of Medical Officer of Health. This was not surprising since many of the medical officers in the Ministry of Health who had drafted the programme had come from local government.

The relationship between the doctors and the Government soured when the medical profession realised they would become civil servants working in health centres. Dr. Charles Hill, Deputy Secretary of the BMA, called for the medical profession to unite and fight for their freedom.⁸² "The profession objected to salaries as a mode of remuneration,

⁷⁹ United Kingdom, "National health services, future of hospitals: Health Services Bill," House of Lords, Parliamentary Debates (London: HMSO, 9 October 1941): col. 1116 - 1119.

⁸⁰ Abel-Smith, *Hospitals*, 1964, 456-57.

⁸¹ Willcocks, *Health Service*, 77.

⁸² Hill became Secretary following the death of Dr. George Anderson in 1944.

to the proposed 'subjection' to local government, and above all to 'the speed at which the Government was moving.'⁸³

The doctors accused the Government of wanting to control the medical profession in order to gain control over the certification of illness.⁸⁴ This brought violent opposition from the BMA, voluntary hospitals and local governments. By the time Henry U. Willink replaced Brown as Minister of Health in December 1943, failure of the Brown Plan was imminent.

4. White Paper

The White Paper on the National Health Service, issued in February 1944, was dubbed "many people's business but nobody's responsibility."⁸⁵ Its recommendations were much less radical than the earlier proposal by Brown: "[it] approaches the millennium somewhat indirectly."⁸⁶ The White Paper admitted its limitations: "The idea of a full health and medical service for the whole population is not a completely new one ... but should be regarded as the natural next development."⁸⁷

The White Paper called for a central administrative body, with the Minister of Health advised by an appointed Central Health Services Council.⁸⁸ The original ideas of regionalism and a unified administrative structure were replaced by a tripartite administrative planning body. There would be a continuation of the dual hospital system, thereby safeguarding the voluntary hospitals. New joint boards of the local authorities and the voluntary hospitals would be responsible for the new Hospital Service. County councils and county borough councils would be responsible for local clinics and domiciliary services. A central medical board would oversee Local General Practitioner Committees. The consultants in hospitals would be employed on a part-time or full-time basis, while salaried doctors would work in health centres side by side with those in private practice.

An Exchequer grant, local authorities and private sources would finance voluntary hospitals.⁸⁹ The local authorities, county councils and county borough councils would

⁸³ Abel-Smith, *Hospitals*, 459.

⁸⁴ Pater, *National Health Service*, 64.

⁸⁵ United Kingdom, Ministry of Health and Department of Health for Scotland (MHDHS), "A National Health Service: Scotland," Cmd. 6502, *Accounts and Papers* (London: HMSO, 1944) quoted in Titmuss, *Problems of Social Policy*, 73. It was prepared by John Hawton. Distinguished members included Lord President Clement Attlee (war-time Labour Party leader), Herbert Morrison, Ernest Bevin and Chairman Lord Woolton, Minister for Reconstruction.

⁸⁶ The *Lancet* quoted in Willcocks, *Health Service*, 39.

⁸⁷ United Kingdom, MHDHS, "A National Health Service," 5.

⁸⁸ United Kingdom, MHDHS, "National Health Service," 12-20.

⁸⁹ United Kingdom, MHDHS, "National Health Service," Appendix E.

finance local services, including new health centres and home nursing services. The estimated cost was £132 for England and Wales and £16 million for Scotland. To finance this expenditure, the new Social Insurance Plan would contribute 27 per cent, local rates 36.4 per cent and the Exchequer 36.6 per cent; under the old system, social insurance would have contributed 20 per cent, local rates 74 per cent and the Exchequer 6 per cent.

The White Paper stimulated the discussion which it had invited.⁹⁰ Prime Minister Winston Churchill fully endorsed the plan: "Our policy is to create a national health service, in order to ensure that everybody in the country, irrespective of means, age, sex or occupation, shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available."⁹¹ Willink honoured its four major principles in the Commons: comprehensiveness, freedom of the individual, democratic responsibility and professional guidance.⁹² In summing up for the Opposition, Greenwood supported the White Paper; Woolton praised it in the Lords.⁹³

As time progressed, however, opposition mounted from almost every sector of the population. Although the *Lancet* favoured the programme,⁹⁴ the *British Medical Journal* was distinctly critical.⁹⁵ Dr. H.G. Dain, the new Chairman of the BMA, caustically summed up the Association's position. "We have stated emphatically that we do not wish to be employed by local authorities, that there should be no civil direction, that there should be no whole-time salaried service for general practice and that we shall have no clinical control.... We prefer these services to proceed by evolution."⁹⁶ Despite the stance of the Association's leadership, an opinion poll showed most members were in favour of the 100 per cent coverage of the population.⁹⁷ The *Lancet* commented that there was some basis for criticism, but that "opposition to the White Paper has been cultivated by zealots," leaving the medical profession open to ridicule.⁹⁸

Other groups entered into the debate attacking the provisions which dealt with the dental, pharmaceutical, optical and nursing professions. Both the County Councils Association and the Association of Municipal Corporations wanted to limit the

⁹⁰ Today the White Paper would have been a Green Paper. It was a consultative document, not a policy statement.

⁹¹ Winston Churchill, quoted in Ross, *National Health Service*, 5.

⁹² United Kingdom, "Henry U. Willink," House of Commons, *Parliamentary Debates* (London: HMSO, 16 March 1944): cols. 427-518.

⁹³ United Kingdom, "Arthur Greenwood," House of Lords, *Parliamentary Debates* (London: HMSO, 16 March 1944): cols. 35-160.

⁹⁴ *Lancet*, "Reactions to the White Paper," *Lancet* 1(4 March 1944): 313-14.

⁹⁵ *British Medical Journal*, "White Paper," *British Medical Journal* (26 February 1944): 293-95.

⁹⁶ Dr. H.G. Dain quoted in Willcocks, *Health Service*, 40.

⁹⁷ *British Medical Journal*, "Gallop poll on White Paper: Comparison with Council's Report," Supplement, *British Medical Journal* (26 February 1944): 63.

⁹⁸ *Lancet*, "Now for negotiation," *Lancet* 2(16 December 1944): 789-90.

jurisdiction of the joint authorities to that of planning. The voluntary hospitals were afraid that granting local authorities jurisdiction over the administration of hospital funds would give them abusive powers. The British Hospital Association rejected the proposal for joint authorities, fearing that this would not promote a true partnership between voluntary and local authorities that was essential for efficient services.⁹⁹

5. Willink's Plan

The debate over the White Paper dragged on for fifteen months. Secret negotiations with the BMA led to further dilution of the contents of earlier proposals. In September 1944, while Willink was still trying to re-draft a blueprint for a National Health Service, a Social Security White Paper appeared containing many recommendations from the Beveridge Report. It aimed to "secure the general prosperity and happiness of the citizens."¹⁰⁰ It would include the following benefits: allowances for families, orphans, training, women, widows, dependents and death, as well as benefits during sickness, hospitalisation, unemployment, accidents at work, retirement and national assistance.

The proposed Social Security Programme would be financed through a 'tripartite' scheme of contributions, with 44 per cent from beneficiaries and employers, 54 per cent from the Exchequer and 2 per cent from interest on existing funds.¹⁰¹ Men would contribute 10d, women 8d and employers 1.5d toward a National Health Service. Income under the new contribution schedule was estimated £429 million, which was higher than the £411 million calculated by Beveridge.¹⁰²

Projected public expenditure on the new Social Security Programme was estimated at £650 million; Beveridge had estimated the same expenditure at £697 million. Several reasons were given to explain this discrepancy: workers' compensation, estimated at £17 million, was treated separately,¹⁰³ savings on delayed health services were estimated at £22 million; savings on family allowances were estimated at £40 million; decreases in unemployment and sickness benefits were estimated at £10 million; and increases in retirement and widows benefits were expected to cost £45 million. Sickness benefits were distributed as follows: £55 million for sickness and invalidity benefits, £9 million for maternity benefits and £17 million for workers' compensation.¹⁰⁴ These

⁹⁹ Willcocks, *Health Service*, 66.

¹⁰⁰ United Kingdom, "Social insurance, part I," Cmd. 6550, *Accounts and Papers* (London: HMSO, September 1944): 5.

¹⁰¹ United Kingdom, "Social insurance, part I," 37.

¹⁰² The difference was mainly due to changes the unemployment programme (lower unemployment and lower interest on funds). United Kingdom, "Social insurance, part I," 55.

¹⁰³ United Kingdom, "Social insurance, part II: Proposals for an industrial injury insurance Scheme - workmen's compensation," Cmd. 6551, *Accounts and Papers* (London: HMSO, September 1944): 53.

¹⁰⁴ United Kingdom, "Social insurance, part I," 49 and 53.

estimates were close to those made by Beveridge: £57 million for sickness benefits, £7 million for maternity benefits and £15 million for worker's compensation.¹⁰⁵

By 1945, the Willink Plan had undergone another revision: "However complicated it appears, it must be conceded to be a masterpiece in the art of compromise."¹⁰⁶ The plan offered little new. A Central Health Services Council, assisted by a Standing Advisory Committees, would advise the Minister of Health. Three tiers -- a Regional Advisory body, an Area Health Authority and a local Hospital Planning Group -- would serve the boroughs. In this way, the local authorities and the voluntary hospitals would remain independent administrative executive units. National Health Insurance Committees, similar to the earlier Insurance Committees, would deal with general practitioners. The plan did not address the questions of doctors' remuneration or the sale of practices. Willink promised a draft legislation by September 1945 at the latest, a "last flicker of life in the dying Government."¹⁰⁷

6. Bevan's Plan

The general elections of August 1945 gave the Labour Government and Clement Attlee, the new Prime Minister, an absolute majority. On 17 August 1945, the Lord Privy Seal (Greenwood) made it clear that the new Labour Government did not intend to abide by the 'muddle' of concessions made by Willink: "We must go back to the beginning. We must go back to the White Paper, which is what my Rt. Hon. Friend the Minister of Health proposes to do."¹⁰⁸

Both Aneurin Bevan, the new Minister of Health, and the Labour Party's policy on health care created much apprehension. Bevan was the 'young' and 'vigorous' left-wing rebel that Churchill had called a 'squalid nuisance' during the war.¹⁰⁹ The Labour Party's proposal for a National Service for Health in April 1943 called for health centres, salaried doctors, abolition of private practice and local authority administrations.¹¹⁰ Its policy was influenced by the Socialist Medical Association which had also recommended a salaried service run by local authorities.¹¹¹

The Prime Minister supported the call for the creation of a National Health Service. Wilson Jameson (Deputy Chief Medical Officer), John Charles (Deputy Chief Medical

¹⁰⁵ The Government actuary G.S.W. Epps had worked out the cost of both programmes.

¹⁰⁶ Willcocks, *Health Service*, 68.

¹⁰⁷ Pater, *National Health Service*, 104.

¹⁰⁸ Ross, *National Health Service*, 90.

¹⁰⁹ Bevan and J. Westwood, the Secretary of State for Scotland, would prepare the future service. Pater, *National Health Service*, 106.

¹¹⁰ Labour Party, "National service."

¹¹¹ Abel-Smith, *Hospitals*, 447.

Officer), William Douglas (Permanent Secretary) Arthur Rucker (Deputy Secretary) and John Hawton (Deputy Secretary after 1947) were ready to support Bevan's plans.¹¹²

Cabinet was, however, divided in its views. Chuter Ede (Home Secretary) feared that a take-over of local authority hospitals would have negative political repercussions. Herbert Morrison (Lord President of the Council), a former leader of the London County Council, was known to favour local government control over the hospitals. He therefore opposed any programme under which local governments would lose power to the Ministry of Health. Winston Churchill, now in the Opposition, tried to pressure the Government into rushing its plans.¹¹³

As expected, the BMA immediately drew its battle-lines. Before participating in a public programme, the Association demanded that seven conditions be met: remuneration without public control, professional freedom, patients' freedom to choose a doctor, doctors' right to mobility, doctors' right to participate in the service, doctors' right to medical representation in the administration of the future system and hospitals' right to be associated with universities.¹¹⁴ Following the war, the medical profession also feared that the Government might use the thousands of demobilised doctors to establish a salaried national service.

Bevan and the doctors first began meeting on social occasions: "The first was a dinner party at the Café Royal on 25 October when Bevan was entertained by Dain, Souttar, Moran, Webb-Johnson, Miller and Hill."¹¹⁵ During these early talks, Bevan tried to win the confidence of the medical profession by emphasising the importance of clinical freedom, choice of doctor by the patient and the special nature of the doctor-patient relationship. He was not the "ranting dogmatist of political caricature" that the medical profession had expected to confront.¹¹⁶

Bevan proceeded to prepare his proposal in secrecy. Following their meetings, Hill claims to have noted, "not a sign of belligerency ... [or] inordinate affection."¹¹⁷ Bevan, on the other hand, remained suspicious of the medical profession, claiming to have "detected a certain gleam in [Hill's] eye."¹¹⁸ When Bevan started more formal meetings with the

¹¹² All had played some role in developing previous plans.

¹¹³ Pater, *National Health Service*, 112.

¹¹⁴ The Medical Practitioners' Union called them 'seven futile clauses' all based on syndicalism. Willcocks, *Health Service*, 42.

¹¹⁵ Pater, *National Health Service*, 107.

¹¹⁶ Pater, *National Health Service*, 107.

¹¹⁷ *British Medical Journal*, "Mr. Bevan's hopes for National Health Service," Supplement, *British Medical Journal* (15 September 1945): 63-5.

¹¹⁸ Abel-Smith, *Hospitals*, 476.

doctors in January 1946 he focussed not on the 'form' of the health service but on the 'terms' of service within it.

7. National Health Service Act of 1946

On 19 March 1946 the National Health Service Bill was presented to the Commons.¹¹⁹ Reaction were varied. The *Lancet* was sympathetic.¹²⁰ The BMA saw the tripartite administrative structure as fragmented rather than unified, and the Association established a 'fighting fund' to challenge the Government.¹²¹ It objected to salaries and the prohibited sale of practices but it supported the call for a comprehensive service and regionalisation.¹²² The British Hospital Association condemned the proposals.

As the legislation slowly made its way through the Commons, the Commons' Standing Committee and the Lords, the level of polemics increased.¹²³ In the Commons, Bevan and Charles Key, the Parliamentary Secretary, praised the legislation. Willink from the Opposition objected to the salaried general practitioners, abolition of voluntary hospitals, weakening of local government, the lack of proper consultation and the control of the medical profession by a tribunal without right of appeal to the High Court. He appeared bitter that Bevan would be credited with creating the National Health Service which he himself had advocated.¹²⁴

In the Lords, Lord Moran welcomed the hospital proposals.¹²⁵ Lord Holder, his rival for the presidency of the Royal College of Physicians, was opposed to a National Health Service and called for 'evolution not revolution'. Bernard Docker called the reorganization of the hospital sector a "mass murder of the voluntary hospitals and their replacement with state institutions."¹²⁶

Although the Lords demanded several amendments, two of which were rejected by the Commons, the National Health Service Bill received Royal Assent on 6 November 1946.

¹¹⁹ United Kingdom, Ministry of Health (MH), "National Health Service Bill," *Accounts and Papers* (London: HMSO, 19 March 1946). Unless otherwise stated, the following description of the 'Bill' refers to the March issue. It was John Hawton, not Bevan, who drafted the final legislation. Hawton had also prepared the 1944 plan.

¹²⁰ *Lancet*, "Participation," *Lancet* (23 March 1946): 421-424.

¹²¹ *Lancet*, "BMA opens emergency fund," *Lancet* 1(9 March 1946): 354.

¹²² *British Medical Journal*, "The BMA Council's Report," Supplement, *British Medical Journal* 1(30 March 1946): 469-474; and *British Medical Journal*, "The press, the Minister and the Bill," Supplement, *British Medical Journal* 1(20 April 1946): 612-613.

¹²³ The initial reading in the House of Commons took place on 30 April 1946.

¹²⁴ In reality the real architects of the NHS were Jameson and Hawton. Pater, *National Health Service*.

¹²⁵ United Kingdom, "Lord Moran," House of Lords, Parliamentary Debates (London: HMSO, 16 April 1946): cols. 822-866.

¹²⁶ Docker, Chairman of the British Hospitals Association, quoted in Pater, *National Health Service*, 122.

In December 1946, Scotland presented its legislation which received Royal Assent on 21 May 1947. Northern Ireland introduced similar legislation on 4 February 1947.¹²⁷

The new National Health Service would adopt a central administrative structure similar to that proposed by Willink. A Central Health Services Council, assisted by a Standing Advisory Committees, would advise the Minister of Health, thereby vesting the power and interest of politicians and civil servants alike. There would be a tripartite administrative structure consisting of hospitals and specialists' services, local authority health and social services, and general practice services (including dental, pharmaceutical and ophthalmic services).¹²⁸

The nationalized voluntary and local authority hospitals would form the future general and teaching hospitals. Both amenity or standard free beds and private charge beds would be available. Nursing homes, however, were excluded from the plan. New hospital regions would be based on university medical schools. General hospitals would be managed through a two-tier structure: regional hospital boards and local hospital committees. Teaching hospitals, however, would be given special treatment, having their own board of governors with direct accountability to the Minister of Health. A central Hospital Endowment Fund would pool the endowments from individual hospitals.

County councils and county borough councils, which would lose authority over their hospitals, would form the new Local Health Authorities branch of the tripartite structure. Such services would expand to offer health centres, clinics, home nursing, midwifery, home help, health visitors, ambulances, vaccination and immunisation.

General Practitioner Services (including pharmaceutical, dental and ophthalmic services) would form the third branch of the tripartite executive structure. These, in turn, would be administered by local executive councils. The sale of practices for goodwill would be abolished, although some official compensation would initially be offered to those affected by this change. Regulations would determine the policy affecting doctors' remuneration and other contentious issues, although a basic salary with a superimposed capitation fee was envisaged from the onset. Mental Health Services, although formally transferred to the Ministry of Health, would be covered under a separate legislation and would have an independent Board of Control to administer the Lunacy Act and other legislations.¹²⁹

¹²⁷ United Kingdom, "An Act to provide for the establishment of a comprehensive health service for Scotland, and for purposes connected therewith," *Statutes* (London: HMSO, 21 May 1947); and United Kingdom, "Northern Ireland Health Services Act," *Statutes* (London: HMSO, 1948).

¹²⁸ The geographic boundaries were non-conterminous.

¹²⁹ United Kingdom, Ministry of Health (MH), "National Health Service Bill," *Accounts and Papers* (London: HMSO, 23 July 1946).

To finance the NHS, national insurance would contribute 21 per cent, local governments would contribute 6 per cent, savings from discontinued grants previously financed through the Ministry of Health and Ministry of National Insurance would contribute 10 per cent and Exchequer funds would contribute 63 per cent. The Exchequer and local authorities would spend £152 million on the service. In the event of a deficit, "expenses incurred by the Minister in the exercise of his functions ... [would] be defrayed out of moneys provided by Parliament."¹³⁰

Many issues had to be settled by regulation following implementation on 5 July 1948.¹³¹ The Government had not yet secured co-operation from the medical profession.¹³² New administrative structures for hospitals and general practitioner services still needed to be created.¹³³ The NHS Act was in a vulnerable position, reminiscent of the New Zealand Social Security Act in 1938. The underlying principles were clear, but making them operational still required much negotiation.

A plebiscite which the BMA carried out among its members indicated that 64 per cent wanted to drop negotiations with the Minister of Health, meaning that the doctors would not work in the new service.¹³⁴ Two questions had dominated professional negotiation over the years: "on the pay of the hospitals, it [was] the dread of being put under local authority, and on the part of general practitioners, it [was] the fear of this whole-time service."¹³⁵ British doctors were aware of the earlier New Zealand experience: "In New Zealand today, so confused is the situation, there are five systems under which a general practitioner may give his service [whole-time salary, capitation, fee for service, partial refund and full refund]."¹³⁶ As a result by March 1948 a representative meeting of the BMA unanimously decided not to enter the new service on Appointment Day unless substantial changes were made.

The medical profession's united front was short lived. With considerable finesse, Bevan managed to "play on the ancient split in the medical profession ... While the negotiating committee under the aegis of the British Medical Association was awaiting a summons to Whitehall, Bevan was dining with Lord Moran (President of the Royal

¹³⁰ United Kingdom, Ministry of Health, "National Health Service Bill, 23 July," col. 52.

¹³¹ The issue of remuneration would be dealt with through regulations and the Spens Committee. United Kingdom, Ministry of Health and Department of Health for Scotland (MHDHS), Inter-Departmental Committee on the Remuneration of Consultants and Specialists (IDCRCS), "Report, [Chairman Will Spens]," Cmd. 7420, *Accounts and Records* (London: HMSO, 1948)

¹³² By then the branches of the medical profession had split, leaving a divided front to face the Government.

¹³³ The local authorities had to expand their scope.

¹³⁴ *British Medical Journal*, "Yes or no," Supplement, *British Medical Journal* 2(16 November 1946): 739-46.

¹³⁵ United Kingdom, "Lord Moran," Col. 833.

¹³⁶ *British Medical Journal*, "Medical Planning in New Zealand," Supplement, *British Medical Journal* (2 September 1944): 51.

College of Physicians) at Prunier's restaurant in St. James's Street.¹³⁷ Moran wanted to raise the Royal College "to the standing it once held but had largely lost, that of adviser to government on matters of health and medical policy."¹³⁸ Offering the specialists a variety of attractive options, including private practice, part-time appointments and special merit awards for senior and renowned specialists, Bevan "stuffed their mouths with gold."¹³⁹

The general practitioners, in contrast, were offered vague promises that they would not become salaried civil servants. Ambiguous messages, such as "I cannot read into the mind of any future minister ... but it is not our intention.... [and] there is all the difference in the world between plucking fruit when it is ripe and plucking it when it is green," however, lowered the credibility of such assurances.¹⁴⁰ Other comments, such as "I have my spies," raised the suspicions of the BMA even further.¹⁴¹ As a result, Hill mounted an intensive campaign to sabotage the new service. Bevan countered by accusing Hill of being a 'saboteur-in-chief' and leading a 'squalid political conspiracy'.¹⁴²

Members of the BMA, nevertheless, approved the new service through a plebiscite. On 17 June 1948, Dr. Guy Dain, then Chairman of the BMA, admitted the Government's victory: "The profession will do its utmost to make the new service a resounding success."¹⁴³

Epps had advised the Government against making precise estimates of the cost of the new service: "it is impracticable at the present time to attempt to measure with any precision the changes which may occur in the social constitution ... [and] ... the war is not yet finished ... it is impossible to assess the extent of future casualties."¹⁴⁴ The Beveridge Report estimated that health care would cost £132 million under the new system compared with £60 million under the previous system. It was on the basis of these projected figures that the Coalition Government committed itself to public financing for universal entitlement to health care. In 1937 PEP had made a much higher estimate of £400 million. More accurate estimates came to £305 million based on the Net Vote of the

¹³⁷ Bevan quoted in Abel-Smith, *Hospitals*, 486-87.

¹³⁸ By a narrow margin he had just renewed his presidency of the Royal College of Physicians against Lord Holdan. His opponent would have made the negotiations much more difficult. Pater, *National Health Service*, 139.

¹³⁹ Bevan quoted in Abel-Smith, *Hospitals*, 48

¹⁴⁰ United Kingdom, "Aneurin Bevan," House of Commons, *Parliamentary Debates* (London: HMSO, 4 November 1946): Col. 1127.

¹⁴¹ Pater, *Health Service*, 172.

¹⁴² United Kingdom, "Aneurin Bevan," House of Commons, *Parliamentary Debates* (London: HMSO, 9 February 1948): cols. 35-160; and Pater, *Health Service*, 156 and 179.

¹⁴³ Dr. Guy Dain writing to the *Times*, on 17 June 1948, quoted in Ross, *National Health Service*, 126; and Pater, *National Health Service*, 163.

¹⁴⁴ United Kingdom, "Social insurance, part II," 56.

Appropriation Accounts, £388 million based on the Gross Vote and £385 million based a later economic appraisal of the British health sector.¹⁴⁵

C. BARRIERS TO UNIVERSAL ENTITLEMENT

1. Administrative Reorganizations

The final version of the National Health Service included many compromises to meet the conflicting demands made by political groups, underlying bureaucratic realities and interest groups. Details of the final act reflected these pressures. There were no salaried service, no health clinics, no elected representation and no local government control. Instead, general practitioners would retain their independent status in private offices, the service would be administered by appointed executives bodies and regionalism would be based on hospital districts with teaching hospitals retaining a special status. The new service did not include broad preventive measures such as environmental services, housing and nutrition, although it did offer specific measures such as vaccination and immunisation.

The act derived as much from the discussions between the medical profession and the Minister of Health as it did from party politics. The decision to create a national health service stemmed from the political mood of the times, calling for a free service with comprehensive benefits and universal entitlement; the final design revealed the influence of many pressure groups. These very compromises, however, may have spared the British NHS the ill fate of New Zealand's short-lived experiment: "Critics who formerly had lamented the creation of the NHS now congratulated themselves on being its originators."¹⁴⁶

Forty years and two major administrative reorganizations later Bevan's NHS has so far stood the test of time.¹⁴⁷ "The most 'socialist' plan came from the Liberal National minister [Ernest Brown], whilst only a middle of the road plan came from the Labour minister [Aneurin Bevan]: an odd political paradox as a memorial to the power of the medical pressure group."¹⁴⁸ Although the introduction of public financing for universal

¹⁴⁵ United Kingdom, Committee of Enquiry into the Cost of the National Health Service (CECNHS), "Report [Chairman C.W. Guillebaud]," Cmd. 9663, *Accounts and Papers* (London: HMSO, 1956): 7; and Brian Abel-Smith and Richard M. Titmuss, *The Cost of the National Health Service in England and Wales* (Cambridge: Cambridge University Press, 1956): 24.

¹⁴⁶ Charles Webster, *The Health Services Since the War*, Volume I, *Problems of Health Care: The National Health Service Before 1957* (London: HMSO, 1988): 389.

¹⁴⁷ The Conservative Government under Prime Minister M. Margaret Thatcher tried to alter this history of the British NHS. United Kingdom, *Working for Patients: the Health Service, Caring for the 1990s* (London: HMSO, 1989).

¹⁴⁸ Willcocks, *National Health Service*, 85.

entitlement made an important contribution to health care in the United Kingdom, "if someone discovered a universal panacea which would guarantee health for everyone throughout their lives he would be hailed as the greatest man on earth."¹⁴⁹

¹⁴⁹ Murray, *Health*, 149.

CHAPTER 5. CANADA

The enemies we shall have to overcome will be on our own Canadian soil. They will make their presence known in the guise of sickness, unemployment and want. It is to plan for a unified campaign in Canada against these enemies of progress and human well-being that we have come together at this time.

Prime Minister Mackenzie King, 1945

A. FINANCIAL INFRASTRUCTURES

1. The British North America Act of 1867

Early colonial outposts in Canada had military infirmaries staffed by commissioned naval surgeons, overseers, dispensers and untrained nurses as in other regions of the new world. Since the British Treasury financed these primitive medical facilities, Canada can be viewed as having begun its colonial history with a 'nationalized' health service. Civilian needs, however, soon outgrew these primitive provisions.

Many of the settlers who had left Great Britain and France to escape the degrading aspects of the Elizabethan Poor Laws were unable to afford the care offered by the colony's few private doctors. Far from their families, the aged, destitute, disabled and sick therefore had little personal support when they needed medical attention. Instead, they sought assistance from religious groups, benevolent societies, quacks, faith healers and frauds.

Medical doctors working for parishes, charitable institutions and voluntary hospitals offered free treatment to the poor in return for the right to treat their private patients on a fee-for-service basis in the same institutions. The treasuries of public authorities were drawn into financing institutional care when many such institutions ran out of funds to finance their operations.

The British North America Act of 1867, which formed a confederation of Canada's four most populous colonies, limited the Federal Government's involvement in health care to issues of national importance such as quarantine and the maintenance of marine hospitals.¹ The Provinces were given exclusive jurisdiction over "the establishment,

¹ Federal Government responsibility included jurisdiction over the Yukon and Northwest Territories in cooperation with local authorities, the military services, the penitentiaries, the Royal Canadian Mounted Police, immigrants, Indians, Eskimos and some aspect of the health care of public employees.

maintenance, and management of hospitals, asylums, charities, and eleemosynary [charitable] institutions in and for the Province, other than marine hospitals.... [and] generally all matters of a merely local or private nature in the Province."²

The Federal Government initially became involved indirectly in matters relating to health care through its Departments of Agriculture, Marines and Fisheries. At the turn of the century, with a population of 5,371,314 living mainly along the southern border of the country's 9,970,610 square kilometers of mountains, hinterlands and lakes, federal involvement in health care was limited as much by physical as by constitutional restraints.³ It nevertheless established the Department of Health in 1919,⁴ and a Select Standing Committee on Industrial and International Relations reported in favor of a national health programme as early as 1929.⁵ By 1935, the Employment and Social Insurance Act created the framework for a national health and welfare plan. Despite such progress at the federal level, infrastructures for the financing of health care first developed in a piecemeal fashion at the provincial not federal level.

2. Provincial Government Health Programmes

Provincial Governments began assuming greater responsibility for health care following World War I. In British Columbia, the Legislative Commission of 1919 recommended the use of health insurance similar to that found in Europe. Saskatchewan took a different path by passing legislation allowing municipalities to levy taxes to pay for their health care services.

Three early tax-financed systems are worthy of mention: the municipal doctor system, the union hospital system and the municipal hospital care plan. The first allowed rural municipalities to offer a salary as an incentive to attract doctors into their areas. The second permitted joint municipalities to build local hospitals.⁶ The third paid for the

² United Kingdom, "British North America Act (BNA Act)," *Statutes* (29 March 1867): 30 & 31 Victoria 7, sec. 92.7.

³ The population for 1901 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962), 264 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 271.

⁴ The Department of Health, created in 1919, became the Department of Pensions and National Health in 1928 through a merger with the Department of Soldiers' Civil Re-establishment, and the Department of National Health and Welfare in 1944.

⁵ Canada, Select Standing Committee on Industrial and International Relations (SSCIIR), *Report* (Ottawa: King's Printer, 1929).

⁶ The Municipal Hospital Plan in Alberta in 1919 and the Newfoundland Cottage Hospitalisation and Medical Care Plan in 1934 offered similar provisions.

running costs of such hospitals. Although the plans were initially financed entirely through local taxes, they required provincial subsidies almost from the outset.⁷

One region, the Swift Current Health Region No. 1, in Saskatchewan, formed the testing ground for the Province's future medicare programme.⁸ The region paid its doctors through funds collected from local taxes, supplemented by provincial grants. Doctors in the region welcomed the initiative since they could not survive on the income that they earned from fee-for-service in private practice.

Other Provinces followed Saskatchewan's lead with programmes of their own. In British Columbia, the Royal Commission on State Health Insurance of 1932 recommended a Provincial Government health insurance programme. Protest from the medical profession and the Manufacturer's Association, however, led to a defeat of the legislation in 1935. Alberta and Manitoba experimented with salaried municipal doctor and hospital plans during the 1930s and 1940s. In Alberta, two Commissions of Inquiry reported in favour of Provincial Government health insurance in 1929 and 1933, but the Government which came to power in 1935 dropped the Health Insurance Act. Manitoba developed a similar plan, and Ontario established the first provincial fund to provide payments for doctors.⁹

By 1937, the Great Depression had forced two-thirds of the population of Saskatchewan onto some form of relief. This created "a mood of rebellion against the universal risks of unemployment and sickness, disability and old age, widowhood and poverty."¹⁰ Those needing help resented having to "crawl on [their] hands and knees to a municipal official before [they could] be admitted to hospital."¹¹

Local rate-payers of municipalities, many of which were near bankruptcy, could no longer carry the financial burden for the sick and poor.¹² The limited personal resources, scattered rural populations and the economic risks of a "one-crop boom or bust grain economy" forced people to look to public financing of health care.¹³

⁷ Dr. Matt Anderson, who had known a similar plan as a boy in Norway, started the first tax-based municipal doctors' systems in Saskatchewan. Robin F. Badgley and Samuel Wolf, *Doctors' Strike: Medical Care and Conflict in Saskatchewan* (New York: Atherton Press, 1967): 13.

⁸ Other early plans included the Rural Doctor Plans of Saskatchewan in 1917 and Manitoba in 1921. E.A. Tollefson, *Bitter Medicine: The Saskatchewan Medicare Feud*, Prairie Books (Saskatoon: Modern Press, 1964): 40.

⁹ Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System* (Montréal: McGill-Queen's University Press, 1978): 6.

¹⁰ Taylor, *Health Insurance*, 2. Personal communication with Dr. Malcolm G. Taylor, historian and professor of political science, University of York, Toronto.

¹¹ Taylor, *Health Insurance*, 4.

¹² The forerunners to these programmes began in Saskatchewan in 1914 in the rural municipality of Sarnia. Taylor, *Health Insurance*, 70.

¹³ Badgley and Wolf, *Doctors' Strike*, 3.

In June 1944, the Cooperative Commonwealth Federation (CCF) took office in Saskatchewan.¹⁴ Tommy C. Douglas, the new Premier, reserved the health portfolio for himself as a signal of the high priority that he would place on health care. He pledged that "someday ... people would be able to get health services just as they [were] able to get educational services, as an inalienable right of being a citizen."¹⁵

By 1946, Saskatchewan was ready to pass its Hospitalization Act despite the lack of financial support for the programme from the Federal Government. It was the first provincial programme to offer universal entitlement to hospital insurance in Canada.¹⁶ That same year, the Saskatchewan Health Services Act expanded the scope of the municipal doctor plans to cover broader health regions.

Other Provinces followed the Saskatchewan example. British Columbia, which introduced its Hospital Insurance Service in 1948, had the painful experience of trying to establish a new infrastructure for collecting its premiums.¹⁷ The oldest Canadian colony, Newfoundland, already had an operating cottage hospital system when it joined the Canadian Confederation in 1949. Alberta introduced limited hospital benefits in 1950 through provincial subsidies for municipal programmes.

Most of the poorer Provinces, however, did not have the economic means to finance health care. Despite constitutional limitations, therefore, the time was ripe for a re-evaluation of federal involvement in the financing of health care.

3. Heagerty Committee Draft Bill of 1944

In 1937, the Rowell-Sirois Royal Commission on Dominion-Provincial Relations examined ways that the Federal Government could become more directly involved in areas of provincial jurisdiction.¹⁸ The Commission warned that constitutional reforms alter the nature of the country, while cost-sharing would lead to a reduced sense of responsibility. This left grants-in-aid as the only option for the Federal Government to finance national programmes that were under provincial jurisdiction.

The Commission recommended greater federal involvement in unemployment insurance and old age pensions, while the Provinces should retain responsibility for health

¹⁴ The party was the forerunner to the New Democratic Party.

¹⁵ Tommy Douglas on 2 April 1954 quoted from the *Regina Leader Post* by Taylor, *Health Insurance*, 81.

¹⁶ The Saskatchewan Hospitalization Act came into effect on 1 January 1947.

¹⁷ Personal communication with Lloyd F. Detwiller, former Commissioner of the British Columbia Hospitals Insurance Service in 1951.

¹⁸ Canada, "Employment and Social Insurance Act," *Statutes* (1935).

insurance and workmen's compensation.¹⁹ "In recommending [maintenance of] provincial jurisdiction over Health Insurance we are aware ... that it may result in inequalities."²⁰

In 1939, Ian MacKenzie, the Minister of Health, suggested to Prime Minister Mackenzie King that the "demand for a national health system is inevitable."²¹ As a result, Dr. J.J. Heagerty, the Director of Public Health, began working on the plans for a Canadian health service in 1941.²² His report was completed in 1943.²³

Following a review of health insurance programmes in Germany, Britain, France and South Africa, the Canadian Medical Association's Advisory Committee on Health Insurance recommended similar insurance for Canada.²⁴ "The CMA ... stands ready to render any assistance in its power towards the solution of one of the country's most important problems, namely the safeguarding of the health of our people."²⁵ The Association had for some time wanted to relieve its members of the burden of providing free care to those who could not afford to pay.

Other organizations supported national involvement in the financing of health care during the 1940s. These included the Canadian Hospital Council, the Canadian Dental Association, the Canadian Life Insurance Officers Association, the Canadian Trades and Labour Congress, the Canadian Congress of Labour and the Canadian Federation of Agriculture.

By 1943, the various groups had completed the first blueprint of a Canadian health insurance plan which advanced several principles: universal entitlement, compulsory membership, prevention, national participation in financing and provincial jurisdiction over the delivery of services.²⁶ The Provinces would pay for the administrative cost while

¹⁹ Canada, Royal Commission on Dominion-Provincial Relations (RCDPR), *Report [Chairman Rowell-Sirois]*, Ottawa: (King's Printer, 1937).

²⁰ Canada, RCDPR, *Rowell-Sirois*, 40-41.

²¹ Ian Mackenzie on 27 December 1939 quoted in Taylor, *Health Insurance*, 16.

²² He used the expertise of the Dominion Council of Health and Dominion Bureau of Statistics (Inter-Departmental Advisory Committee of Health Insurance) to help him draft his plan. The Dominion Council of Health comprised the Ministers of Health from the Provinces.

²³ Canada, Special Committee on Social Security (SCSS), *Report of the advisory committee on health insurance [Chairman J.J. Heagerty]* (Ottawa: King's Printer, 1943).

²⁴ Canadian Medical Association (CMA), Committee on Economics (CE), *Report* (Ottawa: CMA, 1943).

²⁵ The Canadian Medical Association gave evidence to the House of Commons Special Committee on Social Security. Canadian Medical Association, General Council (GC), *Special meeting: Transactions* (Ottawa: CMA, 18 to 19 January 1943); and Canada, House of Commons Special Committee on Social Security (HCSCSS), *Report [Chairman Cyrus MacMillan]* (Ottawa: King's Printer, 1943): 145.

²⁶ Canada, Advisory Committee on Health Insurance (ACHI), *Report [Chairman W.C. Clarke]* (Ottawa: King's Printer, 1943): xi-xxii. Other committees supporting national programmes for social security and health reported during the same year: Canada, HCSCSS, *Cyrus MacMillan*; Canada, SCSS, *Chairman J.J. Heagerty*; and Canada, Committee on Health Insurance Finance (CHIF), "Interim report," *Brooke Claxton Papers* (28 December 1943).

the Federal Government would pay for any expenses not covered by the amount collected from the insured.

W.C. Clarke, the Deputy Minister of Finance, however, advised that federal participation in social security and health insurance should be postponed until after negotiations for a complete re-ordering of the financial relationship between the Provinces and the Federal Government. As a result, the original national health insurance plan was dropped and committees continued working on alternatives throughout the duration of World War II.

MacKenzie and Heagerty nevertheless wanted to proceed with their plan. The rejection rates for preventable conditions had been unacceptably during World War II. Infant mortality rates and maternal mortality rates were high compared with those of other developed countries; so were deaths from communicable diseases such as tuberculosis, influenza, whooping cough and measles.²⁷

By May 1944, the provincial Ministers of Health and their Deputies, the House of Commons Committee, the Advisory Committee and the Finance Committee all approved a draft legislation on health insurance. The Medical Association endorsed the plan clause-by-clause. All political parties supported Federal Government financing of health care during the campaign leading up to the 11 June 1945 general elections.²⁸ Finding a way to extend federal jurisdiction over health care remained the only stumbling block.²⁹

4. Dominion-Provincial Conference of 1945

Inspired by the work of William Beveridge in Britain, Mackenzie King, the Canadian Prime Minister, called for a Dominion-Provincial Conference on post-war reconstruction in 1945.³⁰ "Our lives have been given over largely to life-long study of social problems."³¹ King supported what Winston Churchill called the 'magic' of insurance.³²

²⁷ Canada, National Health and Welfare (NHW), *Illness and Health Care in Canada: Canadian Sickness Survey 1950-51* (Ottawa: Queens Printer, 1960).

²⁸ The parties on the ballot consisted of the Liberal Party led by Mackenzie King, the Conservative Party led by John Bracken of Manitoba, the Cooperative Commonwealth Federation (the New Democratic Party after 1961) led by Stanley Knowles, the Social Credit Party and the Communist Party.

²⁹ An opinion poll indicated that 80 per cent of Canadians supported a national hospital and medical care insurance plan. Taylor, *Health Insurance*, 48.

³⁰ Beveridge visited Ottawa in May 1943.

³¹ Mackenzie King, *Industry and Humanity* quoted in J.W. Pickersgill, *The Mackenzie King Record: 1939-1944*, Volume 1 (Toronto: University of Toronto Press, 1960): 546.

³² Winston Churchill quoted in Taylor, *Health Insurance*, 67.

Leonard Marsh, who had known Beveridge at the London School of Economics and Political Science, was appointed Chairman of a Special Social Security Commission.³³ In his report of 1943, Marsh recommended federal involvement in financing of health care.

When Brooke Claxton succeeded Ian MacKenzie as Minister of the Department of Pensions and National Health, he carried out a departmental reorganization which led to the creation of the Department of National Health and Welfare in 1944. Other members of the Cabinet Committee did not share the new Minister's enthusiasm for constitutional reform to secure the necessary federal jurisdiction over health care.³⁴ King, nevertheless, appointed Claxton as Chairman of a Supervisory Committee of Parliamentary Assistants to oversee the work of the Dominion-Provincial Conference planned for 1945.³⁵

The Green Book proposals presented at the conference were complex. The Federal Government wanted exclusive right to levy personal and corporate income taxes, and succession duties. In return, the Provinces would obtain unconditional annual subsidies for a variety of social security programmes, such as unemployment insurance, children's allowance, pensions, health insurance, and financial assistance for the indigent, aged and physically handicapped.³⁶ The Provinces could finance their share through whichever means they chose, excluding those reserved for the Federal Government.

The Federal Government would finance 20 per cent of the basic cost of a comprehensive social security programme through a Dominion Grant. In addition, it would cover 50 per cent of the running cost up to a predetermined limit. Based on the 1941 census, the estimated annual cost of such a programme would be \$250 million, of which the federal contribution would be \$150 million.³⁷

The Provinces, however, demanded large financial concessions without wanting to surrender the tax fields desired by Ottawa. Premier Drew of Ontario presented a counter-proposal that the Federal Government felt was too expensive. Premier Maurice Duplessis, as expected, accused the Federal Government of interfering with Québec's provincial jurisdiction over health care.

³³ Canada, *Report for social security for Canada [Chairman Leonard Marsh]* (Ottawa: King's Printer, April 1943); and Paul Martin, *A Very Public Life - Far From Home*, Volume 1 (Ottawa: Deneau, 1983): 316.

³⁴ The protest from the Minister of Justice, Louis St. Laurent, foreshadowed the stance he would take later as Prime Minister.

³⁵ The provincial Premiers attending the Conference included Drew from Ontario, Duplessis from Québec, Manning from Ontario, Douglas from Saskatchewan.

³⁶ Canada, Dominion-Provincial Conference (DPC), *1945 Proceedings: Green Book Proposals* (Ottawa: King's Printer, 1945). By 1945, Canada, Australia and the United States were the only three industrialized nations to lack significant social security legislation which included health care provisions.

³⁷ Canada, DPC, *1945 Proceedings*.

The proposals for health care included grants for planning and organization, health insurance grants, health grants and financing for the construction of hospitals.³⁸ Health insurance would cover general practitioner services, hospital care and visiting nurses and later include consultants, specialists, nursing, dental, pharmaceutical and laboratory services.

It soon became evident, however, that to negotiate the terms of a national health insurance programme at a Federal-Provincial Conference on tax reforms was a bad strategy. The Provincial Governments, many of which had already started to introduce their own plans, rejected the joint package.

5. National Hospital and Diagnostic Services Act of 1957

Ten years would pass before another Federal-Provincial Conference would address the same issues. In the intervening time, anticipating a shortage in hospital beds, Paul Martin who replaced Claxton as Minister of Health, started introducing the Green Book Health Grants in 1948.³⁹ "My ultimate aim was to eliminate the extremes of poverty and wealth.... I proposed that government eat away at big incomes ... in favor of an economic and social programme."⁴⁰

The Provinces received grants for the construction of hospitals and to carry out health surveys (planning and organization). "The Prime Minister had seen exactly what I was trying to do -- creating a demand for government action."⁴¹ By the 1950s, many Provinces had begun increasing their institutional capacity by 'milking Martin's millions'.⁴²

During the 1949 federal elections, all political parties advocated some form of health insurance.⁴³ Eighty per cent of the population supported national participation.⁴⁴ During the 1953 elections, the tide had changed.⁴⁵ The Liberal Party platform by this time supported a continuation of the provincial health grants rather than a national health insurance programme: "The Liberal Party is committed to support a policy of

³⁸ According to the British North America Act of 1867, the Provinces also had jurisdiction over medical education.

³⁹ As the general manager of the Metropolitan Life Insurance Company, after a short period in the Ministry of Defence, Claxton became an ardent opponent to medicare.

⁴⁰ Martin, *Public Life*, 317. Personal communication with Paul J.J. Martin, the Minister of Health from 1946 to 1957.

⁴¹ Martin, *Public Life*, 40.

⁴² Taylor, *Health Insurance*, 164.

⁴³ D. Owen Carrigan, *Canadian Party Platforms 1867-1968* (Toronto: Copp Clark, 1968). The major parties were the Liberal Party, the Progressive Conservative Party, the Cooperative Commonwealth Federation and the Social Credit Party.

⁴⁴ Results of a Gallop Poll reported in the *Toronto Daily Star* (13 July 1949) discussed in Taylor, *Health Insurance*, 166.

⁴⁵ Only the Social Credit Party made no direct reference to health insurance in 1953.

contributory health insurance to be administered by the Provinces when most of the Provinces are ready to join."⁴⁶

During the 1955 Federal-Provincial Conference, the issue of national hospital insurance forced itself back onto the agenda in an unforeseen manner.⁴⁷ Trying to avoid a replay of the errors committed in 1945, Prime Minister Louis St. Laurent thought that the "conference [was] most likely to succeed" if the agenda was restricted to a "limited number of subjects of primary importance."⁴⁸ He therefore intended to prevent the provinces from bringing health insurance into the discussions.⁴⁹

Leslie Frost, Ontario's new Conservative Premier, felt that the allegations that the Provinces were holding back health insurance were directed at Ontario.⁵⁰ He raised his objections to these charges at the Federal-Provincial Conference: "Since [health insurance] is one of the great objectives in the field of human betterment, it should be placed on the agenda for study."⁵¹ Most of the other Provinces supported Ontario's proposition, forcing the reluctant Prime Minister to include health insurance in the discussions.⁵²

Following the Conference, St. Laurent appointed a special Federal-Provincial Committee on Health Insurance to examine possible ways that the Federal Government could negotiate the terms of such a plan with the Provinces. He was supported by Martin who wanted "the health grants ... broken away from the fiscal and other social aspects ... [to] prepare the way for introducing health insurance at some later date."⁵³

The Federal Government offered to contribute 25 per cent of the national average per capita cost of hospital services plus 25 per cent of the provincial average per capita cost. This would equalise benefits between the poorer and richer Provinces; the former would receive more than 50 per cent, while the latter would receive less than 50 per cent as a federal grant.

In return for these federal grants, the Provinces had to establish comprehensive hospital and diagnostic services, universal entitlement, out-patients departments and

⁴⁶ The Liberal Party platform for the 1953 general election quoted in Taylor, *Health Insurance*, 108.

⁴⁷ The term 'national health insurance' is a misnomer since the intention was always to use general revenues for the Federal Government component.

⁴⁸ Canada, Federal-Provincial Conference (FPC), *1955 Proceedings* (Ottawa: Queen's Printer, 1955): 2.

⁴⁹ The provincial Premiers attending the Conference were Duplessis (Québec), Frost (Ontario), Hicks (Nova Scotia), Robichaud (New Brunswick), Matheson (Prince Edward Island), Bennett Sr. (British Columbia), Smallwood (Newfoundland), Douglas (Saskatchewan), Campbell (Alberta) and Manning (Alberta).

⁵⁰ Drew became the Conservative Party leader in Ottawa.

⁵¹ Canada, FPC, *1955 Proceedings*, 12-15.

⁵² Québec abstained.

⁵³ Martin, *Public Life*, 47.

prohibit co-insurance. The Provinces also had to cover the full administrative cost: "The governments of the various Provinces [had] to take the initiative in working out plans adapted to local conditions."⁵⁴ Federal support would not start until a majority of the Provinces representing a majority of Canadians, entered into such an agreement with Ottawa.⁵⁵

A variety of circumstances still worked against the establishment of a national programme. First, constitutional legality of a federal-provincial contract for financing health insurance was still uncertain. Second, hospitals were distributed unevenly throughout the Provinces, making services unavailable to many. Third, other programmes such as defence and pensions competed with health care for public funds. Finally, the Canadian Medical Association had abandoned its previous 1943 endorsement of public involvement in a national health insurance programme in 1949.⁵⁶ By the 1950s, the medical profession was fully committed to backing voluntary insurance.⁵⁷

But the most important stumbling block to a national health insurance programme was lack of cooperation from Ontario, without which the Federal Government's demand for support from a majority of Provinces could not be achieved. Frost was determined to avoid introducing universal entitlement which would require compulsory membership and be unpopular with his conservative constituents. To avoid compulsory membership, he asked Ottawa to accept 90 per cent as 'universal'. Following extensive negotiations and an informal promise that Ontario would 'soon' offer universal entitlement on a voluntary basis, the Federal Government accepted Frost's offer.⁵⁸

On 28 March 1957 Ontario finally passed the Hospital Services Commission Act, giving the go-ahead to the Federal Government. Later on 10 April 1957 the Federal Government passed the Hospital Insurance and Diagnostic Services Act by a unanimous vote in the House of Commons; on 12 April 1957 the Senate also gave it a unanimous vote of support.⁵⁹ Ontario introduced its Hospital Services Plan on 1 January 1959. By the end of the year, 92.3 per cent of Ontario's population had joined the provincial programme. This encouraged the other Provinces to enter the agreement.

⁵⁴ Canada, FPC, *1955 Proceedings*, 3-4.

⁵⁵ In practical terms, this meant Ontario plus five other Provinces.

⁵⁶ The 1943 programme was based on a report from 1933. The General Council of the Canadian Medical Association unanimously endorsed this programme on 18 January 1943. The House of Commons Advisory Committee on Health Insurance reported these findings on 23 July 1943.

⁵⁷ Canadian Medical Association, *Policy Statement* (Ottawa: CMA, 1955).

⁵⁸ Other Provinces, wanting to avoid a debate over compulsory insurance, abandoned the premium system in order to comply with the 'universal' clause.

⁵⁹ Opposition leaders were Diefenbaker (Progressive Conservative Party), Knowles (Cooperative Commonwealth Federation) and Hansell (Social Credit Party).

In 1957, before the new Hospital Insurance and Diagnostic Services Act could be implemented at the provincial level the Liberals lost the general election to the Progressive Conservatives. John G. Diefenbaker became the new Prime Minister. During the campaign leading up to the election Diefenbaker had supported a national hospital insurance plan: "We in the Opposition throughout the years have favoured this type of legislation."⁶⁰ Once in office, he amended the Hospital Insurance Act on 26 June 1958, advanced the date of implementation to 1 July 1958, eliminated the six-Province criterion and allowed inclusion of mental and tuberculosis services.⁶¹

Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia already had plans that qualified for federal cost-sharing; Nova Scotia, New Brunswick and Ontario were ready by 1 January 1959. Prince Edward Island joined on 1 October 1959. The Northwest Territories joined on 1 April 1960 and the Yukon on 1 July 1960. Finally, Québec joined on 1 January 1961.

During the 1940s, both the Heagerty Committee and the Canadian Medical Association had advocated a parallel expansion in institutional care, ambulatory care, diagnostic test, convalescent care, chronic care and home care. The introduction of hospital insurance in isolation of other services had many shortcomings. It depended on the good will of hospitals, doctors, civil servants and citizens to use resources without marketplace restraints. It discouraged the use of cheaper and more appropriate ambulatory care, which had to develop independently at the Provincial Government level before federal involvement in their financing.

6. Provincial Health Insurance

The Swift Current Health Region No. 1 medical plan had tested the ground for the tax-supported approach in Saskatchewan. The new federal contribution offered under the Hospital Insurance and Diagnostic Services Act allowed the Provinces that already had provincial hospital insurance to use the new funds to extend other programmes. With new \$13.3 million to finance its hospital plan, Saskatchewan now introduced a provincial health plan to pay for doctors' services.⁶²

⁶⁰ Canada, "John G. Diefenbaker," House of Commons, *Debates* (4 April 1957).

⁶¹ No Province exercised the option of financing their psychiatric services in this way because the Federal Government would subtract from other subsidies an amount equal to the added cost of these services. Instead, most Provinces established psychiatric wards in general hospitals which were covered under the programme.

⁶² British Columbia would use its new funds to subsidise doctors' services for low-income groups, while encouraging the rest of the population to subscribe to voluntary insurance.

The Cooperative Commonwealth Federation had promised the electorate a comprehensive Provincial Government health service throughout its 15 years in power.⁶³ T.C. Douglas renewed his commitment to this policy by promising to uphold "the dignity of the individual ... the undeniable right of every person to health, opportunity and freedom," by introducing universal entitlement to doctors' services.⁶⁴

The Saskatchewan medical profession, led by Dr. Harold Dagleish, hired public-relations experts to conduct a publicity campaign against the Provincial Government's programme.⁶⁵ The doctors argued that universal entitlement and compulsory membership was a threat to their freedom; their stance echoed the arguments used earlier in New Zealand and the United Kingdom. At a general meeting of the Saskatchewan Medical Association, the medical profession voted to refuse to cooperate in carrying out the plan.⁶⁶

After Douglas left provincial politics to lead the federal branch of the Cooperative Commonwealth Federation (CCF), renamed the New Democratic Party (NDP) in 1961, Premier Woodrow S. Lloyd introduced Saskatchewan's health care legislation. Lloyd appointed William G. Davies, a former trade-unionist, as his Minister of Public Health. Davies adopted a strategy of non-communication with the medical profession: "Much damage was done by the failure of the two sides to talk to each other."⁶⁷

Understanding between the Government and the doctors deteriorated rapidly. Both parties adhered to their deeply entrenched ideological beliefs and viewed each other with suspicion. Anticipating work-stoppage pressure tactics, the Government began recruiting doctors from other Provinces and the United Kingdom.

With the support of the Canadian Medical Association, which acted as sponsor for eleven voluntary insurance plans, the Saskatchewan doctors mounted a strong political lobby against the proposed legislation.⁶⁸ When Saskatchewan passed its Medical Care Law on 17 November 1961, the discussions between the medical profession and the Government had completely broken down.

⁶³ The Saskatchewan Medical Care Advisory Planning Committee visited Australia, New Zealand, U.K., Norway, Sweden, Denmark and Holland to obtain information about their health care plans.

⁶⁴ Saskatchewan, "Throne speech [Premier T.C. Douglas]," *Legislative Assembly Debates* (17 April 1960).

⁶⁵ They copied the tactics that the American Medical Association had used to oppose such a plan in the United States. Badgley and Wolf, *Doctors' Strike*, 30.

⁶⁶ Badgley and Wolf, *Doctors' Strike*, 40.

⁶⁷ Badgley and Wolf, *Doctors' Strike*, 44.

⁶⁸ Malcolm G. Taylor, "The role of the medical profession in the formulation and execution of public policy," *Canadian Journal of Economics and Political Science* 25(February 1960): 108-127 and 108-127; and Taylor, *Health Insurance*, 334.

The plan was nevertheless implemented on 1 July 1962 despite 23 days of doctors' strike and a leadership crisis.⁶⁹ By the time the strike ended, the medical profession was accused of having sacrificed patient care to protect its own self-interests, causing doctors to lose much prestige and public sympathy.⁷⁰

B. LANDMARK LEGISLATIVE REFORMS

1. Royal Commission on Health Services

It was Dr. A.D. Kelly, the Executive Director of the Canadian Medical Association, who approached the Diefenbaker Conservative Government to "establish a committee to study the existing and projected health needs and health resources of Canada."⁷¹ The medical profession hoped that such a Commission, appointed by a Conservative Government, would rule in favour of voluntary insurance, thereby avoiding a repetition of Saskatchewan's unfortunate experience. The Prime Minister accepted the request by establishing the Royal Commission on Health Services.⁷²

Diefenbaker appointed a life-long friend, Chief Justice Emmett M. Hall, as Chairman of the Commission. Both came from poor families in Saskatchewan. Both graduated from the same law school in 1919.⁷³ Both were self-proclaimed champions of the needy and believed in the welfare provided by the state. And both came from a Province that accepted universal entitlement to health care as a necessary and just part of public policy.⁷⁴

The reports of the Royal Commission on Health Services were published in 1964 and 1965.⁷⁵ They stressed both the humanitarian and economic grounds for a national programme: "We now believe that an individual family should not have to bear alone the

⁶⁹ The Cooperative Commonwealth Federation lost the 1964 provincial election.

⁷⁰ Badgley and Wolf, *Doctors' Strike*, xi. At the time Canada was the eighth country to introduce universal health care legislation. It was the first to have a doctors' strike over such legislation.

⁷¹ Canadian Medical Association, Committee on Economics (CE), "Transactions of the 94th annual meeting of the CMA," (Ottawa: CMA, 19 to 21 June 1961): 29.

⁷² Canada, Royal Commission on Health Services (RCHS), *Report [Chairman Emmett M. Hall]* (Ottawa: Queen's Printer, 1964).

⁷³ Other members of the Commission were Dr. David Baltzan, a surgeon, Dr. Arthur van Wart, a past president of the Canadian Medical Association, Alice Girard, Dean of University of Montréal School of Nursing, Dr. Leslie Strachan, a dentist and former president of the Ontario Dental Association, Wallace McCutcheon, an industrialist, and Dr. O.J. Firestone, an economist. Professor Bernard Blisshen was research director. Dr. Pierre Jobin and M.G. Taylor were research consultants.

⁷⁴ Diefenbaker's introduction of the Canadian Bill of Rights and Fundamental Freedoms was a great achievement; it makes no mention, however, of social rights or more specifically, rights to health care.

⁷⁵ Personal communication with Justice Emmett M. Hall. Although there was no minority report, winning unanimous support from all the Commissioners required much personal effort by Hall.

full cost of risks that could happen to anyone [sic] of us."⁷⁶ The Canadian Sickness Survey during the 1950s had shown that illness and utilisation of health care services were both directly related to income.⁷⁷

"To the extent, then, that health expenditures prevent or shorten periods of sickness, reduce the extent of disability, postpone death and contribute to the productivity of citizens, then to that degree health expenditures are investments in our human resources, with the prospect of rich dividends."⁷⁸

The first report made an extensive analysis of the protection offered through voluntary pre-payment plans, commercial insurance and cooperatives which had all become increasingly popular during the 1950s and early 1960s.⁷⁹ Through mergers and extensions, these plans offered increasingly complex coverage (deductibles, co-insurance and inter-provincial transportability).⁸⁰ The private insurance industry formed a national group, the Canadian Health Insurance Association (CHIA) in 1959. The medical profession established its own national association, the Trans-Canada Medical Plans (TCMP) in 1951.⁸¹ By the 1960s, the TCMP aimed at offering uniform national coverage and portability across the country.⁸²

Several provincial programmes had likewise opted for the insurance model. On 11 March 1963, Alberta had introduced legislation to subsidise the memberships of low-income earners to encourage them to join voluntary organizations. By October of the same year, voluntary insurance covered 84 per cent of Alberta's population. In April 1963, Ontario had introduced similar medicare legislation to encourage purchase of voluntary insurance, the Ontario Medical Services Insurance Plan. British Columbia followed the example of Ontario, establishing its own agency, the British Columbia Medical Plan, to insure those who could not afford to subscribe to private plans.

Voluntary insurance, however, posed many problems. It offered limited comprehensiveness, incomplete coverage and inequitable access. High premiums excluded the poor. Waivers, waiting periods and carrier cancellation privileges excluded the ill. The excluded were the segment of the population who often needed health care the most, those who sought attention through hospitals and those who received federal

⁷⁶ Canada, RCHS, *Emmett M. Hall*, 5.

⁷⁷ Canada, (NHW), *Illness and Health Care*.

⁷⁸ Canada, RCHS, *Emmett M. Hall*, 6

⁷⁹ C. Howard Shillington, *The Road to Medicare in Canada* (Toronto: Del Graphics, 1972): 44-64.

⁸⁰ Shillington, *Road to Medicare*, 104.

⁸¹ Shillington, *Road to Medicare*, 93.

⁸² Shillington, *Road to Medicare*, 100 and 143. The Canadian Medical Association participated closely in the administration of the TMCP.

and provincial assistance. Finally, the private insurance organizations kept high retention rates despite their public subsidies.⁸³

The commission estimated that to subsidise health insurance premiums, once expenditure rose beyond 5 per cent of income, would require means-testing 10 million Canadians; raising the level to 7 per cent would require means-testing of 15 million.⁸⁴ The Commission also claimed that, although, the federal financial contribution was already 80 per cent of the anticipated full cost of a comprehensive service, it left the most needy unprotected. The cost of extending coverage to the additional 20 per cent would amount to \$466 million: "Surely a nation which spent \$973 million on alcohol ... could afford half of that amount for a vastly improved health system."⁸⁵

The Commission, therefore, recommended that Canadian health policy should correct "the paradox of our age ... the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other."⁸⁶ Canadians would achieve this goal through the application of a *Health Charter for Canadians* enunciated in the report:⁸⁷

The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal Health Services Programme for the Canadian People,

IMPLEMENTED in accordance with Canada's evolving constitutional arrangements;

BASED upon freedom of choice, and upon free and self-governing professions;

FINANCED through prepayment arrangements;

ACCOMPLISHED through the full cooperation of the general public, the health professions, voluntary agencies, all political parties and governments, federal, provincial, and municipal;

DIRECTED towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being.

Universal entitlement meant "adequate health services ... available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations

⁸³ Canada, RCHS, *Emmett M. Hall*, 421.

⁸⁴ Malcolm G. Taylor quoting Hall in Dennis Gruending, *Emmett Hall* (Toronto: Macmillan, 1985), 90.

⁸⁵ Gruending, *Emmett Hall*, 95.

⁸⁶ Canada, RCHS, *Emmett M. Hall*, 10.

⁸⁷ Canada, RCHS, *Emmett M. Hall*, 11.

imposed by geographic factors." Comprehensive services meant "all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide."⁸⁸

To avoid a constitutional challenge, the programme would maintain provincial jurisdiction over health care, allowing the Provinces to finance their share through "premiums, subsidized premiums, sales or other taxes, supplements from provincial general revenues and ... by federal grants taking into account provincial fiscal need."⁸⁹ It would also preserve the freedom of patients to choose their own doctor and the freedom of the medical profession to remain self-governing.⁹⁰

The medical profession and members of the Conservative party who had advocated the appointment of the Commission reacted with consternation. They could not understand how a group of "establishment types, appointed by a Conservative Prime Minister" could arrive at a unanimous decision to advocate universal entitlement, comprehensive benefits, compulsory membership and public financing.⁹¹

By the time the Royal Commission presented its reports, however, the Conservative Party was no longer in power. During the campaign leading up to the 1963 general elections, the Liberal Party had pledged to "establish a medical care plan for all Canadians" in cooperation with the Provinces.⁹² The NDP was equally committed to a national programme.⁹³ Neither the Progressive Conservative Party nor the Social Credit Party, however, mentioned health care in their 1963 election platforms.⁹⁴

Hall defended his recommendations by embarking "on a series of highly controversial public speeches, all urging the implementation of his report, and quickly."⁹⁵ He later defended his actions: "I think we [Hall and Douglas] can both take some satisfaction out of knowing that we have helped push back a little the shadows of fear and anxiety from the lives of many people."⁹⁶ Hall's new audience was attentive.

⁸⁸ Canada, RCHS, *Emmett M. Hall*, 11. The comprehensive provisions were short-sighted, leaving out most ambulatory services other than Doctor's visits.

⁸⁹ Canada, RCHS, *Emmett M. Hall*, 12.

⁹⁰ Canada, RCHS, *Emmett M. Hall*, 11.

⁹¹ Gruending, *Emmett Hall*, 99.

⁹² Taylor, *Health Insurance*, 333.

⁹³ The NDP, formed in 1961, was the federal wing of the Saskatchewan Cooperative Commonwealth Federation.

⁹⁴ Carrigan, *Party Platforms*, 1968.

⁹⁵ This was an unprecedented and questionable action for a Supreme Court Judge to take. Judy LaMarsh, *Memoirs of a Bird in a Gilded Cage* (Toronto: McClelland and Stewart, 1968): 120.

⁹⁶ Tommy Douglas quoted in Gruending, *Emmett Hall*, 80. Personal communication with Emmett M Hall.

2. Federal-Provincial Conference of 1965

Prime Minister Lester B. Pearson, leader of the new Liberal Minority Government, signaled his party's renewed commitment to a national health plan in the Throne Speech of 5 April 1965: "My government will at an early date meet with the governments of the Provinces in order to discuss with them ways in which federal and provincial action can most effectively contribute to programs [sic] that will provide health services to Canadians on a comprehensive basis."⁹⁷ He appointed Walter L. Gordon as Minister of Finance and Judy LaMarsh as Minister of Health and Social Welfare.

A special Federal-Provincial Conference on Health, recommended by the Royal Commission, started on 19 July 1965.⁹⁸ "[It is] the responsibility of the Federal Government to cooperate with the Provinces in making Medicare financially possible for all Canadians."⁹⁹ The conference established four principles for such a service: comprehensive doctor services (general practitioners and specialists), universal entitlement, inter-provincial portability and administration by a public authority.¹⁰⁰ "[The] provision of health services ... the item of our agenda which is most important of all ... [making it] the responsibility of the Federal Government ... [to make] medicare financially possible for all Canadians."¹⁰¹

The Liberal Minority Government needed support from the NDP, led by Douglas, to stay in power.¹⁰² Social legislation, like the national health care programme, was certain to secure this support.

Gordon, had previously been instrumental in developing the party strategy that brought the Liberals back to power; he was the first Minister of Finance with a sympathetic attitude toward a national health care programme.¹⁰³ "A rich man's son from upper-class Tory Toronto who embraced relatively radical views and grew more radical

⁹⁷ Lester Pearson quoted from the Throne Speech. Canada, Parliament, House of Commons, *Debates* (1965): 2-3. The Liberal Party's commitment to a national health insurance programme first appeared in a policy paper in 1919. Carrigan, *Party Platforms*; Taylor, *Health Insurance*, 220; and Martin, *Public Life*, 457.

⁹⁸ Canada, "Throne speech by Prime Minister Lester B. Pearson," House of Commons, *Debates* (5 April 1965): 2-3.

⁹⁹ Canada, Federal-Provincial Conference (FPC), *1965 Proceedings* (Ottawa: Queen's Printer, 19 to 22 July 1965).

¹⁰⁰ A Health Resources Fund would finance medical schools and teaching hospitals.

¹⁰¹ Lester Pearson quoted in the opening address. Canada, Federal-Provincial Conference (FPC), *1965 Proceedings* (Ottawa: Queen's Printer, 19 to 22 July 1965).

¹⁰² The Liberals had 129 seats, NDP 17 seats, Conservatives 95 seats and Social Credits 24 seats.

¹⁰³ Gordon was the Chairman of the Policy Committee of the National Rally of the Liberal Party in 1961.

with age ... made Bay Street shudder."¹⁰⁴ He wanted "better standards of education, better provisions for our old people [and] proper medical care for everyone."¹⁰⁵

LaMarsh had encountered the "shocking examples of the devastating impact of the costs of long-term medical care on meager incomes."¹⁰⁶ Her mother's terminal illness and depletion of her husband's lifetime savings to meet medical expenses had taught her the financial tragedies resulting from the failings of the voluntary health insurance system: "The subject matters dealt with in 'NH&W' [the Department of National Health and Welfare] are 'gut' issues -- basic to the whole philosophy of the role of government in modern society."¹⁰⁷

Many circumstances had changed since the 1950s. The Canadian economy had expanded, freeing the Provinces from their dependence on federal financial support. Most Canadians by then preferred voluntary insurance to compulsory insurance.¹⁰⁸ Six Provinces were led by new parties, and seven had new leaders.¹⁰⁹ "The Quiet Revolution," ushered in by the election of the provincial Liberal Party under Premier Jean Lesage in 1960, reflected Québec's mood for greater political autonomy.¹¹⁰ These changes presented new obstacles to a federal health care programme, adding to the traditional constitutional ones.

3. National Medicare Programme

LaMarsh, with the support of the Prime Minister and the Minister of Finance, however, created a unique and powerful advocacy for national action. The members of the new Liberal Minority Cabinet who supported the programme were optimistic. "Considering the extent of Walter Gordon's commitment to [Pension and Medicare] programmes as campaign chief, [the fight for money] wouldn't be too tough!"¹¹¹

¹⁰⁴ Christopher Young of Southam News Services quoted in Walter Gordon, *A Political Memoir*, [Toronto: McClelland and Stewart 1977], Paperback reprint (Halifax: Goodread Biographies, 1983).

¹⁰⁵ Walter L. Gordon, *Troubled Canada: The Need for New Domestic Policies* (Toronto: McClelland and Stewart, 1961), 3. Personal communication with Walter L. Gordon.

¹⁰⁶ LaMarsh, *Gilded Cage*, 120-21.

¹⁰⁷ LaMarsh, *Gilded Cage*, 48.

¹⁰⁸ Provincial voluntary insurance plans had already forged ahead in British Columbia in September 1965 and Ontario in January 1966.

¹⁰⁹ The Premiers were Lesage (Québec), Robarts (Ontario), Stanfield (Nova Scotia), Fleming (New Brunswick), Shaw (Prince Edward Island), Bennett Sr. (British Columbia), Smallwood (Newfoundland), Thatcher (Saskatchewan), Roblin (Alberta) and Manning (Alberta).

¹¹⁰ He had already convinced the Federal Government to accord Québec taxation points instead of the usual conditional 'grant-in-aid'. Canada, Federal-Provincial Conference (FPC), *1960 Proceedings* (Ottawa: Queen's Printer, 1960).

¹¹¹ LaMarsh, *Gilded Cage*, 48.

Several legislative reforms had already tested the strength of the Minority Government and increased its self-confidence. The Government had survived the long negotiations with Québec over a Canadian Pension Plan. It had increased benefits under the Old Age Security Plan. It had introduced a Student Loan Act. It had brought in a distinctive Canadian flag, discarding the British Union Jack. Finally, it had extended family allowance benefits: "It remained for the Canada Assistance Act and Medicare to be passed ... to have a respectable social-security base."¹¹²

A committee of senior officials from the Department of Health and Department of Finance joined the Privy Council Office to draw up a proposal for the new Medicare programme. The working committee relied extensively on recommendations from Royal Commission on Health Services.¹¹³ To avoid a constitutional challenge, their proposal called for a 50 per cent cost-sharing arrangement between the Federal Government and the Provinces.¹¹⁴ To qualify, a Province had to establish comprehensive, universal, accessible and portable doctor services administered by public non-profit authorities.

Anxious about the risks facing Medicare legislation if introduced by a weak Minority Government, Walter Gordon urged the Prime Minister to hold an election in 1965: "Life as a member of a Minority Government is a most uncertain business."¹¹⁵ When the election failed to give the Liberal Party a majority, Gordon resigned: "I called Mike ... and reminded him of my undertaking to resign if we did not get an over-all majority." Alan MacEachen became the new Minister of Health. Mitchell Sharp became the Minister of Finance.

Gordon represented the left and Sharp the right of the party: left stood for social security programmes and human welfare above financial stability; right stood for postponement when public expenditure strained the economy. "One became uncomfortably aware that there was an undeclared war between the two men [Gordon and Sharp]."¹¹⁶ LaMarsh noted that Sharp "always prefaced his arguments against proceeding with the caveat that he was really in favour of medicare himself. No one ever believed him."¹¹⁷ Sharp claimed that he only wanted to avoid "adding to the already large increases that were taking place in federal expenditures in 1966."¹¹⁸

¹¹² Gordon, *Memoir*, 217.

¹¹³ The Deputy Minister, Dr. G.D.W. Cameron, was responsible for drawing up the early plans. Personal communication with the subsequent Minister of Health, Alan J. MacEachen, and his Deputy Minister, Dr. John N. Crawford.

¹¹⁴ Since distribution would be on a per capita basis, the poorer Provinces would receive nearly 80 per cent, while the wealthier Provinces would receive less than 50 per cent.

¹¹⁵ Gordon, *Memoir*, 219 and 220.

¹¹⁶ LaMarsh, *Gilded Cage*, 323.

¹¹⁷ LaMarsh, *Gilded Cage*, 323.

¹¹⁸ Mitchell Sharp, "The role of economic advice in political decisions," in *Economic Policy Advising in Canada: Essays in Honour of John Deutsch*, edited by David C. Smith (Montréal: C.D. Howe Institute, 1981): 221.

Despite these conflicts, a draft legislation finally appeared in 1966 which called for Medicare to be implemented 1 July 1967. The legislation reflected the recommendations of the Royal Commission on Health Services, adding two new criteria: only the participating Provinces would determine the national average, and private insurance companies could act as provincial carriers, providing that they submitted to a public audit and that they remained accountable to Parliament.¹¹⁹

The summer recess interrupted the second reading, allowing time for opponents to mobilise against the legislation. "The opponents of medicare smelled an ally. They came out from their lairs again; the medical profession, the Provinces, medical care insurers, all of them."¹²⁰ While Pearson went abroad for a Commonwealth Conference in the United Kingdom, Sharp introduced a new austerity programme, calling for a postponement of the Medicare legislation.¹²¹ Later, to justify another delay, "he pulled a one-billion-dollar cost figure from the air (ignoring everything the Hall Report had meticulously documented)... It had a telling effect, coming as it did from the Minister of Finance."¹²²

Everyone supporting the legislation was exasperated: "The cheque the Liberals first wrote in 1919 has been bouncing ever since."¹²³ MacEachen threatened to resign. Tommy Douglas warned that the Conservatives would succeed in introducing their "tin-cup medicare" programme.¹²⁴ Gordon reminded the Liberals that their earlier "collective decision on medicare must be respected and not undermined."¹²⁵

Pearson, however, defended his Minister of Finance: "It was not a question of whether one [was] for or against Medicare ... [Sharp's actions were] in fundamental sympathy with the policies Walter Gordon advocated, but [Sharp] was more careful and cautious in seeking their implementation."¹²⁶ The new date for introducing the national programme was 1 July 1968: "Looking back, it may seem that the one-year delay in the introduction of medicare was hardly worth the bitter political struggle."¹²⁷

¹¹⁹ Canada, "Health Resources Fund Act," *Statutes* (1966). This Act was passed during the negotiations on the Medical Care Act. Under the Act, the Federal Government would pay 50 per cent of approved projects for planning, construction and renovation of teaching and research facilities for health services personnel. This was an important step in securing medical manpower for the future.

¹²⁰ LaMarsh, *Gilded Cage*, 340.

¹²¹ Canada, "Mitchell Sharp," House of Commons, *Debates* (8 September 1966).

¹²² LaMarsh, *Gilded Cage*, 325.

¹²³ Leonard Shifrin, editor of the Liberal Party newspaper quoted in Taylor, *Health Insurance*, 371.

¹²⁴ Denis Smith, *Gentle Patriot: A Political Biography of Walter Gordon* (Edmonton: Hurting, 1973): 291; and Taylor, *Health Insurance*, 372.

¹²⁵ Smith, *Gentle Patriot*, 336.

¹²⁶ Lester B. Pearson, *The Memoirs of The Right Honourable Lester B. Pearson: Mike*, Volume 3., edited by John A. Munro and Alex I. Inglis (Toronto: University of Toronto Press, 1975): 226.

¹²⁷ Sharp, "Economic advice," 221. Personal communication with Mitchell Sharp, his Deputy Minister, R.B. Bryce, and Assistant Deputy Minister, Dr. A.W. Johnson.

The Medical Care Bill passed second reading on 25 October 1966, after eight days of intense debate, and the third reading on 8 December by a vote of 177 to 2. Little debate took place in the Senate and Royal Assent was given on 21 December 1966. Medicare would finally become a reality after twenty years of negotiation on 1 July 1968: "And on that date Medicare did come into operation, without undue strain on our economic capacity."¹²⁸ Among the many reforms introduced by the Liberal Minority Government, Medicare "was to be one of the crowning achievements of the Pearson administration."¹²⁹

Although the Canadian Medical Association protested against the programme throughout the negotiations and legislative process, the abortive Saskatchewan strike was still fresh in the minds of most doctors. The Saskatchewan strike had damaged their public image, prestige and pride. Many doctors were reluctant to become embroiled in a similar controversy at the national level. As a consequence, the Canadian Medical Association urged its members to accept the new Act as law. In effect, the passing of the Canadian Medical Care Act had little immediate effect on doctors; each Province first had to pass its own individual plan.

Implementing federal policies in Canada "requires the same political skills as international diplomacy; the end product is often fraught with compromises."¹³⁰ The Canada Medical Care Act only initiated the introduction of public financing for universal entitlement to health care. The economic impact would not become clear until later.¹³¹ The Provinces still had to establish their own commissions, committees and working groups to evaluate the terms of their respective commitments.¹³² MacEachen assigned his new Deputy Minister of Health, Dr. John N. Crawford, the difficult task of persuading the provincial branches of the Canadian Medical Association to accept the plan.¹³³

4. Strike, Armed Insurrection and War Measures

At the time of the inaugural date on 1 July 1968, only two Provinces qualified for Federal Government funds, Saskatchewan and British Columbia. Others followed over

¹²⁸ Pearson, *Memoirs*, 227.

¹²⁹ LaMarsh, *Gilded Cage*, 122.

¹³⁰ Personal communication with Malcolm G. Taylor

¹³¹ Canada, National Health and Welfare (NHW), Task Force on the Cost of Health Services in Canada (TFCHSC), *Reports* (Ottawa: Information Canada, 1969); and Canada, National Health and Welfare (NHW), *The Community Health Centre in Canada [Chairman J.E.F. Hastings]* (Ottawa: Information Canada, 1973).

¹³² British Columbia, Commission on Health Security for British Columbians (CHSBC), *Report [Chairman Richard G. Foulkes]* (Victoria: Government of the Province of British Columbia, 1973); Québec, Commission of Inquiry on Health and Social Welfare (CIHSW), *Report [Chairman Gérard Nepveu]* (Québec City: Government of the Province of Québec, 1970); and Ontario, Committee on the Healing Arts (OCHA), *Reports* (Toronto: Government of the Province of Ontario, 1970). Other Provinces also commissioned management consultants and special studies.

¹³³ Personal communication with Alan MacEachen.

the next four years. Newfoundland, Nova Scotia and Manitoba qualified on 1 April 1969. Alberta qualified on 1 July 1969, Ontario on 1 October 1969, Québec on 1 November 1970, Prince Edward Island on 1 December 1970, New Brunswick on 1 January 1971, the Northwest Territories on 1 April 1971 and the Yukon on 1 April 1972.

General revenues would finance the new the federal contribution towards the Medicare programme. A three-per cent non-earmarked social development tax was, however, introduced by the Federal Government during the same time. Although the Liberals denied that this tax was intended to finance Medicare, it provided additional funds for the federal treasury.¹³⁴ The Provinces were left to finance their contribution through combinations of provincial general revenues, premiums, user charges, indirect sales taxes, special interest-bearing funds and their share of the federal contribution.

The total cost of the health care services was \$3.3 billion in 1965, \$6 billion in 1970 and \$11 billion in 1975. This made Finance Minister Sharp's earlier prediction of \$1 billion seem conservative. The Canadian Medical Association's warning that abuse would occur if there were no deterrent charges proved invalid; doctors who provided the services, controlled their use.¹³⁵ "Universal health insurance in Canada has not 'broken the bank'."¹³⁶

During the course of implementing the Medical Care Act, Québec's doctors were the most vocal in their opposition. The death of Premier Maurice Duplessis in 1960 had marked the end of a long era of Québec conservatism and traditionalism, during which time a rural, church-bound society was dominated by a rigid Provincial Government. Premier Jean Lesage and later Premier Johnson blocked all federal initiatives which they felt were a threat to Québec's new sense of assertiveness.¹³⁷

Premier Jean-Jacques Bertrand, leader of the Union Nationale Government, who succeeded Johnson, introduced the Québec Health Insurance Bill 8 on 12 March 1970. When the new Provincial Liberal Government, under Premier Robert Bourassa, put the Act into effect, Québec's medical specialists withdrew their services. The Québec Government, less patient than Saskatchewan had been several years earlier, legislated the doctors back to work.

¹³⁴ The Federal Government also benefited from the delayed introduction of Medicare in Ontario and Québec. It collected taxes without having immediately to spend the funds. Personal communication with Mitchell Sharp.

¹³⁵ Lee Soderstrom, *The Canadian Health System* (London: Croom Helm, 1978): 175-85.

¹³⁶ G.H Hatcher, *Universal Free Health Care in Canada, 1947-77* (Washington: U.S Department of Health and Human Services, 1981): 2; and M. LeClair, "The Canadian Health Care System," in *National Health Insurance -- Can We Learn From Canada?* edited by Spyros Andreopoulos (New York: John Wiley and Sons, 1975): 50-51.

¹³⁷ French President Charles de Gaulle encouraged the separatists movement with a tactless 'Vivre le Québec libre' in his speech from the balcony of Montréal's city hall during a visit to the Province of Québec in 1967.

These events coincided with a series of terrorist incidents by small separatist cells of the 'Front de la Libération du Québec' which kidnapped a British diplomat, James Cross, and a provincial Liberal Cabinet Minister, Pierre Laporte.¹³⁸ With the murder of Laporte, the *révolution tranquille* ceased being so 'quiet'. The new Federal Liberal Prime Minister, Pierre Elliott Trudeau, decided to invoke Canada's 1917 War Measures Act, sending in troops to prevent an 'apprehended insurrection' in Quebec. The ongoing power struggle between Ottawa and the Provinces over Medicare occurred against this backdrop.

C. BARRIERS TO UNIVERSAL ENTITLEMENT

1. Canada Health Act of 1984

Despite its general success, Hall's blueprint failed to produce the comprehensive health service conceptualised by early Canadian reformers. The original Federal-Provincial cost-sharing arrangement covered only hospital care and doctors' services. The provision of other ambulatory services was left to the private sector. Individual Provinces eventually introduced some of these services in a piece-meal fashion, but most lacked the political initiative and financial resources to make such programmes uniform across Canada. "The ultimate goal of medicare must be the task of keeping people well rather than just patching them up when they're sick."¹³⁹ This would include aspects of "human biology, environment, lifestyle and health care organization," that cannot be provided merely through hospitalisation and doctors services.¹⁴⁰

Furthermore, successive Federal Governments since the 1960s have tried to limit Ottawa's financial commitment to the Canadian health care system.¹⁴¹ "You will never have another Medicare, I promise you that," Prime Minister Trudeau remarked in 1969.¹⁴² In 1979, a Minority Government formed by the Progressive Conservatives, once again appointed Emmett M. Hall to review the state of the Canadian health care. "Medicare as we knew it is gradually eroding. Through a cumulation of direct charges on

¹³⁸ Québec was the only Province where the doctors went on strike.

¹³⁹ T.C. Douglas, "We must go forward," in *Medicare: The Decisive Year*, Conference Proceedings Series No 3 (Ottawa: Canadian Centre for Policy Alternatives, 1982): 266.

¹⁴⁰ Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document* (Ottawa: Information Canada, 1975): 31. Personal communication with Marc Lalonde, the Minister of Health in 1975.

¹⁴¹ Under the Established Programmes Financing arrangement in 1977, the Federal Government ceased matching the Provinces' health care expenditure under the guise of allowing greater flexibility to the Provinces in establishing their own priorities. Canada, "Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act," *Statutes* (1986).

¹⁴² Prime Minister Pierre Elliott Trudeau speaking to Québec's Minister of Finance, Dozois. Constitutional Conference, February 1969, p. 648 quoted in Taylor, *Health Insurance*, 381.

the sick ... the goal of complete insurance, fully prepaid, is being abandoned."¹⁴³ Hall continued to favour public provision of health care in Canada. Monique Bégin, the Liberal Minister of Health in 1982, supported this stance. She introduced the Canada Health Act of 1984 which combined hospital care and doctors' services under one piece of legislation.

The same principles that were embodied in the 1967 Medical Care Act reappeared in the 1984 Canada Health Act: comprehensiveness, universality, portability, accessibility and public administration.¹⁴⁴ The new law confirmed past commitments by introducing stiff penalties for Provinces that allowed user charges and extra-billing which had increased over time and which were eroding the spirit of the original federal-provincial agreement.¹⁴⁵ The new Hall Report found much work left for the Federal Government to complete. "It may be that the introduction of block-funding has created, in both public and governments, the notion that the federal role in health is completed. This is not so ... without further federal action the gap between levels of service in high and low income Provinces will increase, and the goal of a comprehensive health system will never be met."¹⁴⁶

The Canadian story on universal entitlement is therefore incomplete. The pluralism of the Canadian federal political system has provided an excellent experimental model for testing various modes of financing and delivering health care. Ambulatory care, other than doctors' services, now needs federal action to ensure more comprehensive coverage. Some Provinces have already taken the initiative to extend ambulatory care to services other than those offered by medical doctors. Extending such benefits to the rest of the country remains an important challenge for the Canadian Federal Government.¹⁴⁷

¹⁴³ Canada, National Health and Welfare, "Report, Preserving Universal Medicare by Monique Bégin," *Monograph* (Ottawa: MSSC, 1983): 6. Personal communication with Monique Bégin and Emmett M. Hall.

¹⁴⁴ Sidney S. Lee, "Health insurance in Canada – An overview and commentary," *New England Journal of Medicine* 290(28 March 1974): 716.

¹⁴⁵ The Provinces must still meet the original five criteria to ensure full Federal Government contribution under the Federal-Provincial Fiscal Arrangements Act of 1977. Canada, "Canada Health Act," *Statutes* (1986).

¹⁴⁶ Emmett M. Hall, *Report, Canada's National-Provincial Health Program for the 1980s: A Commitment for Renewal [Commissioner Emmett M. Hall]* (Saskatoon: Government Printer, 1980).

¹⁴⁷ Present plans within the Department of Health and Welfare Canada, however, exclude further Federal Government involvement in the health care field. Personal communication with David Kirkwood, the Deputy Minister of Health in 1986.

CHAPTER 6. AUSTRALIA

The living standards of Australian families have fallen dramatically over the last six years. A major element in this decline has been Mr. Fraser's refusal to honour his unqualified commitment to maintain the universal health care scheme introduced by Bill Hayden in 1974.¹

Australian Labour Party, 1982

A. FINANCIAL INFRASTRUCTURES

1. Colonial Government Health Services

Early European settlements in Australia were established as open prisons for British convicts. The Treasury in London financed these colonies, which had infirmaries staffed by commissioned naval surgeons, overseers, dispensers and untrained nurses.² Australia, therefore, began its modern history with a 'nationalized' health service "admittedly for practical rather than ideological reasons."³ The primitive medical facilities of these penal colonies developed slowly and eventually formed the foundation of the Australian public hospital system.⁴

During the early colonial years, treatment at the penal hospitals was free to anyone who wished to or dared to use such facilities. As the population of free-settlers grew, however, the naval surgeons began offering the freeman private consultations on a fee-for-service basis to treat common afflictions such as scurvy and dysentery. The Colonial Government unsuccessfully contested this practice, arguing that the salaries that the surgeons already received from the Crown should cover all the services that they provided.

Reflecting a mood of professional independence, doctors in New South Wales (NSW) established the NSW Medical Board in 1838 to register and accredit new members.⁵ "Governments were expected to do no more than regulate society so that all persons had

¹ Australian Labor Party [sic], "Cheaper for Australians; Cheaper for Australia: The Hayden Health Plan," (1982): 1.

² Nurses were often elderly infirm prisoners who were incapable of performing heavier duties.

³ Colin Grant, *Australian Hospitals: Operation and Management*, 2nd Edition (Melbourne: Churchill Livingstone, 1985): 9.

⁴ Grant, *Hospitals*, 9.

⁵ Ron Hicks, *Rum Regulations and Riches* (Sydney: Australian Hospital Association, 1981): 3. This was 38 years before a comparable body appeared in England.

opportunities to produce and acquire the commodities essential for well-being, such as food and housing. Medical care belonged in this category."⁶

Dr. William Bland, a naval surgeon sent to New South Wales for killing a ship's purser in 1814, became the colony's first full-time private practitioner when the Governor granted him a pardon the following year.⁷ By 1839, most doctors were charging settlers such direct fees-for-service while the government infirmaries continued to treat the military staff and convicts without a charge.⁸

By the nineteenth century, "drunkenness, lawlessness and squalor prevailed ... almost as universally as dirtiness and the itch."⁹ As most settlers came to Australia alone, the aged, destitute, disabled and sick freemen were usually without family support. Few could afford the fees charged by private doctors. At best, they sought medical attention from religious benevolent societies and faith healers, at worst from quacks and frauds.¹⁰

Voluntary groups formed a system of non-governmental agencies which offered some relief for the destitute, sick and elderly in both outdoor and indoor relief.¹¹ Medical doctors provided free treatment to the poor in these institutions in return for the right to treat private patients.¹²

Private subscribers financed only 20 per cent of the running cost of such institutions, while the Governor and British Treasury provided the rest.¹³ The paid members of the voluntary hospitals gained the right to elect the executive committee and nominate patients for treatment: "Those who could afford it saw a doctor in his rooms and were treated there rather than go into hospital."¹⁴

When the transport of convicts to Australia ended in 1855, the British Government ceased its direct funding of the colony. Neither the parish nor the voluntary organizations,

⁶ Sidney Sax, *A Strife of Interests: Politics and Policies in Australian Health Services* (Sydney: George Allen & Unwin, 1984): 6.

⁷ The absence of physicians led the naval surgeons, who became the country's general practitioners, to learn the skills necessary to perform general medical duties. Bland who founded the Australian Medical Society served as its first president in 1859.

⁸ Sax, *Strife*, 4. Since private care was expensive, most people sought medical attention from out-patient departments of hospitals.

⁹ Sax, *Strife*, 4.

¹⁰ In 1881, only 23 per cent of the medical work-force in Victoria was registered medical practitioners, many of whom lacked basic medical skills. Sax, *Strife*, 12.

¹¹ C.J. Cummins, *The Development of the Benevolent (Sydney) Asylum, 1788-1855* (Sydney: New South Wales Department of Health, 1971). By the 1850, however, the infirmary section of these institutions housed the sick and infirm, not unlike the English workhouses.

¹² This complementary relationship between voluntary organizations and the states also existed in New South Wales, Victoria and Queensland. In South Australia and Tasmania, the states played a central role. Sax, *Strife*, 5.

¹³ Hicks, *Rum Regulations*, 5.

¹⁴ Hicks, *Rum Regulations*, 3.

however, had the resources to take over the financing of existing government services.¹⁵ The Colonial Government was soon financing up to 50 per cent of the capital and running cost of what became the public hospitals.

Those wanting free treatment from the public hospital out-patient departments required a ticket of entry, proving his inability to pay for services. "The individual client was assumed to be in need of correction, not the social structure. Welfare services meant that 'we' who were alright [sic] gave help to 'them' who were not."¹⁶ Since a visit to a private doctor cost the equivalent of one third of the average weekly minimum wage, many people who regarded the entry ticket as degrading simply did without medical attention when sick.

Towards the end of the century, doctors began establishing separate hospitals for their wealthier patients.¹⁷ Although registration with the state Governments was required by law, these institutions retained their independence, eventually developing into many of Australia's modern private hospitals. Tuberculosis and venereal diseases continued to compel the Colonial Government to provide institutional care: "Infections diseases that strike regardless of class dampen arguments against government intervention."¹⁸

The Commonwealth of Australia Constitution Act of 1900, which united the Australian states, gave individual states responsibility for most health services, while the Australian Government retained responsibility for quarantine and industrial hygiene.¹⁹ Two non-health-related areas, placed under central Government jurisdiction, would later play an important role in the country's health policy. Section 51(xiv) empowered the Australian Government to legislate on "insurance, other than state insurance."²⁰ Under special circumstances, Section 96 allowed the Australian Government to grant financial help to states.

The Australian Government also had indirect authority over health-related matters through trade, commerce, imports and exports. These powers were soon exploited by providing "a wide range of physical infrastructure, such as railways, power, drainage and other public services."²¹ Yet, Australia's health care system faced some difficult challenges at the turn of the twentieth century owing to the country's small population of 3,773,801

¹⁵ G.A. Rennison, *We Live Among Strangers* (Melbourne: University Press, 1970).

¹⁶ Ronald F. Henderson, ed., *The Welfare Stakes: Strategies for Australian Social Policy* (Melbourne: University of Melbourne, Institute of Applied Economic and Social Research, 1981): 3.

¹⁷ Later health insurance provided a major source of financing for these hospitals.

¹⁸ J.A. Jones, *The Australian Welfare State: Growth, Crisis and Change*, Revised Edition (Sydney: George Allen & Unwin, 1983): 7.

¹⁹ 'Commonwealth' in Australian refers to the federated states of Australian. c.f. British 'Commonwealth' of Countries.

²⁰ Australia, "Commonwealth of Australia Constitution Act," *Statutes* (9 July 1900): 63 & 64 Victoria.

²¹ Jones, *Welfare State*, 7. As in Britain, a Public Health Act was passed towards the end of the century.

living mainly on the eastern and southeastern coastline of a continent of 7,682,300 square kilometers.²²

2. Doctors and Pre-paid Health Care

Public interest in about pre-paid health care increased at the turn of the century. The Australian friendly societies had by then reached a membership of one million or 25 per cent of the population.²³ The first societies dated back to 1831, when a group of Sydney boat builders formed a mutual aid organization. Other workers established similar societies soon afterward. Their main function was to provide cash income support during illness, and to pay the medical bills of members and their families. Some societies made special arrangements with doctors to work on a capitation basis.

The relationship between the friendly societies and doctors, however, deteriorated over time.²⁴ Although the societies added to the doctors' private incomes and decreased their work-load in the hospitals, the latter felt that the societies interfered with their professional freedom. The medical profession objected to the capitation payments, variations in contracts between societies, non-professional employers and the coverage of high-income families.²⁵

Germany's Bismark Plan (1883) and Britain's Lloyd George Plan (1911) sparked debate on the need for compulsory national health insurance in Australia. The Australian Government statistician, George Knibbs, presented a detailed report on social insurance to Parliament in November 1910, following his review of European programmes: "Inquiries are being made and material is being gathered necessary for the formulation of a comprehensive scheme of national insurance on a contributory basis, embracing sickness, accident, maternity, widowhood and unemployment."²⁶

In 1902, the Australian Labour Party advocated a nationalized health care programme. A few years later, in 1908, the New South Wales Political Labour League made the first call for universal entitlement and free access hospital care. They wanted to finance the programme through municipal taxes. It was during these early years that Australia

²² The population for 1901 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962), 281 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 94.

²³ Hicks, *Rum Regulations*, 13.

²⁴ T.H. Kewley, *Social Security in Australia 1900-72* (Sydney: Sydney University Press, 1973): 12.

²⁵ Sax, *Strife*, 19.

²⁶ Liberal Prime Minister Joseph Cook in 1913 quoted in John C.H. Dewdney, *Australian Health Services* (Sydney: John Wiley and Sons, Australasia, 1972): 28.

became known as a "social laboratory" because of the Labour Party's call for binding arbitration to enforce settlement of industrial disputes.²⁷

The medical profession rejected these options. Their position was enhanced in January 1918 when a third of the country's doctors enrolled in the military service for World War I. The remaining 406 doctors were able to stage an effective protest in Victoria by resigning *en bloc* from the friendly societies. They refused to accept re-appointments until the friendly societies agreed to limit membership to healthy persons and exclude a variety of procedures from the covered services such as operations, anaesthetics and confinement during pregnancy.²⁸

Following World War I, Australia experienced a period of prosperity which created a flourishing petty bourgeoisie of self-employed tradesmen, professionals, small owners, contractors, agents, shopkeepers and farmers. The Conservative Government conducted a "relentless offensive against any kind of socialist or social democratic ideas or indeed any criticism from nationalizts or scrupulous liberals"²⁹ This political mood strengthened the medical profession's stance against collective provisions for health care.

By 1920, these circumstances led to a marked decrease in memberships with the friendly societies.³⁰ In subsequent years, half the population paid doctors directly for private consultations and hospitalisation. Many low-income earners, who could no longer afford the increasing contributions needed to remain a member of the friendly societies, were forced to turn to emergency departments for minor illnesses and public hospitals when seriously ill.³¹

3. Royal Commission on National Insurance of 1923

Hoping to encourage Australians to care for themselves, the Bruce-Page Liberals-Country Party (LCP) Coalition appointed a Royal Commission on National Insurance in 1923. The terms of reference of the Commission were to "inquire into national insurance to provide for sickness, invalidity, unemployment and old age."³² Shortly afterward, carried by the impetus of Dr. J.H.L. Cumpston, the first Director-General of the Department of Health, the Government appointed a Royal

²⁷ Eric Fry, ed., *Common Cause*, Essays in Australian and New Zealand Labour History (Wellington: Allen & Unwin/Port Nicholson, 1986): xiii.

²⁸ Sax, *Strife*, 20.

²⁹ Fry, *Common Cause*, 145.

³⁰ Sax, *Strife*, 20-21.

³¹ Sax, *Strife*, 21.

³² The "Constitution Act" of 1900 gave the Australian Government the power to legislate for invalid and old age pensions. Inquiries into compulsory social insurance began after 1910. Australia, Royal Commission on National Insurance (RCNI), "Report," *Parliamentary Papers* (1923): 1.

Commission on Health.³³ Its terms of reference were to examine the health benefits under a national insurance plan.

Dr. Earl Page, the Treasurer, was a country doctor turned politician. He compared tax-funded public programmes such as pensions to the "poorhouse or soup-kitchen."³⁴ Cutting public expenditures was his main concern. Cumpston, on the other hand, was deeply committed to developing Australia's health care system. He felt that the proper objective of public health was "nothing less than positive health, freedom from all illness and disability for every individual human unit in the community."³⁵

The Royal Commission on Health included four conservative medical practitioners. Not surprisingly, its report of 1926 reflected the traditional view of the medical profession that the Australian Government lacked constitutional powers to provide a national health service, a recommendation which the Government welcomed.³⁶

The Royal Commission on National Insurance, which reported in 1927, recommended a comprehensive compulsory social security and national health insurance plan. Following the report, Page introduced his National Insurance Bill in 1928, describing it as "the most comprehensive and progressive measure of social reform ever brought forward in any Parliament in Australia."³⁷ Benefits would include sickness pay, disablement benefits, widows pensions, orphans support and superannuation financed through an equal flat rate contribution from workers and employers.³⁸

Opposition to the programme was immediate. The state branches of the British Medical Association claimed that direct fee-for-service was the only mode of payment which safe-guarded the doctor-patient relationship.³⁹ The friendly societies feared that health benefits would interfere with the spirit of thrift and independence. J.H. Scullin, the new Labour Prime Minister elected in 1929, felt that social insurance added to the burden of workers: "Where practicable social benefits should be provided on a universal basis to remove from them the stigma of charity."⁴⁰

³³ The Department of Health was created in 1921.

³⁴ Kewley, *Social Security*, 145; and Sax, *Strife*, 36.

³⁵ J.H.L. Cumpston, *Health of the People*, MSS 613,2/4, Canberra: National Library of Australia n.d. quoted in Australia, Senate Standing Committee on Social Welfare (SSCSW), "Through a glass, darkly: Evaluation in Australian health and welfare services," *Parliamentary Papers* (1979): 19.

³⁶ Australia, Royal Commission on Health (RCH), "Report," *Parliamentary Papers* (1926): 1081.

³⁷ Earle Page quoted in Dewdney, *Health Services*, 29. Page's means-tested compulsory insurance of 1928, was more progressive than his later the voluntary insurance model during the 1950s.

³⁸ General revenues would finance superannuation until a fund had time to accumulate reserves.

³⁹ C. Thame, "Health and the state: The development of collective responsibility for health care in the first half of the twentieth century," *Ph.D. Thesis* (Canberra: Australian National University, 1974): 294.

⁴⁰ The Labour Party platform of 1912 quoted in Sax, *Strife*, 34.

4. National Health and Pensions Insurance Act of 1938

In 1931, J.A. Lyons, leader of the United Australia Party, formed a Coalition Government with the Country Party. Wanting to fight the Great Depression by stimulating the nation's private sector, he immediately asked R.G. Casey, the Treasurer, and Frederick Stewart, the Under-Secretary for Employment, to advise him on strategies for cutting public expenditure and stimulating private industry.⁴¹

In 1938, Casey presented a National Health and Pensions Insurance Bill to Parliament. A 2 per cent levy on workers' incomes, with additional financing from employers and the Australian Government would pay for the predominantly self-financing plan.⁴² Dependents, small farmers, the self-employed, most women and the unemployed would be excluded. The plan would include compulsory means-tested health insurance.

All the old opponents once again protested. The unions and employers complained about the proposed levy. John Curtin, the Labour Opposition spokesman, felt that national health services "should be free to all members of the community."⁴³ The friendly societies feared that new agencies would infringe on their domain. Finally, state branches of the British Medical Association, which had formed a Federal Council in 1933, objected to the proposed capitation payments, free medical treatment and public funding.⁴⁴

In response to increased intervention by the Government in health-related matters, the Federal Council for the State Branches of the British Medical Association established the Federal National Health Insurance Committee in 1938. The committee, headed by Dr. George Bell and Dr. W.F. Simmons, concluded that the Medical Association should support "a complete medical service to the nation."⁴⁵ Their proposed general practitioner service, financed on a fee-for-service basis, would focus on health and prevention. In addition, doctors would receive a capitation fee for means-tested low income earners.⁴⁶

Although the National Health and Pensions Insurance Act was passed on 5 July 1938 the Government was unable to secure the cooperation of doctors to staff the new service

⁴¹ Stewart approached Walter Kinnear in the insurance department of the British Ministry of Health for advice. Sax, *Strife*, 39.

⁴² A National Insurance Commission would administer the plan.

⁴³ John Curtin, Labour Opposition spokesman and former Prime Minister during the House of Representatives parliamentary debates quoted in Dewdney, *Health Services*, 30.

⁴⁴ The Federal Committee, established in 1911, became the Federal Council in 1933.

⁴⁵ The choice of terminology, calling it a 'medical' rather than a 'health' service, was important. British Medical Association policy quoted in Sax, *Strife*, 48.

⁴⁶ The Federal Council was especially anxious to distinguish itself from a minority group of doctors who advocated a salaried service.

before the day of enactment on 1 January 1939.⁴⁷ Furthermore, the members of a Royal Negotiation Committee, appointed to carry out further negotiations with the doctors, were killed in an airplane crash: "This tragedy was perhaps symbolic of the fate of the whole scheme."⁴⁸

Following Lyons' death, Robert Menzies, the new Prime Minister, introduced legislation for an indefinite postponement of the programme. "While impending war was a contributory cause for ending the national insurance project in 1939, there can be no doubt that the decisive factor was the determined opposition of the medical profession.... The medical profession had demonstrated that it had become a highly organized and repeatedly effective pressure group, having had its way with the friendly societies in the 1920s and the national insurance proposals in the 1930s."⁴⁹

5. National Health Services Act of 1948

In October 1941, John Curtin was elected Prime Minister, beginning eight years of Labour Government. While in the Opposition, Curtin had expressed his views on health care. "The Labour Party believes that the time has arrived when national health services should be treated, in principle, in the same way as education. They should be free to all members of the community."⁵⁰

Australia's involvement in World War II enhanced the Government's plans to create a national health service in two ways. First, the war mobilised a planning bureaucracy which could potentially be used for social planning after the war. Secondly, the war helped the public to grow accustomed to increased tax-rates which, if maintained after the war, would help finance such social programmes.⁵¹

Three groups produced independent reports during World War II, making this period a "critical historical juncture in the development of [Australian] national health policy."⁵² First, in November 1941, the National Health and Medical Research Council recommended a free comprehensive national health service run by salaried doctors.⁵³

⁴⁷ Personal communication with Professor George R. Palmer, School of Health Administration at the University of New South Wales. George R. Palmer, "Health," in *Public Policy in Australia*, edited by Roy Forward (Melbourne: Cheshire, 1974): 181. A similar sequence of events had taken place in New Zealand.

⁴⁸ Dewdney, *Health Services*, 31.

⁴⁹ Sax, *Strife*, 42.

⁵⁰ Australia, "John Curtin," House of Representatives, House of Representatives, *Parliamentary Debates* 155(1938): 1329-30.

⁵¹ Dewdney, *Health Services*, 34; Malcolm C. Brown, *National Health Insurance in Canada and Australia: A Comparative Political Economy Analysis*, Health Economics Research Unit, Research Monograph 3 (Canberra: Australian National University, 1983): 63-64.

⁵² Thelma Hunter quoted in Palmer, "Health," (1974): 181-82.

⁵³ Australia, National Health and Medical Research Council (NHMRC), "Recommendations on the reorganization of medical services in Australia," *Parliamentary Papers* (July 1941); Australia, National Health and

Secondly, an Australian Medical Association Sub-Committee recommended a health service with minimal public interference, financed through voluntary contributory insurance and run by doctors receiving direct fee-for-service payments.⁵⁴ Finally, in October 1942, the fifth report of the Joint Parliamentary Committee on Social Security recommended a comprehensive social security plan including a health service.⁵⁵

During the parliamentary debates in 1943, Joseph Benedict Chifley, the Minister for Post-War Reconstruction and Treasurer, announced the Government's intention to establish a comprehensive social security plan as part of the Australian post-war reconstruction.⁵⁶ To initiate the process, he established a National Welfare Fund into which the Government would deposit an annual sum of £30 million or 25 per cent of individual income-tax. Following the war, there would be two separate income-tax levies, one of which would be set aside for the Fund.⁵⁷

During the parliamentary debates, Opposition leader Robert Menzies advocated a non-means-tested contributory plan which he said upheld self-respect and dignity of the individual.⁵⁸ The Government, wanting to finance its proposed social security programme through general revenues, argued that contributory financing put an additional burden of the cost on workers, who would indirectly pay for the Government's contribution through taxes and indirectly pay for the employer's contributions through increased prices. The Government used the theories of British economist John Maynard Keynes to support their argument: "The subsequent public expenditure programmes generated out of necessity by World War II seemed to validate [Keynes'] theoretical approach."⁵⁹

Anticipating that the states would challenge the proposals on constitutional grounds, the bill gave the Australian Government the necessary powers to introduce its post-war

Medical Research Council (NHMRC), "Outline of a possible scheme for a salaried medical service," *Parliamentary Papers* (November 1941); and Sax, *Strife*, 49.

⁵⁴ Australian Medical Association, "A general medical service in Australia," *Medical Journal of Australia* (November 1941): 513-26; and Australian Medical Association, "Principles which should govern a general medical service in Australia," *Medical Journal of Australia* (March 1943): 370-71.

⁵⁵ The committee, which produced nine reports, was appointed by Robert Menzies Government in July 1941. Australia, Joint Parliamentary Committee on Social Security (JPCSS), "Fifth interim report," *Parliamentary Papers* (October 1942). Apart from a salaried health service, the sixth report also recommended free hospital treatment on public wards and public subsidies for non-public patients. Australia, Joint Parliamentary Committee on Social Security (JPCSS), "Sixth interim report," *Parliamentary Papers* (July 1943): Appendix C.

⁵⁶ Australia, "Joseph Benedict Chifley," House of Representatives, *Parliamentary Debates* (1943): 548-49. Chifley became Prime Minister after Curtin's death on 5 July 1945. Sax, *Strife*, 50.

⁵⁷ The seventh report recommended a graduated income-tax to finance the National Welfare Fund. Australia, Joint Parliamentary Committee on Social Security (JPCSS), "Seventh interim report," *Parliamentary Papers* (March 1944).

⁵⁸ Australia, "Robert Menzies," House of Representatives, *Parliamentary Debates* (1944): 2263; and Sax, *Strife*, 51.

⁵⁹ Brown, *Health Insurance*, 63-64.

Social Reconstruction Programme.⁶⁰ When the states refused to approve the legislation, Chifley called a national referendum in August 1944 which he lost despite Labour's substantial majority following the 1943 elections.⁶¹

The Government, nevertheless, pressed ahead with the Pharmaceutical Benefits Act of 1944, which offered a restricted list of free prescription drugs. The medical profession, however, boycotted the programme, claiming that a limited formulary and official forms represented unconstitutional interference with doctors' clinical freedom. In 1945, the Government lost another challenge on this issue in the High Court in Victoria.⁶²

A renewed attempt to alter the Constitution in 1946 was finally successful, leading to the Constitution Alteration (Social Services) Act of 1946.⁶³ This act allowed the Australian Government to provide maternity allowances, widows' pensions, child endowments, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services, benefits to students and family allowances. Parts of this legislation, however, greatly limited the Government's options.⁶⁴

The Government later introduced a variety of health programmes in a piecemeal fashion. Notable among these was the Hospital Benefits Act of 1946 which made public wards free of charge and increased subsidies on non-public wards.⁶⁵ Although the programme eventually collapsed in all states but Queensland, it represented an early attempt at universal entitlement to institutional care.⁶⁶

Doctors, claiming that negotiation with the Government amounted to 'professional euthanasia', continued to boycott the introduction of free drugs.⁶⁷ Instead of proceeding with the implementation of the new National Service, the Government passed another Pharmaceutical Benefits Act in 1947, making it compulsory for doctors to use official prescription forms for drugs that were on the official formulary. The medical profession once again successfully challenged this legislation on constitutional grounds in October 1949.⁶⁸

⁶⁰ The states rejected the legislation in October 1942.

⁶¹ Section 128 of the "Constitution Act" of 1900 requires a referendum to approve amendments to the Act.

⁶² Palmer, "Health," (1974): 183.

⁶³ Australia, "Constitution Alteration (Social Services) Act," *Statutes* (1946): Sec. 51(23A).

⁶⁴ Robert G. Menzies, Leader of the Opposition, introduced a restriction prohibiting 'civil conscription' of doctors. This was recommended by Dr. Henry Newland, later President of the Australian Medical Association (AMA), and accepted by the Attorney-General, Dr. H.V. Evatt.

⁶⁵ Sax, *Strife*, 56.

⁶⁶ Sax, *Strife*, 57. The Country-Liberal Party Coalition Government, which came to power in Queensland in 1957, retained the programme. Palmer, "Health," (1974): 180.

⁶⁷ Hicks, *Rum Regulations*, 18.

⁶⁸ Sax, *Strife*, 55; and R. Sackville, "Social Welfare in Australia: the constitutional framework," in *Perspectives in Australian Social Policy*, edited by Adam Graycar (Melbourne: MacMillan, 1978).

The National Health Services Act, introduced by the new Minister for Health, Senator McKenna, and later passed by Parliament in November 1948, called for universal entitlement to a National Health and Dental Service which would be administered by the Department of Health.⁶⁹ The Act empowered the Australian Government to engage directly in the provision of services, including the establishment, take-over, and management of hospitals and other health care organizations.⁷⁰ Everyone living in Australia would qualify for medical attention without any direct charges at the time of treatment.

A delay in implementing the National Health Services Act, however, gave its opponents time to mount a publicity campaign which portrayed the legislation as being the first step towards the creation of a socialist state. This hit home because nationalization had become the symbol of 'ideological purity' to the radicals in the Labour Party, rather than a commitment to practical social reform.⁷¹ Although the Labour Party strove for popular issues, such as stability in the economy, full employment and a gradual social transformation, Chifley's Government was defeated in December 1949.⁷²

6. Earl Page Voluntary Insurance of 1953

When the Liberal-Country Party Coalition under the leadership of Robert G. Menzies took office in 1949, Earle Page, Treasurer in the Bruce-Page Coalition, became the Minister for Health. During the elections, the Coalition Government had promised to introduce its own version of a comprehensive national health insurance plan. "The great danger in any government-aided health scheme is the tendency to develop a psychology of dependence and diminished personal and community responsibility. The fundamental aim of any social security scheme should be to raise the individual to a level at which he can help himself."⁷³

As a member of the Australian Medical Association and founder of the Royal Australasian College of Surgeons, Page cautiously refrained from introducing any radical elements in his proposal.⁷⁴ "Indeed it is not unreasonable to describe the Earl Page health benefits programme, introduced in 1953, as consisting essentially of the AMA's proposals of 1943."⁷⁵ He rapidly reached an agreement for his new plan with the Pharmacy Guild,

⁶⁹ Australia, "National Health Services Act," Statutes (1948).

⁷⁰ The Australian reform was more progressive than its British counterpart which did not recommend nationalization of ambulatory care.

⁷¹ Edward Gough Whitlam, *The Whitlam Government 1972-1975* (Harmondsworth: Penguin Books, 1985): 335.

⁷² Palmer, "Health," (1974): 184. The trade unions continued to advocated more militant policies. Fry, *Common Cause*, xv.

⁷³ Australia, "Earle Page," House of Representatives, Parliamentary Debates 221(1953): 1757; and Sax, *Strife*, 59.

⁷⁴ Sax, *Strife*, 59.

⁷⁵ Palmer, "Health," (1974): 185.

the medical profession and the friendly societies. "The socialist policies of the Labour Party were anathema to us," Page observed.⁷⁶

Non-profit voluntary insurance organizations would pay for the programme under which the states would reintroduce a means-test to determine who would receive free treatment on public wards of hospitals and the combined Australian Commonwealth-Insurance Fund benefit could not exceed 90 per cent doctors' charges.⁷⁷ Finally, there would be no attempt by the Government to control the fee-for-service charged by the doctors, and the freedom of choice by both doctors and patients would be guaranteed.

Since the Menzies Government lacked a majority in the Senate, it conveniently introduced the new programme through amendments to existing provisions of the National Health Services Act of 1948, thereby avoiding having to pass new legislation. Through regulations, the Government later introduced pharmaceutical benefits (1950), pensioner health services (1951), hospital benefits (1952) and medical benefits (1953).⁷⁸ The National Health Act of 1953 consolidated these benefits.⁷⁹

"Almost from its inception, adjustments began to be made in Earle Page's national health scheme."⁸⁰ The rise in medical fees and expensive medical procedures outstripped the refunds leaving even insured patients with a significant portion of the bill. The patient paid the difference which steadily rose.⁸¹ Only 11 per cent of the total cost of the health services were financed through voluntary funds, whose retention rates were in the order of 24 per cent.⁸² Many people were under-insured, 15 to 17 per cent were left without coverage and people had to go into debt or declare bankruptcy to pay their medical bills.⁸³

The Coalition Government, however, was initially successful in 'defusing health' [sic] as a political question. "An important reason for this success was the failure of the Labour

⁷⁶ Page quoted in L.F. Crisp, *Australian National Government, 5th Edition* (Melbourne: Longman Cheshire, 1983): 226.

⁷⁷ The Government would subsidise these voluntary insurance organizations.

⁷⁸ The doctors immediately accepted the new Government's Pharmaceutical Benefit Scheme offering 139 life-saving drugs.

⁷⁹ Australia, "National Health Act," *Statutes* (1953).

⁸⁰ Sax, *Strife*, 75.

⁸¹ This became known as the 'one-third' formula: one third finance out of pocket, one third by health insurance organizations and one third by the patient.

⁸² Richard B. Scotton, "Voluntary health insurance in Australia," *Australian Economic Review*, 2nd Quarter (1967): 37-44. A retention rate of 21 per cent in Canada was a major reason that the Canadian Royal Commission on Health Services advocated universal entitlement under a plan administered through public agencies.

⁸³ The non-insured were often the segment of the population in greatest need of medical attention. Richard Bailey Scotton, "The Nimmo Report: A new deal for patients?" *Australian Journal of Social Issues* 4(1969): 85-87. Personal communication with Richard B. Scotton.

Party ... to produce effective criticism of the Government's health scheme."⁸⁴ Following 15 years of Conservative Coalition Governments, critics such as Scotton and Deeble began pointing to some major flaws in the Page-inspired voluntary insurance system.⁸⁵ The arrangements were scathingly described as "private practice publicly supported".⁸⁶

B. LANDMARK LEGISLATIVE REFORMS

1. Committee of Inquiry into Health Insurance of 1968

In April 1968, the Labour Opposition which had a majority in the Senate appointed a Senate Select Committee, chaired by Senator Ivy Wedgwood, to examine medical and hospital costs.⁸⁷ Two weeks later, on 18 April 1968, Prime Minister John Gorton appointed a Commonwealth of Australia, Committee of Inquiry into Health Insurance to counter the mounting criticism against the Government's health insurance policy.

The three-man Commonwealth Committee of Inquiry consisted of Justice John A. Nimmo, Leslie Melville and Norman McIntosh. "The Government was opposed to a universally compulsive [sic] plan, however financed and was careful to restrict the terms of reference of our committee... [to voluntary insurance]."⁸⁸

In its report of 25 March 1969, the committee condemned the inadequate provisions offered under voluntary insurance: the existing system was too complex; benefits were below the costs of treatment; contributions were prohibitive for many people; rules were excessively cumbersome; insurance organizations kept high retention rates and unnecessary reserves; services were incomplete, excluding coverage of optometry, chiropractic and dentistry.⁸⁹

The committee then made a series of recommendations that it felt would improve the system: standard hospital wards with salaried doctors should be free to everyone; insurance organizations should be regionalised; disclaimers should be eliminated; and fee

⁸⁴ From 1951 to 1966, health insurance was an insignificant campaign issue at election time. Palmer, "Health," (1974): 186.

⁸⁵ John S. Deeble, "The costs and sources of finance of Australian health services," *The Economic Record* 43(1967): 518-43; Scotton, "Voluntary health insurance, 37-44; and Richard B. Scotton and John S. Deeble, "Compulsory health insurance for Australia," *Australian Economic Review*, 4th Quarter (1968): 9-16.

⁸⁶ T. Fox, "Antipodes: Private practice publicly supported," *Lancet* 1(1963): 875; and Sax, *Strife*, 66.

⁸⁷ Australia, Senate Select Committee on Health (SSCH), "Report on medical and hospital costs [Chairman Ivy Wedgwood]," *Parliamentary Papers* (1970).

⁸⁸ Personal communication with John A. Nimmo, Chairman of the committee.

⁸⁹ Australia, Commonwealth Committee of Inquiry into Health Insurance (CCEHI), "Report," *Parliamentary Papers* (1969): 8.

schedules should be standardised.⁹⁰ It also recommended that an independent authority, a National Health Insurance Commission, should be established to run the new service with representatives from the Department of Health, the medical profession, hospitals, consumers and the financial world.

In its first report of September 1969 and final report of 2 June 1970, the Senate Select Committee followed the general lines of the Commonwealth Committee of Inquiry by calling for an expanded and subsidised voluntary insurance system: "As a programme for reforming a voluntary insurance scheme, the Nimmo Committee's proposals are comprehensive and well considered."⁹¹ As a programme for improving the health care system, however, it represented a "marginal modification, rather than fundamental reform."⁹² Two Labour Senators, therefore, wrote a minority report, calling for a "universal health scheme financed by a surcharge on taxable income."⁹³

2. Scotton-Deeble Compulsory Insurance Plan of 1969

During the deliberations of the Committee of Inquiry, two economists, Richard Bailey Scotton and John S. Deeble, published an independent report. They claimed that a compulsory and public-administered plan was "simply the most efficient and equitable method of achieving universally acknowledged objectives."⁹⁴ Their proposal called for free ambulatory health care services, free treatment on public hospital wards, restricted choice of doctor, curtailed private practice and centralised health planning.

A statutory Health Insurance Commission would administer a new health fund which would be financed by a 1.25 per cent income-tax levy, matching Australian Government subsidy, combined workmen's compensation contribution and third party motor insurers contribution. Even with an upper limit for the contributions, the levy would make health contributions more progressive in nature and, therefore, more equitable than in the past: "The whole plan could be seen as a very astute exercise in producing a policy with maximum political acceptability."⁹⁵

Although doctors would be encouraged to 'bulk-bill' the new Health Insurance Commission, they would still be allowed to charge patients directly. Eighty-five per cent of such fees would be reimbursed based on a standard fixed fee.⁹⁶ The remaining 15 per cent

⁹⁰ When the Liberal-Country Coalition returned to power, the new Government introduced a similar health insurance plan in 1970. Palmer, "Health," (1974): 192.

⁹¹ Richard Bailey Scotton and John S. Deeble, "The Nimmo report," *The Economic Report* 45(June 1969): 275.

⁹² Scotton, "Nimmo Report," 85.

⁹³ Hicks, *Rum Regulations*, 31.

⁹⁴ Scotton and Deeble, "Compulsory health insurance," 14.

⁹⁵ Palmer, "Health," (1974): 189.

⁹⁶ To avoid another constitutional debate, the authors omitted any reference to a compulsory fee schedule.

would act as a small deterrent charge to prevent abuse. Voluntary insurance could cover the 'gap', but such expenses would no longer be tax-deductible.

The authors estimated that under their plan, doctors' incomes would rise, while patients' payments would fall. They also projected that their plan would decrease the cost of the Australian health care system through savings on administrative expenses and elimination of the high retention rates by the voluntary insurance funds. They calculated the cost of the existing system for hospital and health care in 1965-66 as \$326 million, while the projected cost under their proposed plan would be only \$312 million.⁹⁷

Deeble and Scotton presented their recommendation to the Senate Select Committee in September 1968 and privately to the Opposition Labour Party leader, Edward Gough Whitlam, who accepted the plan as the Labour Party's official platform on health care.⁹⁸ There was little formal consultation on the Deeble-Scotton proposal: "The decision to adopt this policy appears to have been taken by Mr. Whitlam, no doubt in consultation with the Labour Party's health spokesman at that time, Mr. Hayden."⁹⁹

3. Whitlam Labour Government of 1972

Labour policies of the late 1960s represented a pragmatic compromise as part of an attempt to regain a political base following the setback of the Chifley era: "Whitlam's energetic leadership, sensitive to the strong 'middle-classing' [sic] of modern Australian standards and expectations," brought success to Whitlam himself and led to a re-emergence of the Labour Party's strength in Australia.¹⁰⁰ During the years before the 1969 and 1972 general elections, Whitlam travelled extensively throughout the country selling the party's platform on health care: "Governments have a responsibility to ensure that health services are provided free of cost to the individual."¹⁰¹

There was less "socialism vs. free enterprise, collectivism vs. individualism, the rights of the poor vs. the privileges of the rich, anarchy vs. law and order, equality vs. freedom, the public sector vs. the private sector and so on."¹⁰² Instead, a political convergence emerged "with Labour accepting moderate reformism [sic] within a 'mixed' economy, and the Liberals accepting high levels of welfare expenditure and various forms of government control over the economy."¹⁰³ In this context, Labour tried to play down the role of

⁹⁷ Scotton and Deeble, "Compulsory health insurance," 13.

⁹⁸ Personal communication with John S. Deeble and Richard B Scotton.

⁹⁹ Palmer, "Health," (1974): 199. Personal communication with John S. Deeble and Richard B. Scotton.

¹⁰⁰ Crisp, *Government*, 225.

¹⁰¹ Whitlam, *Government*, 333.

¹⁰² Allan Patience and Brian Head, eds., *From Whitlam to Fraser: Reform and Reaction in Australian Politics* (Melbourne: Oxford University Press, 1979): 1.

¹⁰³ Patience and Head, *Whitlam to Fraser*, 2.

"stifling or intrusive government ... and introduce[d] a universal health insurance scheme that would be funded according to one's ability to pay."¹⁰⁴

Several circumstances contributed to the development of moderate political platforms: an increasingly affluent society had shifted the political spectrum to the centre; there was an increased competition for this important uncommitted centre of the electorate; bureaucratic and constitutional structures made it difficult to introduce radical reforms; and vested-interest groups and limited public revenues curtailed major public expenditure programmes.¹⁰⁵

As a result, the Australian Labour Party's social insurance policy during the late 1960s "could hardly be regarded as radical, even in the forms in which they were originally developed."¹⁰⁶ Following the resignation of Robert Menzies, the Liberal Party's founder and patriarch, the Government continued to lose popular support, while the Labour Opposition gained strength.¹⁰⁷ Worried about losing further electoral support, non-Labour policies were equally marked by moderation.¹⁰⁸

During the 1969 general elections and the 1970 Senate election, voluntary health insurance became a major political theme. John Gorton, the incumbent, campaigned in favour of increasing health care coverage through the expansion of the existing voluntary insurance system in line with the recommendations of the majority report of the earlier Commonwealth Committee of Inquiry.¹⁰⁹ When the Liberal-National Country Party returned to power, it introduced a Health Benefits Plan in 1970 which was based on the recommendations of the majority report of the committee.

To please the medical profession, many important recommendations were omitted from the plan. This greatly embittered some of the former committee members: "There is a history in Australia of governments ignoring the findings of commissions and committees."¹¹⁰ Their outrage was in vain. When William McMahon replaced Gorton, and Senator Greenwood, the Minister for Health, replaced Forbes, the non-conciliatory approach of Forbes enraged the doctors.¹¹¹

¹⁰⁴ Bill Hayden, "The contemporary implications of democratic socialism," in *Labour Essays 1982: Socialist Principles and Parliamentary Government*, edited by Gareth Evans and John Reeves (Richmond, Victoria: Drummond, 1982): 3.

¹⁰⁵ Patience and Head, *Whitlam to Fraser*, 3-8.

¹⁰⁶ George R. Palmer, "Health," in *From Whitlam to Fraser: Reform and Reaction in Australian Politics*, edited by Allan Patience and Brian Head (Melbourne: Oxford University Press, 1979): 123.

¹⁰⁷ Stephen J. Duckett, "Structural interests and Australian health policy," *Social Science and Medicine* 18(1984): 959.

¹⁰⁸ Crisp, *Government*, 229.

¹⁰⁹ The Australian Medical Association supported this approach.

¹¹⁰ This style of policy-making is common in Australia. Personal communication with John A. Nimmo.

¹¹¹ The Australian Medical Association had evolved out of the independent state branches of the British Medical Association in 1963.

Taking advantage of the Liberal's Party's troubles, Labour set out to defeat the Government which had held power for more than two decades, using a slogan 'It's Time'. To avoid a confrontation with the medical profession, Whitlam avoided the topic of financing of health care during his pre-election speeches. Instead, Bill Hayden, the Labour Shadow Minister for Health and Social Welfare, outlined the party's platform which consisted of universal entitlement to health care offering regional health services, nursing homes, domiciliary services, school dental care, national aboriginal health care, prevention, rehabilitation, integrated psychiatric services and general practitioner services.¹¹²

"The defeat of the Labour Government in 1949, after its unsuccessful attempts to move in the direction of a social-welfare oriented health system, made the [Australian Labour Party] cautious of pursuing radical policies in this field."¹¹³ Unknown to the Liberals, the slick Labour political machine successfully cloaked the potentially threatening parts of the party's dogma.¹¹⁴ Following Labour's success in the 1972 elections, however, "the new Government, no matter what its complexion, was headed for trouble from a disgruntled medical profession."¹¹⁵

4. Medibank I

After winning the general elections on 2 December 1972, Whitlam's Labour Government established the Hospitals and Health Services Commission to plan the health services and the Health Insurance Planning Commission to prepare the health insurance programme (Medibank). Dr. Douglas Everingham became the Minister for Health, and Bill Hayden became the Minister for Social Security. When Dr. Gwen Howells replaced Dr. William D. Refshauge as Director-General of the Department of Health in 1973, the medical profession lost one of its most loyal lieutenants within the Department.¹¹⁶

Dr. Sydney Sax was later appointed Chairman of the Hospitals and Health Services Commission, which submitted its first report on a Community Health Program for Australia on 28 May 1973. His committee called for an extensive, integrated and equitably

¹¹² Announced at the Australian Hospital Association's National Congress in Melbourne, October 1972. Sax, *Strife*, 101.

¹¹³ Palmer, "Health," (1974): 206.

¹¹⁴ Mick Young, "The build-up to 1972," in *The Whitlam Phenomenon*, edited by Fabian Papers (Ringwood, Victoria, 1986): 92.

¹¹⁵ Hicks, *Rum Regulations*, 34.

¹¹⁶ Personal communication with Dr. Douglas Everingham and Dr. Gwen Howells. Douglas Everingham, "Towards a healthier Australia," *Parliamentary Papers* (1974); Australia, Australian Department of Health (ADH), "Annual report of the director-general of health 1972-73," *Parliamentary Papers* (1973); and Australia, Australian Department of Health (ADH), "Australian health expenditure 1975-76 to 1979-80: An analysis," *Parliamentary Papers* (September 1983).

distributed primary health care network offering health care, nursing care, health outreach (education) and social advocacy (liaison between services) for the daily personal health care needs of the population.¹¹⁷

Although Parliament failed to pass the enabling legislation to finance the full Community Health Program for Australia as proposed by the Hospitals and Health Services Commission, it did approve a \$10 million allocation for a more limited programme intended to expand non-institutional care. The latter programme intended to establish an extensive network of community health clinics as an alternative to private practice.

At Hayden's request, the responsibility for health insurance was undertaken by Department of Social Security rather than the Department of Health.¹¹⁸ Hayden claimed that separation of health insurance from the Department of Health was necessary to allow him to focus fully on the financial aspects of the new plan.¹¹⁹ It also permitted him to distance himself from direct contact with the medical profession.¹²⁰

During the early planning stage, Hayden continued to rely extensively on the advice of John Deeble who became Chairman of the Health Insurance Planning Committee and Richard B. Scotton who became one of its members. L.J. Daniels, the new Director-General of Social Security, was given the task of carrying out a "complete re-structuring of charges and benefits" under the new programme.¹²¹

In April 1973, the Health Insurance Planning Committee released its Green Paper on Health Insurance.¹²² A Health Insurance Fund, Medibank, would finance medical and hospital benefits under a new Australian Health Insurance Program designed to replace the amended provisions of the National Health Act of 1948. The programme would cover "all residents of Australia, without payment of any premium or contribution, in respect of

¹¹⁷ Sax was involved only in the planning of the new programme, not in its eventual administration. Australia, Health Insurance Planning Committee (HIPC), "Report to the Minister for Social Security," *Parliamentary Papers* (1973). Personal communication with Dr. Gwen Howells, the former Director-General of the Department of Health.

¹¹⁸ Because of these changes, the Department of Health played a subsidiary role in the introduction of Medibank.

¹¹⁹ Palmer, "Health," (1974): 197.

¹²⁰ Personal communication with Dr. Keith Jones, President of the Australian Medical Association during the Whitlam years, and with Dr. William D. Refshauge, Director-General of the Department of Health up until 1972.

¹²¹ Personal communication with L.J. Daniels, previously Deputy director of the financial branch of the Department of Health.

¹²² Australia, "The Australian health insurance program," *Parliamentary Papers* (November 1973); and Australia, "Health program," *Parliamentary Papers* (1973).

services received inside and outside Australia.¹²³ Medibank's first General Managers, Roy William and his successor C. Robert Wilcox, would face the difficult challenge of creating an efficient and workable administration for the programme.¹²⁴

Under Medibank, 85 per cent of approved doctors fees would be reimbursed. Private insurers would be allowed to cover the 15 per cent 'gap' up to a maximum of \$5. To avoid having them stage a repeated constitutional challenge, doctors were permitted to continue billing patients directly. Those who wished to do so, however, were given various incentives to 'bulk-bill' Medibank directly.¹²⁵ "The [Programme] will not interfere in the doctor-patient relationship nor in the practice of private medicine."¹²⁶

All hospital in-patient and out-patient care on standard wards would be universally available, free of charge and staffed by salaried doctors. The Australian Government would reimburse the states for any additional cost incurred through offering such services.¹²⁷ Private patients would continue to have the option to contract independently for services but they would no longer be able to use such treatment as tax-deductible expenses.

Medibank would be financed through a 1.35 per cent health insurance levy on personal taxable incomes and a Government subsidy of 1.5 per cent (1.28 in the first year) drawn from consolidated revenues.¹²⁸ A smaller contribution from workmen's compensation and automobile insurers would supplement this source of financing. Low-income earners would not make contributions, while a ceiling would exist for contributions from high-income earners.¹²⁹

Medibank posed a direct threat to many of the vested-interest groups. Coverage by independent health insurance organization was limited to insuring the 'gap' between the established schedule and the fees charged by doctors. The increase in free beds in the public wards lowered the demand for private beds and private hospitals. The medical professions feared a salaried national health service.

¹²³ Australia, Health Insurance Commission (HIC), "First annual report 1974-75," *Parliamentary Papers* (1975): 3. The old system covered 87 per cent of the population. Bureau of Census and statistics, Bulletin No. 17.7, 31 May 1973 quoted in Australia, "Health insurance program," 3.

¹²⁴ Personal communication with Dr. Gwen Howells, the Director-General of the Department of Health after 1972, and C. Robert Wilcox, the present General Manager.

¹²⁵ By the end of Medibank's 15-month existence, more than 70 per cent of doctors used bulk billing.

¹²⁶ Australia, "Health insurance program," 2.

¹²⁷ The Government's proposal simplified this arrangement: the Australian Government would pay 50 per cent of the future operating cost.

¹²⁸ Australia, "Health insurance program," Sec. 7.1.

¹²⁹ Contributions to private health insurance organizations continued to qualify as tax deductible.

"The AMA refused to cooperate when it was informed that the principles of the scheme were non-negotiable."¹³⁰ To fight the plan, they established a 'fighting fund' by raising \$2 million to finance an extensive advertising campaign against Medibank.¹³¹ They unilaterally increased their fees by 25-29 per cent in July 1973.

Since reimbursing these fees would exceed the Government's planned financial outlay on the new programme, Hayden countered with a 10 per cent interim offer.¹³² A medical fee tribunal under Justice Ludeke, however, came out in favour of a fee increase of 20 per cent.¹³³ Despite this generous decision, the AMA went ahead with its earlier recommendations, letting doctors decide which fee to charge.¹³⁴

The Liberal-Country Party won a majority in the Senate in the following mid-term elections. A Canberra lobby, established by the medical profession, private hospital and private health insurance organizations, immediately pressured the Senate to block the Government's proposed Medibank legislation: "The profession achieved a lot of success in having its view accepted."¹³⁵ Ignoring this threat, the Labour Government introduced its legislation to the House of Representatives which passed the Health Insurance Commission Bill and Health Insurance Bill on 11 December 1973. The Senate, under pressure from opponents, defeated both legislations on 12 December 1973.

The Government reintroduced its proposed bills on 4 April 1974 in the House of Representatives, but both pieces of legislation were once again defeated in the Senate on 9 April 1974.¹³⁶ "In defence of their wealthy friends and vested interests, they [the Opposition in the Senate] have rejected the democratic principle of equal electorates."¹³⁷ Finally, when Opposition leader, Snedden, threatened that he would block Supply Bills in the Senate, Whitlam asking the Governor-General, Paul Hasluck, to call a double dissolution of Parliament under Section 57 of the Constitution.

During the brief campaign leading up to the general elections of 18 May 1974, the Liberal-Country Party alliance called for a return to voluntary health insurance with free

¹³⁰ Personal communication with Dr. Keith Jones. The private health insurance organizations, using reserves from their contributors staged, similar protests.

¹³¹ Whitlam, *Government*, 345.

¹³² The Medibank proposal had recommended a general increase in the order of 6 per cent.

¹³³ The committee had powers to determine the level of health insurance refunds not to set fees charged by medical practitioners. Sax, *Strife*, 110.

¹³⁴ The conflict over the official fee schedule recurred on a yearly basis.

¹³⁵ Personal communication with Keith Jones.

¹³⁶ During the first year of the Labour Government, the Opposition parties which dominated the Senate, rejected 13 bills, deferred 10 bills and amended another 20. Stephen J. Duckett, "Chopping and changing Medibank, Part I," *Australian Journal of Social Issues* 14(1979): 232.

¹³⁷ Prime Minister Gough Whitlam quoted in Duckett, "Medibank, Part I," 232.

care limited to those falling below a means-tested poverty line. The Labour Party promised to reintroduce its health insurance bills.

When the Labour Government returned to power on 18 May 1974 with a majority in the House of Representatives, it still lacked control over the Senate. Both Labour and non-Labour each obtained 29 seats in the Senate, leaving control of the Parliament in the hands of two Independents. By June 1975, two unprecedented state appointments of non-Labour replacements to vacancies in the Senate and the death of a Labour Senator gave the Opposition an absolute majority in the Upper House.¹³⁸

The Government reintroduced the two bills to Parliament for a third time on 10 July 1974 with the same result as before. By this time, the Government had also introduced two supplementary pieces of legislation: the Health Insurance Levy Bill and Health Insurance Levy Assessment Bill. These described the Australian Government's future financial obligations to Medibank. The Senate rejected both levy bills on 31 July 1974.¹³⁹

To break the deadlock, the Government called for a joint sitting of the two Houses on 7 August 1974 when both the Health Insurance Bill and Health Insurance Commission Bill finally passed.¹⁴⁰ The levy bills, however, were still at the beginning of this convoluted legislative procedure.¹⁴¹ "By this obstructive manoeuvre the Opposition forced the Government to finance all of its universal insurance scheme from general revenue funds. Medibank was scheduled to be implemented on 1 July 1975."¹⁴²

"Deeble originally estimated that Medibank would cost the Government \$595 million in its first year, starting 1 July 1974."¹⁴³ Because of the delaying tactics of the Opposition, "Medibank was introduced in July 1975 a year later than planned, at roughly double the original estimated cost [to the Australian Government] and with virtually no visible contribution by the public."¹⁴⁴ A later estimate for 1974-75 was \$898 million. In addition, the National Welfare Fund would contribute an additional \$66 million for pensioners, special account deficits and other existing arrangements, and \$5.7 million in transfer liabilities on outstanding arrangements not affecting the Fund.¹⁴⁵ The Opposition used

¹³⁸ Crisp, *Government*, 411.

¹³⁹ Under Medibank II, the Fraser Government introduced a health insurance levy of 2.5 per cent, which exempted those who bought basic insurance from private organizations for making such a contribution.

¹⁴⁰ Australia, "Health insurance levy assessment bill," *Parliamentary Papers* (1974); and Australia, "Health insurance levy bill," *Parliamentary Papers* (1974). The rules of Parliament called for such a joint sitting when a deadlock arose between the two Houses. Parliament gave assent to the Health Insurance Act on 8 August 1974. Australia, "Health Insurance Act," *Statutes* (1973): 187.

¹⁴¹ This procedure did not repeal the earlier National Health Act of 1954.

¹⁴² Sax, *Strife*, 117.

¹⁴³ Hicks, *Rum Regulations*, 36. (\$360 million from the levy on taxable income; \$508 million from consolidated revenues; and \$60 million from third-party insurers). Australia, "Health insurance program," Sec. 7.15.

¹⁴⁴ Hicks, *Rum Regulations*, 39.

¹⁴⁵ Australia, "Health insurance program," Secs. 7.11 and 7.12.

this discrepancy between the original estimates and the actual cost of Medibank to criticise the new programme.

The battle between the medical profession and the Government continued. To encourage executive management boards to eliminate the honorary system of staffing hospitals with doctors and offer free treatment on public wards, the Government agreed to pay 50 per cent of their net operational deficit. During the July 1975 Premiers' Conference, Whitlam informed the four Liberal-National Country Party Premiers that unless they signed the Medicare agreement his Government would withdraw all financial support from their hospitals. This threat proved effective in forcing the states to accept his offer.¹⁴⁶ Labour-held states of South Australia and Tasmania readily signed the agreement. The conservative states of New South Wales, Victoria, Western Australia and Queensland joined soon afterwards.

The medical specialists, hoping to frustrate the programme until the Opposition had a chance to defeat the Government, refused to accept their new hospital appointments. The private insurance organizations backed this strategy and refused to act as agents for the programme.¹⁴⁷ To counter the refusal of the private insurance organizations to cooperate, the Health Insurance Commission organized a network of retail pharmacies which agreed to act as agents. Although this was an effective strategy against the private insurance organizations, it did not resolve the conflict with the medical profession or increase support from the Senate.

The Opposition leader, Malcolm Fraser, once again threatened to have the Senate block the supply bills.¹⁴⁸ Preempting a deadlock, which might have paralysed the public sector, Governor-General John Kerr dismissed the Labour Government on 11 November 1975 and installed the former Opposition leader, Malcolm Fraser, as caretaker Prime Minister. The process leading to the dismissal of the Government involved a series of unprecedented consultations between the Governor-General, the Opposition and non-governmental advisors: "The Prime Minister of Australia [Malcolm Fraser], came to power through a decidedly unconservative [sic] constitutional 'coup d'état'."¹⁴⁹

¹⁴⁶ The states who opted out would lose millions of dollars each week.

¹⁴⁷ Similar tactics had been used in 1916 when the New South Wales Labour Government wanted to introduce free hospital care, in 1938 when the Casey Government tried to introduce the National Health and Pensions Act and in 1948 when Parliament passed the Chifley Government's National Health Services Act. Sax, *Strife*, 117.

¹⁴⁸ Previous Australian convention held that the less democratically-constituted Senate would approve Supply Bills recommended by the House of Representatives.

¹⁴⁹ Neal Blewett, "The challenge of the new conservatism," in *Labor [sic] Essays 1982: Socialist Principles and Parliamentary Government*, edited by Gareth Evans and John Reeves (Richmond, Victoria: Drummond, 1982): 35. Also see Crisp, *Government*, 412-414. Normally the Governor-General would first consult with the Government in power. Edward Gough Whitlam, *The Truth of the Matter* (Harmondsworth: Penguin Books, 1979): xii.

The Labour Party and Whitlam were intensely bitter about the dismissal of the Labour Government and the repeated court challenges which had frustrated Labour's health care legislation: "After the manipulation of the monarchy in 1975, I became committed to the Australian republic," Whitlam observed.¹⁵⁰ He later protested that the Australian Labour Party "had to devise policies which could secure not only the approval of electors but also the approval of judges."¹⁵¹ Opponents of Medibank had succeeded in putting universal entitlement in peril almost immediately after it was implemented in Australia.

C. BARRIERS TO UNIVERSAL ENTITLEMENT

1. Earl Page Revisited

The election campaign which followed focused on high taxation and inflation, not health care. On 13 December 1975, the conservative Liberal-Country Party Coalition headed by Malcolm Fraser won a large majority in both Houses of Parliament on a platform of cutting inflation and reducing the Government deficit: "We will not dismantle Medibank," Fraser promised.¹⁵²

The following eight years, nevertheless, witnessed a gradual return to a voluntary health insurance programme similar to that which Earle Page had introduced during the 1950s. "Within a year of its introduction, Medibank had undergone a massive restructuring: it changed from a system which was providing medical insurance to the whole population to one which covered about [50] per cent."¹⁵³

The new Government introduced a series of amendments to the original Medibank legislation which encouraged people to opt-out of the national programme in favour of subsidised private plans. Medibank Private, a publicly run programme, would compete with the private insurance funds: "Instead of a better, brighter health insurance scheme, we appear to have a costlier, unwieldier [sic], class conscious, divisive and confusing rag bag."¹⁵⁴

The Fraser Government argued that the Labour programme had been too expensive because of over-utilisation: "Ironically one of greatest increases in utilisation took place in

¹⁵⁰ Whitlam, *Government*, 185.

¹⁵¹ Queen Elizabeth II refused to grant Whitlam an audience in London, deferring to her official representative Governor-General John Kerr. Whitlam, *Government*, 2.

¹⁵² *Financial Review* (17 May 1976) quoted in Sax, *Strife*, 126; Whitlam, *Government*, 348.

¹⁵³ Duckett, "Medibank, Part I," 230; and Stephen J. Duckett, "Chopping and changing Medibank, Part II," *Australian Journal of Social Issues* 15(1980): 79-90.

¹⁵⁴ Editorial, "Medi-gamble," *The Launceston Examiner* (30 July 1976).

1976-77, the year following the emasculation of Medibank.¹⁵⁵ The Minister for Health, Ralph J. Hunt, realised this too late: "In retrospect I believe it would have been far better to have adhered to the first change or to have reverted to the original health insurance arrangements prior to the election of the Whitlam Government."¹⁵⁶

Early rises in cost occurred before Medibank was fully implemented.¹⁵⁷ The cost in real terms to the Australian Government alone was \$931 million (1973-74), \$1,271 million (1973-74) and \$2,716 million (1975-76). The cost to the state and local government was \$892 million, \$1,340 million and \$2,716 million for the same years. "Medibank did cost somewhat more than originally estimated but not because of mistaken estimates but primarily because of Senate refusal to pass the levy legislation and to a lesser extent because of the widening of the benefits."¹⁵⁸

By 1977, 58.5 per cent of the population had opted-out of Medibank in favor of private insurance.¹⁵⁹ The estimated savings of \$170 million for 1976-77 and \$90 million for 1977-78 were offset by an even greater decrease in revenues from persons opting-out.¹⁶⁰ Furthermore, by 1979, a major portion of ambulatory care was no longer financed directly by Canberra, forcing many to use costly institutional care as the only available source of free health care: "One sees in health and welfare in Australia a system out of control."¹⁶¹

Wishing to diminish its involvement in the provision of health care, the Government next established an inquiry into its role in financing hospitals.¹⁶² The terms of reference of the Commission of Inquiry into the Efficiency and Administration of Hospitals were to examine the costs, resource allocations, efficiency and cost containment in hospitals, as well as related institutions and services.¹⁶³

¹⁵⁵ Whitlam, *Government*, 48.

¹⁵⁶ Personal communication with Ralph J. Hunt.

¹⁵⁷ Various authors have since criticised the Department of Health's estimates of health care costs: Richard B. Scotton, "Medibank 1976," *Australian Economic Review* 1st Quarter (1977): 23-36; Richard B. Scotton, "Costs and use of medical services," *Australian Economic Review* 2nd Quarter (1978): 72-76; John S. Deeble, *Health expenditures in Australia 1960-61 to 1975-76*, Research Report No. 1 (Canberra: Australian National University, Health, 1978); and John S. Deeble, "Financing health care in a static economy," *Social Science and Medicine* 16(1982): 713-24.

¹⁵⁸ Neal Blewett while Shadow Minister for Health. Neal Blewett, "Consistency and consensus in Labor's [sic] health policy," *Australian Health Review* 5(December 1982): 8.

¹⁵⁹ Australia, Department of Health (CDH), "Annual report, 1976-77," *Parliamentary Papers* (1977). *Sax, Strife*, 131.

¹⁶⁰ Richard B. Scotton, "The Fraser Government and social expenditures," in *Public Expenditure and Social Policy in Australia*, Volume 2 edited by Richard Bailey Scotton and Helen Ferber (Melbourne: Longman Cheshire, 1980): 181 and 205.

¹⁶¹ Australia, SSCSW, "Through a glass," 1.

¹⁶² Australia, Commission of Inquiry into the Efficiency and Administration of Hospitals (CIEAH), "J.H. Jamison," *Parliamentary Papers* (1980).

¹⁶³ Its Chairman was J.H. Jamison.

The resulting Health Acts Amendment Act of 1981 ignored most of the Commission's recommendations.¹⁶⁴ Instead, it introduced block grants to replace the previous cost-sharing arrangements. This policy intended to return the financial responsibility for health care to the states. It represented a throwback to the basic principles of the 1950 Earl Page Programme.

2. Medicare of 1984

If history is said to repeat itself, then Australia has repeated its history of financing health care several times. The early colonial settlements depended entirely on public funding for health services. As middle-class free settlers, they embraced an independent pioneer self-help philosophy and rejected public intervention only to find that their levels of personal income prevented the voluntary hospital movement from remaining self-sufficient. The growing public subsidies for the voluntary hospitals represented a drift back to public funding.

Following legislation introduced in 1928 and 1938, Labour Governments refused to cooperate with contributory compulsory means-tested health insurance plans that previous politically Conservative Coalition Governments had introduced. On two other occasions, following legislation introduced in 1948 and 1973, Conservative Coalition Governments refused to cooperate with universal entitlement under national health insurance programmes that previous Labour Governments had introduced. Between each of these events, interim health policy consisted of limited voluntary health insurance.

Throughout these events "the dominant characteristic of welfare action in Australia [became] its *ad hoc* nature and lack of reference to general principles of development."¹⁶⁵ The clear losers were the Australian people who were deprived of a universal entitlement to health care. When Labour came to power again in 1983, they were determined to repeat this history.

The Hayden Family Health Plan of 1979 and the official Hayden Health Plan of 1982 promised that, if elected in 1983, "Labour [would] return to the basic principles of the Bill Hayden's original health scheme.... This return to Medibank principles [would] restore equity in health contribution rates, universality of cover, and simplicity and efficiency in operation."¹⁶⁶ All Labour had to do was win the election.¹⁶⁷

¹⁶⁴ The Minister for Health, M.J.R. MacKellar, was opposed by the Cabinet and treasury over which recommendations to introduce. Personal communication with J.R. MacKellar and J.H. Jamison.

¹⁶⁵ Ronald Mendelsohn, *The Condition of the People: Social Welfare in Australia 1900-1975*, Revised Edition (Sydney: George Allen & Unwin, 1982): 321.

¹⁶⁶ Australian Labor Party [sic], "Cheaper for Australians," 1.

¹⁶⁷ Neal Blewett, "Australian Labor Party [sic] viewpoint," in *Perspectives in Health Policy* edited by Michael Tatchell (Canberra: Australian National University, Health Economics Research Unit, 1984): 252.

After Labour did win a large majority on 5 March 1983, the new Minister for Health, Neal Blewett, quickly presented a Health Legislation Amendment Bill which reintroduced universal entitlement under a renewed medicare programme.¹⁶⁸ Parliament passed the legislation on 1 February 1984.

The new programme also aimed to promote a physical and social environment conducive to good health, encourage community participation, ensure access for all and help the less advantaged in society.¹⁶⁹ The Department of Health and Social Welfare formalised these ideas in a detailed proposal for an Australian *Health for All* programme based on the World Health Organization's guidelines.¹⁷⁰ Health policy would focus on health not just health care.

The vested-interest groups in Australia are, however, equally committed to repeating rather than learning from the past. The Australian Medical Association still maintains its old position: "It is [the] Government's job to manage the economy and keep public expenditure under control."¹⁷¹ The Opposition vows to re-privatisation of Medicare Mark II if given the chance.

¹⁶⁸ A 1 per cent levy on personal taxable income and health insurance subsidies provided the financing for the new medicare programme.

¹⁶⁹ Australian Labor Party [sic], "Australian Labor Party [sic] platform, constitution and rules 1984," (1984): 111 and 119, sec. 74.

¹⁷⁰ Australia, Department of Health (CDH), "Advancing Australia's health: Towards national strategies and objectives for health advancement," Draft Plan, *Parliamentary Papers* (1985): 3-15. Personal communication with Bernie McKay, present Director-General of the Department of Health and Social Affairs.

¹⁷¹ Dr. Lindsay Thompson, past President of the AMA. Lindsay Thompson, "Australian Medical Association viewpoint," in *Perspectives in Health Policy*, edited by Michael Tatchell (Canberra: Australian National University, Health Economics Research Unit, 1984): 256.

CHAPTER 7. DENMARK

For the revolutionary, the struggle for reform involves strategy, ... to overthrow the [class structure].... For the reformist, the reforms are goals in themselves.¹

Jens Otto Krag, n.d.

A. FINANCIAL INFRASTRUCTURES

1. Early Danish Sickness Funds

The Danish Poor Laws during the nineteenth century reflected the existing liberal self-help philosophy and therefore offered only the most basic provisions for health care. The sickness funds, on the other hand, allowed the individual to preserve his dignity, while maintaining some protection against the uncertainties of illness.

Tradesmen and industrial workers were the first to benefit from the sickness funds, the first of which was established in Soroe on 3 October 1841.² Similar organizations were rapidly set up throughout the country during the latter part of the nineteenth and beginning of the twentieth centuries.³ The new sickness funds were, however, soon threatened by the proposed Trade Act which called for the elimination of all medieval trade guilds.⁴

Danish doctors immediately recognised the potential of the sickness funds as an important source of income. Not surprisingly, a key item on the agenda of the first General Assembly of the Danish Medical Association in 1857 was a defence of these organizations. The medical profession, therefore, was pleased when the sickness funds were preserved in the form of mutual aid organizations in 1861.

¹ Jens Otto Krag quoted in Jens Engberg et al., *Dansk Arbejderbevægelse: Med Kritik af Jens Otto Krag, Ib Noerlund og Gert Petersen, Seks Foredrag*, No. 5 (Århus: SFAH'S Publikationsserie, 1976): 84.

² H.C. Hansen, *Historien om Sygekasseerne* (Copenhagen: De Samvirkende Centralforeninger af Sygekasser i Danmark, 1974): 26.

³ During the reign of 13th century Danish monarch Queen Margrethe I, private associations and tradesmen's guilds provided some financial assistance to their members during periods of illnesses or to the families of the deceased. Hansen, *Sygekasseerne*, 9; and Ole Rasmussen, *Sygesikringsloven med Kommentarer* (Copenhagen: Juristforbundets Forlag, 1979): 48.

⁴ The law passed on 29 December 1857 and come into effect in 1861. Rasmussen, *Sygesikringsloven*, 48; and Hirobumi Ito, "Health insurance and medical services in Sweden and Denmark 1850-1950," in *The Shaping of the Swedish Health System*, edited by Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 50.

By 1871, 60 per cent of doctors in Denmark were in private practice.⁵ Under the existing arrangements, doctors treated members of the sickness funds and their families free of charge, receiving payment for their services from the organizations. This eliminated all direct financial transactions between the patient and the doctor. The capitation system developed as a norm for paying doctors, with the Medical Association negotiating the fee schedule.⁶

Over the next forty years, four separate commissions determined the direction of the voluntary sickness fund system in Denmark which in turn later paved the way for universal entitlement to health care. The prevailing ethos remained that the 'state should pay but not say'.⁷

2. Law on Recognised Sickness Funds of 1892

The early sickness funds were slow to gain official recognition. Mayor S. Linnemann of Copenhagen became the Chairman of the first Sickness Fund Commission on 18 November 1861. His Commission recommended a continuation of the existing *laissez-faire* system, without government interference or financial support. C.N. David, a former Minister for Finance, became the Chairman of the second Sickness Fund Commission on 10 February 1866. He supported a similar 'hands-off' approach. Both felt that the sickness funds were an important part of the existing liberal self-help system, which should remain voluntary with minimal regulation or financial support from the state.⁸

Opposition to this liberal view increased with the gradual emergence of an organized labour movement in Denmark. As early as 1876, E. W. Klein, the Chairman of the Central Administration of the Socialist Trade Unions, proposed that the sickness funds should amalgamate to create a common fund covering all workers. He felt that the state and municipal governments should finance such a system through general revenues.⁹ The Permanent Secretary of the Department of the Interior, Christian Bache, backed this approach.

When E.E. Rosenoern became the Chairman of the third Sickness Fund Commission on 20 September 1875, he favoured a compromise system which would require low-income workers to become members of sickness funds.¹⁰ Under his proposal, the state

⁵ Ito, "Health insurance," 54.

⁶ Ito, "Health insurance," 52.

⁷ Ito, "Health insurance," 60.

⁸ Hansen, *Sygekasseme*, 46 and 49.

⁹ Hansen, *Sygekasseme*, 53.

¹⁰ His report was published on 25 October 1878. Hansen, *Sygekasseme*, 55.

and municipal governments would subsidise the sickness funds, thereby lowering the direct cost for members.¹¹

Although the Conservative Government in the Upper Chamber of Parliament opposed such a programme, a new and more favorable political climate was developing in the Lower Chamber. Following the general elections of June 1884, the Left (Liberals) controlled the Lower Chamber by holding 83 seats against the Social Democratic Party's 2 seats and the Right's (Conservatives) 19 seats.¹² The two Social Democratic Party members, who were elected to Parliament for the first time in 1884, strongly advocated financing of health care through public funds.¹³

When H.N. Hansen became Chairman of the fourth Sickness Fund Commission on 4 July 1885, his Commission recommended some public financing and control over the sickness funds.¹⁴ The new Minister for the Interior in 1885, H.P. Ingerslev, adopted these recommendations in the hope that the long-standing debate on the sickness fund would come to a conclusion. The first draft legislation for official recognition and public subsidies for the sickness funds was presented in 1887; the law passed in Parliament on 12 April 1892.¹⁵

Under the new law, the state gave a generous grant to the sickness funds which met certain official criteria. Approved sickness funds had to prove that they were an association of 50 people or more representing a local municipality, trade group or profession.¹⁶ They also had to provide free medical care, free drugs, free hospitalisation and limited income support for their members during periods of illness.¹⁷

A sickness fund Inspector, appointed by the Minister for the Interior, decided which sickness funds qualified for the programme.¹⁸ A representative from the local municipalities, a representative from the sickness funds and a doctor formed a committee which determined which workers were eligible as new members.¹⁹ Eligible workers had to be 15 years old, healthy and belong to a trade group.

¹¹ Otto von Bismark, influenced by the German socialist workers' movement, introduced similar compulsory sickness and accident insurance for workers in Germany on 15 June 1883.

¹² The King had absolute power as head of state. He appointed the J. Estrup of the Right, which still had a majority in the Second Chamber, to lead the Government. The position as president of the Council later became the position of Prime Minister.

¹³ Hansen, *Sygekasseme*, 58.

¹⁴ Dr. T. Soerensen (later sickness fund Inspector) was a member of the Commission which reported on 31 July 1885. Hansen, *Sygekasseme*, 65.

¹⁵ Denmark, "Lov om Anerkendte Sygekasser," (Copenhagen: Folketinget, 12 April 1892).

¹⁶ Denmark, "Lov om Anerkendte Sygekasser," para. 1.

¹⁷ The wives and children of working members were automatically covered by the sickness funds.

¹⁸ Denmark, "Lov om Anerkendte Sygekasser," para. 24.

¹⁹ Denmark, "Lov om Anerkendte Sygekasser," para. 12.

The voluntary sickness funds could sign on two types of members. 'Active' members, usually from low-income groups, received the benefit of full health care coverage. Such benefits included free health care, drugs and hospitalisation. 'Passive' members, usually from higher income groups, received no direct health coverage, but their 'passive' membership made them eligible for benefits from other social programmes such as pensions.

As a result of these arrangements, health care by doctors rather than cash benefits was the major expense for the Danish sickness funds.²⁰ Cash payments of up to two-thirds of the usual wage were, however, available to members for a limited period of time. Members could also subscribe to additional cash benefits, burial benefits and old age benefits.²¹

Workers, the state and the municipalities shared the financing of the new programme. In addition, the municipalities contributed indirectly to the financing of health care by independently financing hospitals. As the Poor Laws still held them responsible for providing medical attention to the sick and destitute, the municipalities welcomed the sickness fund system, hoping that it would lower the need for different kinds of public assistance.

3. Danish Medical Association

It was within this historical context that the Danish Medical Association was founded on 1 September 1857. One of the original goals of the Association was to unite Danish doctors and to "serve as the body through which the medical profession's influence [might] be exercised on general social issues."²²

The medical profession welcomed the 1892 Sickness Insurance Law: "The law guaranteed financial security to a large proportion of Danish private practitioners and has continued to be an important financial benefit to them."²³ Some of the medical profession's most prominent members had played important roles in shaping many of the early official regulations affecting the sickness funds. Their participation in official enquiries ensured that the terms affecting the organizations were favourable to doctors.²⁴

²⁰ In the other Nordic countries, cash benefits, which the individual could use to pay his health care, comprised the main expense for the sickness funds.

²¹ Denmark, "Lov om Anerkendte Sygekasser," para. 17. Illnesses caused by drunkenness, venereal disease or fights were not covered.

²² Danish Medical Association statutes quoted from an Information Brochure by the Association available in 1986.

²³ Ito, "Health insurance," 52.

²⁴ Ito, "Health insurance," 51.

Dr. L.I. Brandes, a member of the 1862 and 1866 Sickness Fund Commissions, had earlier established his own sickness fund in Copenhagen. Dr. T.M. Trautner, a member of the 1885 Labour Commission, was instrumental in formulating the 1892 Sickness Fund Law. He was also founder of a sickness fund in Odense. Trautner later served as Superintendent Medical Officer in Odense and Chairman of the Danish Medical Association. Dr. T. Soerensen, also a member of the early Sickness Fund Commissions, became the first Sickness Fund Inspector under the new law.²⁵

In 1847, the medical profession established a Health Collegiate as a central health bureaucracy. It was the forerunner of the present National Board of Health which the Government established in 1909.²⁶ The new law, therefore, gave official recognition to a system which the medical profession had helped nurture and supported.²⁷

Following passage of the legislation, conflicts similar to those which took place in other countries nevertheless soon took place between the medical profession and sickness funds. These disagreements centred on income of doctors, their conditions of employment and protection of clinical freedom.²⁸ At first, an independent Arbitration Chamber settled such disputes.²⁹ After 1915, a public authority, the National Arbitration Board, assumed this responsibility.³⁰

The rapid growth of the voluntary sickness funds gave doctors in private practice a sense of economic security, sparing Denmark from the protectionist manpower policies that were implemented in the other Nordic countries.³¹ This resulted in the spontaneous growth of an extensive network of private medical practices for Denmark's population of 2,449,540, which at the turn of the century was scattered over 43,084 square kilometers of flat farm-lands and islands.³²

It also lessened the role of the District Medical Officers of Health, who did not have to perform clinical duties as did their counterparts in countries where the primary care

²⁵ Ito, "Health insurance," 51.

²⁶ Ito, "Health insurance," 50.

²⁷ In Sweden, the early state subsidies were so low that the sickness funds considered them insignificant.

²⁸ Hansen, *Sygekasseme*, 121-132.

²⁹ The Federation of Central Sickness Funds, the Danish Medical Association and the county councils all sat on the local Administrative Board.

³⁰ Ito, "Health insurance," 49.

³¹ Ito, "Health insurance," 51.

³² At the time, the Danish economy was largely based on agriculture and the population was mainly rural. The population for 1901 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962): 277 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 405.

network was less well developed. Reflecting this trend, the Danish Medical Officers' Association remained weak and a separate body from the Danish Medical Association.³³

Danish legislators accurately predicted that the voluntary system would draw a large membership if generous public subsidies supported the sickness funds. The programme became so popular that within a few years the entire country had local sickness funds.³⁴ Their membership rates grew rapidly during the early years, increasing from 10 per cent of the population before the 1892 law to 35 per cent by 1911.

4. Minor Social Reform of 1921

A revised Sickness Fund Law was passed in 1921 through the Minor Social Reform.³⁵ Yet the underlying principles of the 1892 Sickness Insurance Law remained in force under which memberships, contributions, benefits, regulations and public subsidies increased slowly over time.

Under the Minor Social Reform the existing sickness fund system expanded to cover all Danes in need of collective provisions to pay for health care. Public subsidies expanded, coverage increased to include those over 40 years of age, provisions were made to include the employed who were chronically ill and a separate bill was introduced to include disability insurance. The municipalities became responsible for providing medical attention for those in need who were not covered by existing programmes.³⁶

By 1925, as a result of these reforms, the voluntary sickness insurance system in Denmark had achieved a membership rate of 42.5 per cent of the population, outstripping all other countries in Europe: "By the early 1930s, the Danish programme came close to full coverage of the needy population,"³⁷ reaching 90 per cent of those qualifying for the disability pensions programme of 1921. Later, eligibility for benefits under the old age pensions programme of 1937 became conditional to being a member in a sickness fund.

Despite the success of the voluntary movement, in which "the role of government was more to support the private sector's activities rather than interfere with them," these measures became inadequate during the Great Depression.³⁸ The economic pressures of the 1930s provided the impetus for political change which led to further social reforms.

³³ Ito, "Health insurance," 56; and V.A. Fenger, *Den Almindelige Danske Lægeforening 1857-1957* (Copenhagen: Nordisk Forlag, 1957): 219.

³⁴ Hansen, *Sygekasseme*, 90.

³⁵ A Revised Sickness Fund Law was passed in 1915 but it offered few significant improvements over the previous law. In 1901, the sickness funds in Denmark formed a National Federation of Sickness Funds.

³⁶ Hansen, *Sygekasseme*, 151.

³⁷ Ito, "Health insurance," 45.

³⁸ Ito, "Health insurance," 49.

5. Social Insurance Law of 1933

The general elections of 24 April 1929 resulted in a Social Democratic Party - Radical Liberal Party (SDP-RLP) Coalition Government under Prime Minister Thorvald Stauning (SDP).³⁹ Although the Danish Social Democratic Party was founded in 1871, it was not until Stauning developed its platform and bolstered its strength during the 1920s that the party became a political reality.⁴⁰ The new Government prepared to introduce the welfare reforms that the SDP had earlier planned as part of their series of social programmes called 'Denmark for the People'.⁴¹

K.K. Steincke, the new Minister for Social Affairs, quickly set about preparing an extensive social reform. Steincke had previously worked as an Inspector for the Frederiksberg Poor Law programme in Copenhagen. He wanted to unify the numerous and splintered social welfare programmes that had slowly evolved over the years. Provisions for public assistance alone, for example, emanated from 41 different pieces of legislation.⁴² Through the reforms that he introduced, Steincke became known as the "lawyer whose greatest achievement was ... the socio-political reform of 1933."⁴³

A new Social Insurance Law was passed on 20 May 1933; it came into effect on 1 October 1933. The reform, known as the Major Social Reform, was timely.⁴⁴ "It was difficult to be unemployed at that time. Public assistance was low. There were long waiting periods [for unemployment benefits], and the benefits were quickly used up."⁴⁵ The new Social Insurance Law incorporated the previous sickness funds into a unified social insurance system which included public assistance, national insurance (including the sickness funds), accident insurance, disability insurance and unemployment insurance.⁴⁶

Under the new Law, health care benefits offered through the Sickness Insurance Law were once again increased. 'Passive' membership became compulsory for all persons under the age of 60. Greater 'active' membership was encouraged through a generous 33 per cent state subsidy and other associated benefits such as pensions. Previous restrictions on memberships were removed. The sickness funds could no longer impose limits on age or physical health. The maximum waiting period for new members was reduced. Finally,

³⁹ Stauning formed the first Social Democrat - Radical Left Coalition Government from 1924-26.

⁴⁰ It changed its name from the International Workers' Association to the SDP in 1878.

⁴¹ Knud Tågholt, *Hvem var Minister. Dansk Politik Gennem Mere end 100 År* (Århus: Forlaget Aros, 1984): 168.

⁴² Hansen, *Sygekasseme*, 166.

⁴³ Rasmussen, *Sygesikringsloven*, 18.

⁴⁴ Tågholt, *Hvem var Minister*, 168.

⁴⁵ Anker Joergensen, *Styrk Digerne: Artikler og Taler 1972-82 i Udvalg ved Harry Rasmussen* (Copenhagen: Socialdemokratiet Fremad, 1982): 174.

⁴⁶ Denmark, "Lov om Folkeforsikring," (Copenhagen: Folketinget, 20 May 1933).

benefits became more comprehensive, including the cost of drugs. The 1933 Law aimed "to fill out the framework of the social reforms, and to combat the [Great Depression] and its inevitable companion, a high rate of unemployment."⁴⁷

6. World War II

The Nazi occupation ended this golden period of social reform. The non-aggression pact concluded between Germany and Denmark was short lived. On 9 April 1940, Denmark was swiftly overrun by Hitler's forces: "In that pocket handkerchief-size country on Germany's border, the Nazis set out to create a docile fiefdom as a demonstration to the world that their occupation was benign and even welcome."⁴⁸

During the first three years of the war, there was some political continuity despite the occupation. Thorvald Stauning, the previous Social Democratic Party Prime Minister, formed war-time Coalition Government: "We choose that way to spare the country and its people an inevitable state of war."⁴⁹ As a consequence of its rapid surrender to German forces, Denmark did not suffer the same devastating physical destruction that occurred in other occupied countries.

After five years and four Coalition Governments, the Danes emerged from World War II having passively resisted the Germans "with a high degree of effectiveness and with the subtle humor that is so much part of the Danish temperament."⁵⁰ A post-war reconstruction programme was nevertheless necessary to resurrect many of the benefits introduced during the 1930s.

7. Public Sickness Insurance Law of 1960

Further social reforms were slow to develop in the post-war period. Although Jens Stroem, the Minister for Social Affairs, appointed an expert committee of civil servants to examine the sickness funds in 1946, this committee never reported.⁵¹ During the decade which followed, the cost of health benefits to the sickness funds continued to rise without parallel increases in their revenues.

As a result of what they saw as inaction by the expert committee, the sickness funds established their own Joint Advisory Committee with Ernst Larsen as Chairman and H.C.

⁴⁷ Rasmussen, *Sygesikringsloven*, 20.

⁴⁸ Marquis W. Childs, *Sweden: The Middle Way on Trial* (New Haven: Yale University Press, 1980): 127.

⁴⁹ Wartime Prime Minister Thorvald Stauning quoted in Julius Bomholt, ed., *Bogen om Stauning* (Copenhagen: Westermanns Forlag, 1950): 288.

⁵⁰ Childs, *Sweden 1980*, 127.

⁵¹ The committee never issued a report.

Hanson as Administrative Director.⁵² The committee, concluding that the sickness funds were underfunded, requested that Stroem constitute a formal Commission of Inquiry on Sickness Insurance.⁵³

On 28 May 1954, the Minister for Social Affairs appointed P. Juhl-Christensen as Chairman of a broadly represented Sickness Fund Commission. Its terms of reference were to review the benefits offered through the sickness funds, their administrative structure and eligibility for 'active' membership.⁵⁴ The Commission published its report in 1959, a document which formed the basis for the Public Sickness Insurance Law of 1960.⁵⁵ The new law was introduced by the Minister for Social Affairs, J. Bomholt, and came into effect on 1 April 1961.

The 1960 Law limited the number of sickness funds to one per municipality. Each municipalities had to appoint a representative to the executive management board of their respective sickness fund to ensure public representation. The Ministry of Social Affairs appointed a Director who would be directly responsible for overseeing and coordinating the activities of the organizations.⁵⁶

The Law offered improved benefits for 'active' members, including free medical attendance by general practitioners and specialists, free hospitalisation, coverage for 75 per cent of the cost of drugs, school dental services, home nursing, prosthesis, maternity benefits, funeral benefits, transport, cash allowances and sickness pay for all wage earners. It also removed many of the previous restrictions on membership. Furthermore, the sickness funds could no longer exclude groups such as the elderly, the chronically ill or those who had already used up their statutory benefits.

Workers, local municipalities and the state continued financing the programme. The means-test for compulsory membership was, however, "fixed so high that 80 per cent of the population [became] A-members ['active']".⁵⁷ Through these reforms, the voluntary sickness funds in Denmark evolved to offer near universal entitlement.⁵⁸

⁵² A different H.C. Hansen was the Social Democratic Party Prime Minister at this time.

⁵³ Hansen, *Sygekasseme*, 187.

⁵⁴ The Commission included representatives from all the political parties. Others included Niels Moerk from the Social Democratic Party, Dr. J. Frandsen from the Board of Health, Ernst Larsen (P.F. Olsen, J.W. Joergensen and H.C. Hansen after the death of Larsen), Drs. C. Jacobsen, J. Riising and T. Krarup from the Medical Association, and representatives from a variety of labour organizations and local governments. Denmark, "Betænkning fra Sygekassekommissionen" (Copenhagen: Folketinget, 1959).

⁵⁵ Denmark, "Lov om Offentlig Sygeforsikring" (Copenhagen: Folketinget, 10 June 1960).

⁵⁶ Denmark, "Lov om Offentlig Sygeforsikring," ch. VII, para. 41.

⁵⁷ Joergen Koch and C. Toftemark, *NHS and EEC - Denmark* (London: King Edward's Hospital Fund, 1974): 8.

⁵⁸ Personal communication with Allan Gersnov.

The 1960 reforms increased memberships with the sickness funds and thereby strengthened the financial position of the organizations: "Even though the law did not introduce increases in contributions ... this became a prosperous time for the sickness funds."⁵⁹ The evolving social democratic mood in Denmark would soon make such privileges enjoyed by one segment of society unacceptable.

B. LANDMARK LEGISLATIVE REFORMS

1. Danish Social Politics

In September 1962, when Jens Otto Krag became leader of the Social Democratic Party, replacing Viggo Kampmann as Prime Minister, he symbolically ended the period of unstable Coalition Governments which followed the war: "After tobacconist Thorvald Stauning, lithographer Hans Hedtoft and typographer H.C. Hansen, academic Social Democrat leaders entered the political arena."⁶⁰ This change would eventually have a profound effect on public involvement in the financing of health care.

Schooled in economics, Krag had acted as advisor to the Danish Ambassador in Washington during the early 1950s. He believed in peaceful social transformation, rejecting the revolutionary socialism that had swept across eastern Europe: "For the revolutionary, the struggle for reform involves strategy, ... to overthrow the [class structure].... For the reformist, the reforms are goals in themselves."⁶¹ Danish social reforms were introduced through the latter process.⁶²

Krag was responsible for formulating one of the party's early platforms, 'Future Denmark 1945', which introduced a progressive income tax-system which collected contributions at source.⁶³ Under a later policy, the 'Way Forward 1961', the party aimed "to guarantee security and to offer the opportunity for [the] development of responsibility for fellowship."⁶⁴ Putting these ideals into practice was the party's major challenge during the 1960s and early 1970s, laying the foundation for what became known as the 'New Society 1969'.⁶⁵

⁵⁹ Hansen, *Sygekasseme*, 192.

⁶⁰ Harry Rasmussen quoted in the forward to Joergensen, *Styrk Digerne*, 9.

⁶¹ Jens Otto Krag quoted in Engberg et al., *Dansk Arbejderbevægelse*, 84.

⁶² Personal communication with Jacob Vedel Petersen, Director of the Danish Social Research Institute.

⁶³ Viggo Kampmann, *Seks Socialdemokratiske Statsministre: Skildret af den Syvende* (Copenhagen: Fredmad, 1973): 58.

⁶⁴ Social Democratic Party platform expressed at the 28 Congress of the party in June 1961, quoted in Lars Bille, *Danske Partiprogrammer 1945-70: Historie og Samfund - Kilder og tal* (Copenhagen: Gyldendal, 1972): 15.

⁶⁵ Bille, *Danske Partiprogrammer*, 12-20.

The other major political parties each had their own platforms. The Liberals believed that freedom involved responsibility, since "individual freedom is realised in fellowship with other human beings.... Society must give support to those fellow citizens, who because of age, illness, mental or physical handicaps or failed possibilities for employment have a need for such assistance."⁶⁶ They stressed that the individual was responsible for himself and that society was only responsible for those who were unable to achieve such self-reliance.

The Radical Liberals believed that public outlay on education, research, health care and social security was necessary since demand for such benefits would increase more rapidly than private investments in these areas. They felt that careful long-term planning under public control was necessary to ensure efficient functioning of social policies.⁶⁷

As for the Conservatives, they believed that careful long-term planning and public administration was necessary to control the cost of social programmes. They therefore advocated a complete re-examination and revision of the public sector with the aim to cut public expenditure.⁶⁸

Although their expressed aims were far apart, all the parties advocated far-reaching reforms and increased public control over social planning; some intended to cut public expenditure while others intended to increase it.⁶⁹ "The years since 1968 ... represent the most extensive administrative reforms that the local and regional administration has experienced in modern times."⁷⁰ In 1968, when the Liberals took office, Hilmar Baunsgaard (Radical Liberal) became the Prime Minister of a Coalition Government formed by Liberals, Radical Liberals and Conservatives. This allowed the Liberals and Conservatives to carry out their version of 'social reorganization'.⁷¹

2. County Councils and Municipalities

A re-organization of local government into new self-sufficient geographic and financial entities and a unification of the Danish social welfare system during the 1960s had a

⁶⁶ Based on the Liberal Party's political platform in 1963, prior to the parliamentary resolution. Bille, *Danske Partiprogrammer*, 72.

⁶⁷ Based on the Radical Liberal Party's political platform in 1969, at the time of the first report of the Social Reform Commission. Bille, *Danske Partiprogrammer*, 42.

⁶⁸ Based on the Conservative Party's political platform in 1966. During the work of the Social Reform Commission. Bille, *Danske Partiprogrammer*, 53.

⁶⁹ In 1963, Danes voted in favour of joining the European Economic Community (EEC).

⁷⁰ Poul Meyer, *Dansk Politik 1944-1984* (Copenhagen: G.E.C. Gads Forlag, 1984): 119.

⁷¹ Ito, "Health insurance," 46.

profound effect on the collective provisions for sickness insurance and the future of the sickness funds.⁷²

The local government reforms followed the recommendations of the Local Government Reform Commission which presented its findings in 1968. It recommended a re-structuring of the existing geographic boundaries "to provide the local governments at both levels [municipal and county] with a better foundation, population-wise and therefore also tax-wise, for providing and managing those services which, according to tradition and to the general political philosophy in Denmark, should be left to the responsibility of locally elected councils."⁷³

Most of the political parties were in favor of local government reforms but for greatly varied reasons. The Social Democratic Party was deeply committed to reforms which would lead to decentralisation and increase its political control over local government. The Conservative Party and Liberal Party also supported such reforms which they felt would lead to greater self-sufficiency and fiscal responsibility of local governments. They also hoped that a reorganization of local government would dislodge the Social Democratic Party from their traditional stronghold.⁷⁴

Under the reform, local governments would continue to receive a major part of their financing from local taxation, including income taxes. The provision of health care would remain their major activity.⁷⁵ "In fact, the committee, which prepared the local government reform, based its recommendation on the idea that a population of this size [was] required to satisfy and to motivate a degree of specialisation within the hospital service, which ... [was] desirable, from the point of view of the patients as well as that of the medical profession."⁷⁶

3. Parliamentary Resolution of 1964

The political motives for the reforms in the social welfare system which eventually led to universal entitlement to health care were equally diverse. It was the Liberals and

⁷² Denmark, Ministry of Social Affairs (MSA), National Board of Social Welfare (NBSW) "Social and health planning: Administrative organization and decentralisation" (Copenhagen: MSA, NBSW, 1982): 1.

⁷³ Denmark, Indenrigsministeren (I), "Kommunalreformkommissionen," (Copenhagen: Indenrigsministeren, 1968): 1; and L.H.W. Paine, "Health services in Denmark: NHS and EEC," *Health and Social Service Journal* 84(3 August 1974): 1743. The 23 county councils and the 1,300 municipalities were reorganized into 14 and 217 new natural geographical and political areas. Councils, elected every four years, would administer the new local governments.

⁷⁴ Personal communication with Adam Trier, Deputy Secretary in the Ministry of Social Affairs, former Member of the Social Reform Commission

⁷⁵ This reform was similar the local government reforms following the Seebohm Report England. Paine, "Health services," 1743.

⁷⁶ Koch and Toftemark, *NHS and EEC*, 5.

Conservatives who, on 9 April 1964, presented a parliamentary resolution which prompted the Minister for Social Affairs, Kaj Bundvad, to set up a Social Reform Commission: "On behalf of the Liberals and Conservative Parties, I [P.E. Eriksen] have the honour to present a 'Proposal for a parliamentary resolution for the preparation of a Social Reform' through the appointment of a Commission to examine and prepare a new social reform."⁷⁷ The terms of reference for the Commission were to "unify [the] social security system's organizational, administrative and financial structure and to present the necessary recommendations for preparing legislation in this regard."⁷⁸

The forced cooperation between the Social Democratic Party [Socialdemokratiet], Radical Liberals, Liberals and the Conservatives during the 1960s became even more strained than it had been in the past. The Liberals and Conservatives wanted to simplify a system which they felt had become cumbersome, excessive and difficult to control financially. The Social Democratic Party, on the other hand, wanted to unify, decentralise and expand the existing system.⁷⁹

By being the ones to present the parliamentary resolution, the Liberals and Conservatives had stolen some of the political gains that the Social Democratic Party had hoped to reap from proposing such an inquiry. Not surprisingly, the Social Democratic Party found it hard to embrace the Government's initiative with enthusiasm even if they supported the call for reform. They therefore quietly accepted the inquiry, hoping that they could turn it to their advantage at some later stage.

4. Social Reform Commission of 1969

The Minister for Social Affairs, Kaj Bundvad, responded to the parliamentary resolution by appointing a Social Reform Commission on 29 May 1964. Its terms of reference aimed to eliminate the redundancies in the existing social security system, while retaining its base of public financing.⁸⁰ The honeymoon atmosphere that the Sickness Insurance Law of 1960 had created for the sickness funds would soon be over.

⁷⁷ P. E. Eriksen quoted from parliamentary resolution. Denmark, "Forslag til folketingsbeslutning om forberedelse af en socialreform," (Copenhagen: Folketinget, 12 March 64): 3767. E. Eriksen, leader of the Liberal Party and former Prime Minister, was a law reformer who had earlier been responsible for the constitutional reforms in 1953. Poul Soerensen from the Conservative Party proposed the reform.

⁷⁸ Denmark, "Forberedelse af en socialreform," 1674.

⁷⁹ Personal communication with Ernst Andersen who was responsible for drafting the Radical Liberals' original proposal for a Social Reform Commission.

⁸⁰ Denmark, Socialministeriet (S), "Socialreformkommissionens 1, det sociale tryghedssystem: Struktur og dagpenge," Betænkning No. 543 (Copenhagen: Statens Trykningskontor, 1969): 3. During the 1960s, a variety of laws and regulations on sickness insurance had already extended existing provisions, which had evolved into a comprehensive but unnecessarily complicated system.

The Chairman of the Commission, H.C. Seierup, was also Chairman of the Association of Disability Organizations.⁸¹ The Assistant Chairmen were Niels Moerk of the Social Democratic Party and Finn Nielsen, the Permanent Secretary of the Department of Social Affairs. Commissioners were drawn from a broad non-partisan representation; the five major parties, Parliament itself, the county councils and other interested parties such as the sickness funds were all represented. Rudy Schroeder and H.C. Hansen represented the sickness funds. By their own choice, however, neither the Danish Medical Association nor the Danish Board of Health participated directly in the Commission's work.⁸²

The Danish Medical Association "did not wish to be represented on the Commission," hoping to remain neutral in the impending confrontation between the Government and the sickness funds.⁸³ It nevertheless kept up the appearance of supporting the organizations, claiming that doctors could not "see any problems in an extension in ... the existing sickness funds."⁸⁴ In the same breath, however, the Association offered its full support to reforms proposed by the Government.⁸⁵

Despite the Medical Association's claim that it wanted to maintain a neutral stance, it emphasised its preference for allowing patients freedom to in choosing a doctor and doctors clinical freedom treating patients. Doctors warned that a universal system with completely free attendance paid through taxes would lead to abuses. The Association, therefore, recommended that an income barrier be maintained for membership and that patients should contribute at least a token amount towards the cost of their treatment.

The first report produced by the Social Reform Commission appeared in October 1969. The majority report lodged a strong criticism against the established order. It felt that a new unified health care system should be completely public and available to the whole population through a truly unified public administration, the county councils. It also recommended that health care, like other public services, should be financed through general revenues.

⁸¹ Kaj Andersen, the first Chairman, resigned to accept a cabinet post.

⁸² Both the Danish Medical Association and the Danish Board of Health declined to offer representatives for the Commission. Personal communication with Dr. Ester Ammundsen, former Director-General of the Danish Board of Health and Ove Baggesen, Director of the Danish Medical Association.

⁸³ Denmark, S, "Socialreformkommissionens 1," 416. Supported through personal communication with Dr. Jens Larsen, President of the Danish Medical Association 1964-70, Ove Baggesen, Director of the General Practitioners' Branch of the Danish Medical Association since 1971 and member of the Secretariat of the Social Reform Commission, and Dr. Joergen Fog, Deputy Director General of the National Board of Health and former leader of the Danish Younger Doctors Association [FayL].

⁸⁴ From the brief submitted by the Danish Medical Association to the Social Reform Commission on 20 December 1968. Denmark, S, "Socialreformkommissionens 1," 425.

⁸⁵ Denmark, S, "Socialreformkommissionens 1," 425.

The Commission was critical of the lack of true public representation under the existing system. Rules specifying that members of the sickness funds had a voting right in appointing representatives on the organizations' boards of administration were inadequate, since only a few members exercised this right.⁸⁶

The slow evolution of the various health benefits available to the public under the existing system had led to poor inter-sectorial coordination.⁸⁷ Benefits such as routine health exams, disability pensions, rehabilitation, maternity help and nursing homes were offered through separate provisions. Furthermore, the protection offered through the sickness funds applied mainly to curative care not prevention.

The report made extensive reference to other proposals for combined reforms in both local government and health care which had been made in Norway, Sweden and Great Britain.⁸⁸ In particular, the Commission drew special attention to the British Seebom Report, which recommended similar local government reforms.

The Commission considered both earmarked sickness insurance contributions and general revenues as the basis for financing the proposed reform. General revenues was favoured as "simpler than a system of collection of a special sickness insurance contribution, that [would] have the character of a special tax."⁸⁹ To emphasise its preference, the Commission stressed that most other public services were financed through general revenues.

The division of patients into two groups by the sickness funds -- group A and group B -- did not distribute the burden of the cost of illness evenly. Families with children living at home beyond the age of 16 had to pay contributions which often worsened their financial predicament. The Commission emphasised that, although well-to-do members enjoyed generous state subsidies, 10 per cent of the population who needed health care or public assistance remained ineligible for such benefits.⁹⁰

Various interest groups submitted dissenting opinions to the Commission. Kurt Brauer, representing the Socialist People's Party, called for a more radical arrangement in dealing with the doctors to "secure the effectiveness of the social structure in the future."⁹¹ He recommended the creation of a salaried national health service.

⁸⁶ Denmark, S, "Socialreformkommissionens 1," 203, para. 52.

⁸⁷ Supported by personal communication with Ole Hoeeg, present Permanent Secretary in the Department of Social Affairs, and Adam Trier, present Deputy Permanent Secretary in the Ministry of Social Affairs, who were both actively involved as members of the secretariat of the Social Reform Commission.

⁸⁸ Denmark, S, "Socialreformkommissionens 1," 377.

⁸⁹ Denmark, S, "Socialreformkommissionens 1," 220.

⁹⁰ In contrast to Norway, assistance for the excluded 10 per cent was available in Denmark following the reforms of 1960.

⁹¹ Denmark, S, "Socialreformkommissionens 1," 319.

Niels Moerk, representing the Social Democratic Party, also felt that the recommended reforms had not gone far enough. He advocated that the new system should include compulsory accident insurance, full compensation for lost wages during illness and financing through a single progressive income tax. Furthermore, he felt that there should be no exchange of money between doctors and patients, and that universal entitlement should include pap-tests, breast cancer screening, routine medical exams, abortions, chiropractic care and dental care. Moerk also defended the sickness funds: "The Danish sickness funds have ... solved many problems throughout the years."⁹² It would be wrong, he felt, to exclude them in the new system.⁹³ This stance was not surprising, since the Social Democratic Party was heavily represented on the administrative boards of the sickness funds.⁹⁴

A. C. Hansen and Rudy Schroeder, representing the sickness funds, felt that continued use of the existing organizations offered "the simplest... [and] the least expensive solution."⁹⁵ They warned that other options, such as administration through special health organizations, municipal councils, county councils or the state, would not alleviate the problems of coordinating the various services. They rejected the options of a salaried health service and a refund system as steps backward.

The Commission conceded that the existing system had already spontaneously evolved in the desired direction: "Part of the rules that earlier gave cause for criticism were changed through the Sickness Insurance Fund Law of 1960."⁹⁶ Following introduction of this law, the sickness funds could no longer exclude groups such as the elderly, the chronically ill and those who had already used up their benefits.⁹⁷ The Commission nevertheless concluded that the time was ripe for a unified system which would leave little room for the sickness funds: "Public sickness insurance should withdraw from [reliance on] the private insurance system, based on voluntary membership."⁹⁸ The report was a 'death sentence' for the sickness funds.⁹⁹

⁹² Denmark, S, "Socialreformkommissionens 1," 322.

⁹³ Hansen, *Sygekasseme*, 217.

⁹⁴ Personal communication with Adam Trier, Deputy Secretary in the Ministry of Social Affairs, former Member of the Social Reform Commission.

⁹⁵ Denmark, S, "Socialreformkommissionens 1," 322 and 409-416.

⁹⁶ Denmark, S, "Socialreformkommissionens 1," 203, para. 51.

⁹⁷ Unlike the situation in Norway before the introduction of compulsory insurance, those most needing medical attention in Denmark did not form part of the unprotected 10 percent.

⁹⁸ Denmark, S, "Socialreformkommissionens 1," 203, para. 50.

⁹⁹ Hansen, *Sygekasseme*, 238.

5. Sickness Funds' Publicity Campaign

The sickness funds, realising that the proposed reforms threatened their existence, fought back in August 1969, with a major publicity campaign to inform the public of their stance.¹⁰⁰ They accused the Commission of advocating a 'multicolored supermarket' of social benefits.¹⁰¹ "One has a feeling, that from a political point of view, there was a greater interest in the administrative problems than in the improvement of social benefits."¹⁰² The sickness funds claimed that a unified system would be too large to cope with the complexities of the many proposed benefits.¹⁰³ Furthermore, they felt that the Commission's recommendations for a unified system represented change for the sake of change rather than an effort to improve the existing system.¹⁰⁴

Instead, the sickness funds recommended that the Government establish independent health organizations which would be administered through a continuation of the existing system.¹⁰⁵ Such health organizations would follow the lines of the existing system. Coverage would include universal compulsory membership, universal access to doctors, comprehensive benefits and a removal of all economic barriers to health care.

Finally, the sickness funds claimed that a moderate reform would avoid major additional financial outlays by the Government, since the existing system already covered more than 90 per cent of the population.¹⁰⁶ The cost for 1967 under the existing system was estimated at 990 million Crowns for health benefits and 211 million Crowns for cash benefits. On the other hand, according to the sickness funds the Commission's reforms would lead to a 50 per cent increase in cost.¹⁰⁷

The sickness funds announced their campaign in all the major newspapers and through distribution of leaflets, in the hope that their members would support them.¹⁰⁸ The public, however, reacted with hostility to this publicity which they felt used members' contributions to protect the comfortable jobs of a few administrators.¹⁰⁹ Finally, after a

¹⁰⁰ Hansen, *Sygekasseme*, 238.

¹⁰¹ Hansen, *Sygekasseme*, 218.

¹⁰² Hansen, *Sygekasseme*, 218.

¹⁰³ Denmark, S, "Socialreformkommissionens 1," 409.

¹⁰⁴ Brief submitted to the Social Reform Commission by the Danish Co-operative of Central Sickness Funds in August 1968. Denmark, S, "Socialreformkommissionens 1," 409-415.

¹⁰⁵ Denmark, S, "Socialreformkommissionens 1," 413.

¹⁰⁶ Hansen, *Sygekasseme*, 233.

¹⁰⁷ Denmark, S, "Socialreformkommissionens 1," 412.

¹⁰⁸ Denmark, S, "Socialreformkommissionens 1," 238.

¹⁰⁹ An opinion poll, conducted before the publicity campaign, suggested that 41 per cent of the public favoured a system without the sickness funds, 28 per cent supported a continuation of the existing role of the sickness funds and 31 per cent did not express a preference. Following the publicity campaign, those supporting a continuation of the sickness funds had dropped to 26 per cent.

difficult struggle "the sickness funds realised that it was impossible to change the direction of the stream."¹¹⁰

6. Social Reform Investigations

The social reforms of the 1960s had captured the imagination of the Danish intellectual community. At the request of the Social Reform Commission, Bent Rold Andersen, Kaj Westergård, Anders From and Jytte Ussing produced four volumes of data to support the need for such reforms.¹¹¹ "It is evident that the Social Reform Commission should, on the one hand, examine ways to unify and improve the effectiveness of the social administration, on the other hand, examine [its] consequences."¹¹²

In Volume II of the investigations, Bent Rold Andersen described the ethos of the 1960s: "The social-political debate and legislation has [in Denmark] undergone a change since the end of the Second World War."¹¹³ Before the war there was a focus on social insurance and welfare aimed at extending the existing provisions through compulsory membership: "The theoretical debate concerned itself especially with the demarcation between public involvement in insurance and benefits together with the financing and distribution in these connections."¹¹⁴ The main problem was to find a balance between the individual's responsibility and that of the society. Excessive public intervention was seen as an unwanted intrusion.

Following the war, it became fashionable "to put added weight on service and outcome" than dogma. Debate on welfare were less about the ideology of individual and social responsibility than about relieving social hardship, improving well-being and providing better lifestyles for the population.

The previous approach had been to offer benefits after an individual had fallen below a certain unacceptable standard. The new philosophy set out to provide such assistance long before the individual reached this low point. Help would be offered commensurate with the normal standards of different groups in society in the hope that this would allow them to regain independence and productivity before becoming completely incapacitated

¹¹⁰ Hansen, *Sygekasseme*, 239.

¹¹¹ They worked at the Danish National Institute of Social Research which the Commission had asked to conduct an extensive review of social reforms.

¹¹² Kaj Westergård, *Socialreformundersøgelserne: De Sociale Ydelser*, Volume 2, Socialforskningsinstituttet Publication No. 53 (Copenhagen: Teknisk Forlag, 1971): 13.

¹¹³ Bent Rold Andersen, *Socialreformundersøgelserne: Borgeren og Tryghedssystemet*, Volume 2, Socialforskningsinstituttet Publication No. 44 (Copenhagen: Teknisk Forlag, 1970), 13. Bent Rold Andersen directed the Social Reform Investigations for the Social Reform Commission.

¹¹⁴ Andersen, *Socialreformundersøgelserne*, 13.

and dependent on public assistance: "Behind this shift in the social-political theory and practice lay a change in the understanding of the goals and aims of social benefits."¹¹⁵

Andersen recommended six major changes in the existing system: unification of the existing public assistance programmes, cooperation between social and health sectors, simplification of the existing complicated system, improved benefits, increased staff to deal with clients and greater emphasis on the delivery of services than on control.¹¹⁶

This re-orientation in the approach to social welfare advocated by Andersen and his group had clear implications for health care. Offering health care only after the individual had become ill was no longer acceptable; whenever possible health promotion through education, prevention, rehabilitation and care should be aim to avoid such illness in the first place.¹¹⁷

7. Sickness Insurance Law of 1971

Hilmar Baunsgaard (Radical Liberals), Denmark's new Prime Minister, appointed Ms. Nathalie Lind (Liberal) as Minister for Social Affairs in 1968. Lind's experience as a lawyer enabled her to oversee the myriad of legislative changes necessary to carry out the desired social security reform and to coordinate these with a decentralisation in local government.

Lind announced the proposed legislation in Parliament on 14 January 1970: "A proposal for a law on the introduction of a local authority administered public sickness insurance system for the whole population will be presented to Parliament during the Parliamentary year 1970-71."¹¹⁸

Because the conflicting points of view about the sickness funds had been thoroughly discussed in the past, Lind wanted to avoid renewing these in Parliament. She promised that the new administration would employ the staff of the sickness funds.¹¹⁹ This reassurance helped limit the parliamentary debates to two days, 12 and 13 May 1970.

The formal proposal for the new Public Sickness Insurance Law was tabled on 13 January 1971. It closely followed the recommendations of the majority report of the

¹¹⁵ Andersen, *Socialreformundersoegelse*, 14.

¹¹⁶ Andersen, *Socialreformundersoegelse*, 13 and 264-65.

¹¹⁷ Andersen, *Socialreformundersoegelse*, 13 and 277.

¹¹⁸ Nathalie Lind, presenting the Sickness Insurance Legislation to Parliament. Denmark, "Lovforslag til Sygesikringsloven," (Copenhagen: Folketinget, 14 January 1970): 1953-84; and Denmark, "Sygesikringsloven" (Copenhagen: Folketinget, 9 June 1971): 2434.

¹¹⁹ Personal communication with Nathalie Lind, Minister for Social Affairs from 1968-71 and Commissioner for the Social Reform Commission of 1969.

Social Reform Commission of 1969.¹²⁰ The law passed its three readings in Parliament on the 14, 26 and 28 May 1971.¹²¹ When implemented on 1 April 1973, the new law offered residents of Denmark public financing for universal entitlement to health care.¹²² A central body, the National Board of Insurance, would administer the running of the new programme.

Under the new system the population was given "equal, sufficient and free access.... [to the general practitioner], the first and most essential link in the service chain.... the key person and gatekeeper."¹²³ New County Council Committees representing various social and health care organizations would deal with all negotiations with the medical profession.

The reserves amassed by the abolished sickness funds were pooled into a new Health Fund, later used to pay for research, medical education, nursing homes and pensions for the non-employable members of the sickness funds.¹²⁴

The new programme would, however, maintain the previous two groups of beneficiaries. Those earning below a certain income, would qualify for completely free medical care; those above this yearly income would pay for visits to doctors but qualify for partial reimbursements and special treatment.

The cost of health care to the central government in Denmark in 1969 had been 1,356 million Crowns. Of this, members had financed 73 per cent, the state 22 per cent, and other sources 3 per cent.¹²⁵ The estimated cost of the new system, in 1969 prices, was 1,096 million Crowns. Since hospitalisation would be financed through the county councils under the new system, and the 7 per cent administrative cost previously used for the sickness funds would be eliminated, the net cost of the reform to the central government was anticipated to decrease.¹²⁶

¹²⁰ The new law would apply only to health care; sickness pay was not included under this reform.

¹²¹ The sickness funds were dissolved 17 March 1973.

¹²² Denmark, "Lovforslag til Sygesikringsloven, "1982-84 and Denmark, "Sygesikringsloven," 2434. The Faroe Islands and Greenland were not included under the law.

¹²³ Soeren K. Soerensen, *Public Administration and Health Care in Denmark* (Copenhagen: National Board of Health, 1984): 7; and Dorte Gannik, Erik Holst and Marsden Wagner, "The national health system in Denmark: A descriptive analysis," Department of Health, Education and Welfare (DHEW) and National Institute for Health (NIH), Monograph, Publication No. 77-673 (Washington: John E. Fogarty International Center for Advanced Study in Health Sciences, 1976): 36.

¹²⁴ Expropriation would have required compensation which the Government of course wanted to avoid.

¹²⁵ Denmark, "Sygesikringsloven," 2456.

¹²⁶ Cash benefits were part of later reforms on public assistance. Denmark, "Lov om Social Bistand," No. 333 (Copenhagen: Folketinget, 19 June 1974); and Ove Baggesen, Grethe Buss and Birthe Frederiksen, *Bistandsloven* (Copenhagen: Juristforbundets Forlag, 1981).

"The major effect of the sickness insurance reform ... [was therefore], that the expenses of health care [were] no longer shared by the population on a per capita basis but ... according to income."¹²⁷ Even the sickness funds recognized the positive contribution to health care made by the new law: "A country's culture can be measured by the quality of the help and support, that benefits the society's sick and weak."¹²⁸ The reformers felt that the new law would allow the Danish health care system to begin focusing on health, not just universal entitlement to health care as it had under the old sickness insurance system.

C. BARRIERS TO UNIVERSAL ENTITLEMENT

1. Groennegår Committee of 1986

Universal entitlement to health care in Denmark had several unique characteristics and shortcomings. First, an income determined means-test continued to divide the population into two groups of patients: the well-to-do and those of ordinary means. According to this system, Personal wealth therefore continued to determine the nature of services enjoyed by an individual.

Secondly, the reforms failed to secure improved inter-sectorial cooperation, despite the fact that this was one of the main ideological reasons for recommending that a broad social reform should include the health sector: "The collaboration between the primary health care sector and the social welfare sector needs strengthening if the objectives of developing alternative models for comprehensive health care at the grass roots level are to be achieved."¹²⁹

Finally, raising the threshold for the welfare safety net still did not prevent a small group from persistently 'falling between the cracks'.¹³⁰ This small group, comprising 10 to 15 per cent of cases needing public assistance, became chronically dependent on the welfare system, resisting all efforts to make them self-sufficient.¹³¹

¹²⁷ Koch and Toftemark, *NHS and EEC*, 9.

¹²⁸ Personal communication with H.C. Hansen, representative from the sickness funds to the Social Reform Commission.

¹²⁹ Personal communication with Dr. Joergen Fog, the present Deputy Director of the National Board of Health, who was also one of the leaders of the FayL during the late 1960s. Joergen Fog, "Primary health care services in Denmark," Paper presented at San Marino (Copenhagen: National Board of Health, 11-13 October 1985): 12.

¹³⁰ Personal communication with Torben Fridberg, member of the follow up studies to the Social Research Investigations of the 1960s at the Danish Institute of Social Research.

¹³¹ Winnie Joergensen and Ivan Thaulow, *Socialreformundersoegelse 6: Klienternes Levekår og Problemer*, Publikation 130 (Copenhagen: Socialforskningsinstituttet, 1984); and Mette Roerbeck et al., *Socialreformundersoegelse 7: Hvordan Går det Klienterne?* Publikation 136 (Copenhagen: Socialforskningsinstituttet, 1985).

In 1982, institutional care remained totally financed by public funds, while ambulatory care still offered financing through the two-group system.¹³² Although in principle universal entitlement existed for all inhabitants as a 'paper right', in practice comprehensiveness was limited by an income barrier for ambulatory care for some, and universal access was limited through poor inter-sectorial cooperation.

Dr. Joergen Fog, current Deputy Director of the National Board of Health, and Dr. Esther Ammundsen, past Director General of the Board of Health, emphasise the importance of public participation to promotion of health: "Maintaining good health is something you have to engage yourself in and fight for with the support of your community and your professional servants: the primary health workers. The responsibility for the care of those with, or in risk of, ill health in the community must be shared by the health people in solidarity."¹³³ Such participation in healthy living cannot be provided through legislative reforms alone but requires a reorientation of people's approach to health and illness.¹³⁴

To encourage such public participation, the Groennegår Committee of 1986 examined the possibility of handing over a larger share of health financing to the primary health care sector, which, in turn, would have to contract services from the hospital sector. This would encourage primary health care doctors to become more self-sufficient, avoid unnecessary use of institutional care, and offer an incentive for patients to seek healthy life styles.¹³⁵

¹³² Alexander S. Preker, "Public finance and provision of health care services in Québec: An international perspective," *Brief*, presented to the Commission of Inquiry into the Health and Social Services of Québec [Chairman Jean Rochon] (London: IIHS, December 1986): 27; and Organization for Economic Co-operation and Development (OECD), *Measuring Health Care 1960-1983: Expenditure Costs and Performance*, OECD Social Policy Studies No. 2 (Paris: OECD, 1985): 68-69 and 74-75.

¹³³ Fog, "Primary health care," 13.

¹³⁴ Personal communication with Dr. Esther Ammundsen, the Director General of the National Board of Health during the period of the reforms.

¹³⁵ Personal communication with Adam Trier, Deputy Secretary in the Ministry of Social Affairs, former Member of the Social Reform Commission and present member of the Groennegår Committee.

CHAPTER 8. NORWAY

Without an effectively developed health care system, our country's defences can be completely paralysed. Such a health care system must be developed so that it not only takes into consideration the 10-15 per cent of the population who will be mobilised during war, but also the remaining 85-90 per cent.¹

Rakel Seweriin, 1955

A. FINANCIAL INFRASTRUCTURES

1. Sickness Funds

During the nineteenth century only the rich in Norway could afford to receive treatment from private medical doctors.² "The introduction of prepaid medical care in Norway was not opposed by the medical profession," since doctors found it difficult to survive on the income that they earned from the well-to-do alone.³ Private practitioners were therefore scarce, leaving a few publicly employed county officers of health and hospitals responsible for most of the medical care in the community.⁴

Private charities, religious groups and the Poor Laws likewise offered only minimal provisions for the sick and destitute. Although centuries earlier King Magnus the Law-Mender (1263-80) had enforced a limited national social aid programme for the needy, most Norwegians had to rely on the informal network of health care during the nineteenth century.⁵

Towards the latter part of the previous century, as urbanization accompanied early industrialization, working Norwegians sought other ways to finance health care than through handouts. Trade guilds and small private insurance groups, established by lodges and labour unions, provided limited financial aid to its members. Both of these were more acceptable to the ordinary working man than charity.⁶ This led King Oscar II, of the joint

¹ Rakel Seweriin introducing the Civil Defence Health Plan in Parliament in 1955. Norway "Lov om Helsemessig Beredskap," *Ot. ppp.* 39(2 December 1955): 1.

² State employed district doctors, however, were available in Norway at an early stage.

³ S.E. Ekeid, "Health services in Norway: Commitment to decentralisation" *Monograph* (Oslo: Directorate of Health, n.d.): 8.

⁴ Salaried doctors staffed hospitals.

⁵ On 14 January 1814, after four hundred years under the Danish Crown, Denmark handed Norway over to the King of Sweden as part of a war settlement. Although never accepted by Norway, this union existed until 7 June 1905.

⁶ Norway, *Social Insurance in Norway* (Stockholm: National Insurance Administration, 1984): 5.

Swedish-Norwegian Kingdom, to become interested in the Bismarkian model of sickness insurance.⁷

In December 1884, the King asked Johan Sverdrup, the Prime Minister, to examine the social benefits enjoyed by industrial workers. A. Hedin, a member of the Swedish Parliament, had proposed a motion for increasing the obligations of employers earlier that year: "The same question [concerning workmen's welfare] is posed in all of the civilized world; it can no longer be avoided."⁸

In response to the King's initiative, the Minister of the Interior established a Commission on Labour 19 August 1885 under the Chairmanship of Christian Arneberg. Its terms of reference were to examine social insurance available to workers, including sickness insurance.⁹ The Commission presented its report on sickness insurance for workers in February 1890. It called for compulsory sickness insurance for all workers earning less than 1200 Crowns per year, excluding certain groups such as farmers, forestry workers, seamen or fishermen.¹⁰

Gunnar Knudsen, one of the members of the Commission (later Prime Minister), felt that contributions from members should finance the entire plan.¹¹ According to his recommendations, there would be no state subsidies or employer contributions. The programme would offer cash benefit only, not medical treatment. Sickness funds administer the plan, under the supervision of a public authority, the National Sickness Fund. The latter would in turn have its own branches in all municipalities and ensure coverage for those not holding private insurance.

The Accident Insurance Law of 1894, which passed following the Commission's study, limited coverage to industrial accidents.¹² More comprehensive sickness insurance, which had been discussed during the Commission's inquiry, was not introduced until years later. Shortly after the introduction of the new law, Parliament established two new working groups to continue examining the many unsettled issues.

2. County Medical Officer

The Norwegian Health Act of 1860 placed the responsibility for public health on the local authorities whose jurisdiction was soon extended to include other aspects of health

⁷ Norway, *Social Insurance in Norway*, 5.

⁸ Prime Minister Sverdrup quoted in Nils Urdal, *Syketrygden i Femti År. Historien om en Grunnleggende Social Reform* (Oslo: Norges Trygdekasselag, 1961): 12.

⁹ Urdal, *Syketrygden*, 17.

¹⁰ Urdal, *Syketrygden*, 20.

¹¹ Urdal, *Syketrygden*, 22.

¹² A corresponding programme for sailors and fishermen followed in 1911.

care.¹³ Each municipality established a Board of Health to oversee hygiene and disease prevention in the community.¹⁴ These provisions expanded to include midwives, public health nurses, home nurses, clinics for children, clinics for mothers and school health.¹⁵

County Medical Officers of Health, who existed in Norway since the 17th century, were responsible for traditional public health duties, such as prevention, inspection, control of epidemics and administration.¹⁶ Of necessity, they also provided clinical care for the poor and destitute.¹⁷ "The result was that primary health care -- in the widest sense of the term -- came to be regarded from the very start as the prerogative of a local Medical Officer with both preventive and curative duties."¹⁸

The national Government paid the Norwegian Medical Officers of Health a basic salary for their public health duties, while patients paid fee-for-service for medical care. This combined income allowed the doctors to enjoy a much higher standard of living and status than their medical counterparts in other Nordic countries.¹⁹ Despite their increase, the Norwegian Medical Officers of health nevertheless remained too few to provide adequate health care for Norway's population of 2,240,032, which at the turn of the century was scattered over 3,243,878 square kilometers of mountains, desolate fjords and northern wastelands.²⁰

3. Committee Work

The Permanent Social Affairs Standing Committee, established in 1894, with Gunnar Knudsen as its Chairman, recommended the appointment of a Parliamentary Select Commission on Labour to review disability insurance and old age pensions. W. Konow, Minister of the Interior, became its Chairman.²¹

¹³ The District Doctor Law of 26 July 1912, required the presence of a County Medical Officer of Health in each municipality.

¹⁴ The County Medical Officer of Health acted as Chairman.

¹⁵ Kaare Salvesen, "Norwegian health administration: Past and present," *Monograph* (Oslo: Royal Norwegian Ministry of Health and Social Affairs, 1985): 5.

¹⁶ Ex officio, he was the Chairman of the local Board of Health and the National Health Administration Representative.

¹⁷ Ekeid, "Health services in Norway," 6. Much later the state appointed a County Medical Officer of Health at the level of the regional county. His duty was to supervise and enforce the health related statutory responsibilities of the counties.

¹⁸ Ekeid, "Health services in Norway," 6.

¹⁹ Karl Evang, "Public health services," *Den Norske Lægeforening* 90(1970): 1141.

²⁰ At the time the population was mainly rural, and the Norwegian economy was largely based on non-industrial activities such as fishing, forestry, mining and some agriculture in arable regions. The population for 1900 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962): 280 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 929.

²¹ Urdal, *Syketrygden*, 31. A second Commission, established in 1902, reported in 1904.

In subsequent years, these two groups presented proposals for sickness insurance to Parliament at regular intervals. The debate became deadlocked over two conflicting approaches: Knudsen on the Standing Committee supported a comprehensive sickness insurance programme, while Konow on the Select Commission advocated limited accident and disability insurance.²²

As time passed, several major questions were raised. First, should the programme include treatment by doctors, medications and cash benefits?²³ Secondly, should the state, employers and workers all contribute towards the financing of the programme? Finally, should supplementary insurance be offered on a voluntary basis to those who did not qualify for the basic programme?

Both the Secretary of the Norwegian Medical Association, Dr. R. Hansson, and the Director-General of Health feared that unlimited coverage would be abused and become too expensive. They also warned that without a means-test the number of applicants for the programme would quickly outstrip the capacity of the health care system to deliver the required services.²⁴

In 1908, O.A. Eferstoel became Chairman of the Social Affairs Standing Committee.²⁵ Wishing to break the long-standing stalemate in the sickness insurance debate, Eferstoel tried to convince the Minister of Social Affairs, Johan Castberg, that a comprehensive compulsory sickness insurance programme was superior to a separate accident and disability insurance.

Under Eferstoel's direction, the Committee outlined a means-tested programme which would aim at select groups of workers and be administered through local sickness funds. Benefits would include sickness pay, treatment by medical doctors and various prostheses such as glasses. Four groups would contribute towards the financing of the programme which would cost 6.6 million Crowns: workers (60 per cent), employers (10 per cent), municipalities (10 per cent) and the state (20 per cent).²⁶

²² Urdal, *Syketrygden*, 37.

²³ Urdal, *Syketrygden*, 29.

²⁴ Urdal, *Syketrygden*, 45.

²⁵ Dr. R. Hansson became an important member of this Committee. A second parliamentary Commission had been unsuccessful in securing public and political support for its work.

²⁶ Urdal, *Syketrygden*, 53.

4. The Labour Party

The Norwegian Labour Party became active in the health care debate at an early stage.²⁷ Dr. Oscar Nissen, the Chairman of the party in 1908, supported Labour's earlier call for health care financing through general revenues.²⁸ "There is only one way to go: all the sick must be covered by one system. Doctors and midwives must become public employees and prohibited from accepting private cash. Only in this way can all be made equal, so that there is no reason to treat one human being differently from another."²⁹

Nissen criticised the sickness insurance model which he felt would only create an added burden for workers and provide inadequate coverage for those who needed help the most. His alternative was "health care through taxation."³⁰ When asked how a doctor could function on a salary, Nissen replied that there was no reason that doctors paid a regular salary and guaranteed a pension could not work with the same sense of responsibility as before.

The Labour Party's proposal was presented to Parliament on 27 February 1907: "Through an insurance programme, there can never be enough help for those who need it. ... As most other solutions through workers' insurance, sickness insurance is in reality experienced by workers not as a relief but as an added burden."³¹ The Labour Party claimed that only taxation could justly distribute the financial burden of illness more evenly across society.

The Norwegian Medical Association initially accepted the general principles of a national programme with doctors on salaries financed through general revenues.³² At their Annual Meeting in 1909, the Association declared that, although it preferred direct fee-for-service with free choice of doctor, it would co-operate with a salaried service: "The Norwegian Medical Association declares that, from a hygienic point of view, there are no objections to a transfer of doctors to a taxation system."³³

At the insistence of one of its members, Lars O. Sæboe, the Social Affairs Standing Committee examined the Labour Party's proposal. The Committee, however, concluded that the proposal was too radical, having no parallel programme in Western Europe.

²⁷ The Norwegian political parties include: Party of Progress, Conservative Party, Christian Democratic Party, Centre Party, Labour Party, Social Democratic Party, and Socialist Left Party.

²⁸ Norwegian Labour Party Platform of 1893. Urdal, *Syketrygden*, 56.

²⁹ Urdal, *Syketrygden*, 56.

³⁰ Urdal, *Syketrygden*, 56.

³¹ Urdal, *Syketrygden*, 60.

³² Most doctors would benefit from the new system; only a few doctors making unreasonably high incomes would suffer.

³³ Norwegian Medical Association quoted in Urdal, *Syketrygden*, 76.

Furthermore, it felt that old age pensions and disability insurance should be introduced before comprehensive sickness insurance.

Sæboe, defending the Labour Party position, sounded a note of dissent. He pointed out the absurdity of sickness insurance which offered sick pay without health care, especially when the former was inadequate.³⁴ He also objected to giving old age pensions and disability insurance a higher priority than sickness insurance.³⁵

The Secretary of State for Commerce and Industry, Lars Abrahamsen, presented the draft legislation for a Sickness Insurance Law to Parliament on the 17 August 1909. The proposal followed the lines of the recommendation made by the Social Affairs Standing Committee.³⁶ Although more conservative supporters of Konow and the socialist supporters of Sæboe immediately voiced objections, Eferstoel was able to convince Parliament to accept his compromise plan, reminding its members that Sweden, Denmark and Germany had already introduced such Government supported sickness insurance: "We feel ... that it is necessary to proceed in a step-wise fashion."³⁷ The upper house of Parliament passed the means-tested Compulsory Sickness Insurance Law on 18 September 1909 which would be implemented on 1 July 1911.

5. Compulsory Sickness Insurance Law of 1909

Workers' and employers' contributions as well as subsidies from local municipalities and the state financed the new programme. To qualify for state subsidies, a sickness fund had to comply with the criteria established under the law. These rules included the public election of members to the sickness funds' administrative boards and the provision of a variety of predetermined benefits, such as free medical treatment in hospitals, and sick pay for members and their families. A later amendment allowed non-wage earners to join a supplementary voluntary programme.

Several administrative changes were introduced through the reform. A public authority, the National Insurance Institute, would oversee the sickness funds which would be established in each municipality.³⁸ The sickness funds in turn formed a National Association of Insurance Offices. Finally, the Ministry of Social Affairs assumed the responsibility for health care from the Ministry of the Interior in 1913.

³⁴ Considering the limited effectiveness of medical science at the turn of the century, compensation for lost income during illness may in fact have been more important than medical treatment.

³⁵ Urdal, *Syketrygden*, 69.

³⁶ The state subsidy was decreased while employer contributions were increased.

³⁷ Eferstoel quoted in Urdal, *Syketrygden*, 75.

³⁸ T. Stroem became its director.

The new programme was immediately contested by several groups. The National Association of Insurance Offices wanted the means-test raised. The labour unions and the Social Democratic Party objected to such means-tests, the exclusion of certain groups of workers and lack of coverage for certain categories of illnesses.³⁹ Konow continued to press for a postponement of the date of implementation, while Sæboe still advocated a universal salaried doctor service.

Despite such criticisms, "the programme became immediately popular: even though members paid a good share of the expenses themselves through premiums and ordinary taxes, more people constantly desired to be included."⁴⁰ The Compulsory Sickness Insurance Law of 1909 was a landmark in Norway because it created the terms of collective financing of health care which the country would follow over the next 50 years: "In my opinion, it was an ingenious thought that became law ... the family insurance principle."⁴¹ Later reforms would expand and modify its provisions but not its basic underlying principles.⁴²

6. Norwegian Medical Association

The Norwegian Medical Association, which was created in 1886, made sure that the views of the medical profession were heard by early legislators.⁴³ R. Hansson, General Secretary of the Association, was a member of both the Social Affairs Standing Committee and the Finance Committee which prepared the 1909 legislation.⁴⁴ This reflected the philosophy of the Association to "strive for greater influence and thus enhance its authority," an objective which was quickly fulfilled.⁴⁵

Most doctors in private practice and County Medical Officers of Health had found it difficult to survive on the small incomes available through fee-for-service before the

³⁹ Urdal, *Syketrygden*, 105-114.

⁴⁰ Karl Evang, *Health Services in Norway*, 4th Edition (Oslo: Universitetsforlaget, 1976): 37.

⁴¹ The Minister of Health in 1955, Dr. Gudmund Harlem, referring to the earlier Compulsory Sickness Insurance Law of 1909. Urdal, *Syketrygden*, 369.

⁴² Harold Siem, *Choices for Health: An Introduction to the Health Services in Norway* (Oslo: Universitetsforlaget, 1985): 53. By the 1930s, access to services financed through public funds were already considered as right by the population, not as a condition of charity and poor relief. Personal communication with Dr. Harold Siem, author on the Norwegian health care system.

⁴³ Axel Boeck Aubert, "The Norwegian Medical Association as it should be," *Tidsskrift for Den Norske Lægeforening* 10(30 May 1970): 51. Today, the Norwegian Medical Association considers itself a "trade union" like its counterpart in Sweden. Harald Hauge, "The view of the Norwegian Medical Association," in *Scandinavian Health Care: Report of an Estes Park Conference* edited by Richard C. Bates (Englewood, Colorado: Estes Park Institute, 1983): 32.

⁴⁴ Ole Berg, "Verdier og interesser: Den Norske Lægeforenings fremvekst og utvikling," in *Legerne of Samfunnet* edited by Oeivind Larsen, Ole Berg and Fritz Hodne (Oslo: Den Norske Lægeforening, 1986): 255. Personal communication with Dr. Ole Berg, Associate Professor at the Institute of Political Science, University of Oslo.

⁴⁵ Odd Bjercke, "The Norwegian Medical Association as it is," *Tidsskrift for Den Norske Lægeforening* 10(30 May 1970): 48.

introduction of the 1909 law. Sickness Insurance "not only created 'health security' in the field of curative medicine for the population but also provided a higher degree of financial security for the doctor."⁴⁶

The 1909 law was therefore welcomed by most of the medical profession. Private doctors retained their full professional freedom, obtained virtually unlimited third party payments on a fee-for-service basis in urban areas and remained free to determine their own fees. Doctors hailed the new act for making them financially more secure and freer in their work.⁴⁷ The state-salaried district doctors continued to treat patients in the less populated rural areas. Patients continued to have a free choice of doctor. This, Hansson believed, would avoid a small group of panel doctors from gaining control of all benefits evolving out of the new law.

Despite such praise, the shortcomings of health care coverage through third party insurance soon became apparent. "The Sickness Insurance Law has given the doctors a unique power over the district insurance funds. The law requires that the sickness funds provide its members and their families with free health care. But it does not compel the doctors to respect whatsoever the terms of such health care."⁴⁸ Since each sickness fund had to negotiate with its own doctors, there was no standard fee-schedule, and doctors were accused of 'plundering' the sickness funds.⁴⁹

A variety of unsuccessful attempts were made to settle this conflict. Professor A. Palmstroem, an actuary familiar with the Lloyd George plan in Great Britain, suggested collective negotiations in 1912. This led to an informal agreement on a fee schedule between the Norwegian Medical Association and the National Association of Insurance Offices.⁵⁰ This and later collective agreements were, however, often ignored by many doctors who continued charging patients whatever they wished.

By the mid-1920s, difficult economic times in Norway forced the Government to look for ways to limit public expenditure. This led Parliament to introduce a reimbursement principle for sickness insurance in 1925, ending a golden era for the medical profession.⁵¹ Under the revised system, doctors charged the patient directly instead of being reimbursed by the sickness funds for offering free medical treatment. It was now patients that had to claim reimbursements based on a fixed pre-established fee schedule. Any

⁴⁶ Evang, *Health Services*, 46.

⁴⁷ Berg, "Verdier og interesser," 255.

⁴⁸ Urdal, *Syketrygden*, 126.

⁴⁹ Dr. M. Solberg from Drangedal quoted in Urdal, *Syketrygden*, 117.

⁵⁰ Urdal, *Syketrygden*, 116.

⁵¹ Despite these conflicts, the rising membership with the sickness funds included 22 per cent of the population.

difference in the amount charged by the doctor and the official fee schedule was borne by the patient.⁵²

Although the new system succeeded in stemming the growth in public subsidies for the sickness funds, a gap soon developed between the recommended fee schedule and what was charged by doctors. Everyone lost through this new policy: patients now had to pay not only health care contributions and taxes but also a fee-for-service; doctors had to handle cash transactions during patient visits; and the Government and the sickness funds still had no control over the fees charged by the medical profession or the overall and the cost of health care.

B. LANDMARK LEGISLATIVE REFORMS

1. The Great Depression

Unemployment and the Great Depression led to a collapse of the Mowinckel Government, and with it a political era ended in Norway. The Labour Party, which formed a Minority Coalition Government in 1933, would remain in power for the next 10 years and mark the beginning of 30 years of intermittent Labour rule.⁵³ "With Nygaardsvold's Government in March 1935, we entered a new epoch in the Norwegian people's history."⁵⁴

Prime Minister Johan Nygaardsvold's wanted to combat unemployment and the effects of the Great Depression with a program of economic and social reform.⁵⁵ Despite the lack of economic resources to finance such reforms, Oscar Torp, the Minister of Social Affairs in 1936 (later Prime Minister), "eagerly went to work implementing the social reforms that the Nygaardsvold Government had recommended."⁵⁶

Shortly after taking office the new Government was troubled by new developments in Europe, forcing it to take an active stance on defence. In approving the previous Government's defence budget, Nygaardsvold said with dismay: "I hope that you do not want me to go farther than Mowinckel did."⁵⁷ Despite this additional economic burden, the Labor Government pressed on with its proposed social reforms.

⁵² Urdal, *Syketrygden*, 219.

⁵³ Vidkun Quisling, the fascist and Nazi sympathiser who had been appointed Minister of Defence under the Mowinckel Government, would soon haunt Norwegians.

⁵⁴ Einar Gerhardsen, *Unge År: Erindinger fra Århundreskifter Fram til 1940* (Oslo: Tiden Norsk Forlag, 1974): 297.

⁵⁵ Egil Helle, *Oscar Torp: Arbeidergutt og Statsmann* (Oslo: Gyldendal Norsk Forlag, 1982): 134; and Urdal, *Syketrygden*, 271.

⁵⁶ Helle, *Oscar Torp*, 134. Torp replaced Kornelius Bergsvik who took the portfolio as Minister of Finance.

⁵⁷ Gerhardsen, *Unge År*, 353.

The Permanent Secretary of the Department of Social Affairs, Berger Ulsaker, became the Secretary of a Social Legislation Committee. The terms of reference of the Committee were to review and improve existing social security provisions.⁵⁸ Within a short period of time, Norway had introduced "old age pensions, blindness and disability insurance, insurance for fishermen and sailors, unemployment insurance and preparations for [a new] sickness insurance."⁵⁹ Gunnar Stoervold, Director of the National Insurance Institute, in 1937, stressed that future reforms should include health care: "It has already been advocated that a further evolution should be ... sickness insurance for the whole population."⁶⁰ He added, "I am very interested in an evolution in that direction."⁶¹

At a general meeting of the National Association of Insurance Offices, the organization supported an "efficient social insurance programme covering the whole population."⁶² Such a programme would include sickness insurance, a stance that the Association would maintain after the report of the Social Legislation Committee was released in 1939.

Gunnar Stoervold and M. Ormestad presented their proposal for a joint law on health and disability insurance in 1935.⁶³ Their proposal recommending that everyone between the ages of 5 and 70 be included, continued the Labour Party's platform on universal entitlement to health care that it had first advanced in 1909. The Social Legislation Committee that finally reported to Parliament on sickness insurance on 4 March 1939, called for a new Universal Compulsory Sickness Insurance Law similar to that proposed by Stoervold and Ormestad.⁶⁴ It also recommended that disability insurance be examined separately in greater detail before its inclusion.

The Committee denounced the practice of limiting social insurance to the employed, claiming that the many farmers, self-employed, artisans and other small business people had an equal right to benefits: "The main part of [the excluded] population live under economic conditions that are not better but probably rather worse than they are for a

⁵⁸ Norway, "Innstilling om en Lov om Syketrygd," *Innstilling*, No. 4 from Sosiallovkomitéen (4 March 1939). The Committee began its work on sickness insurance in 1937, following its reports on old age pensions, and insurance for unemployment, blindness and disability.

⁵⁹ Gerhardsen, *Unge Ar*, 298.

⁶⁰ Gunnar Stoervold quoted in Urdal, *Syketrygden*, 285.

⁶¹ Gunnar Stoervold quoted in Urdal, *Syketrygden*, 285.

⁶² Personal communication with Ottar Lund, committee member from the Department of Social Affairs to the expert working group drafting the Sickness Insurance Law of 1955.

⁶³ Norway, "Innstilling om en Lov om Syketrygd." Stoervold was then head of a division in the National Insurance Institution; Ormestad was the Chairman of the Norwegian Sickness Fund Society and Director of the Oslo Insurance Office.

⁶⁴ Norway, "Innstilling om en Lov om Syketrygd"; and Norway, "Folketrygden om pliktig syketrygd for alle," *Innstilling*, No. 2 form Folketrygdkomitéen (1954): 5. Both Stoervold and Ormestad were also members of the Social Legislation Committee.

large part of those who are now covered by the compulsory insurance."⁶⁵ Such extension in coverage was justified not only as a general claim for equality of treatment between the different groups of the population but also because it was felt that a fully effective sickness insurance programme warranted such measures.⁶⁶

By 1937 the sickness funds had attained a membership of 1 million, comprising 60 per cent of the population.⁶⁷ However, many had by this time run into financial difficulties, owing the National Insurance Institute over 3 million Crowns by 1939.⁶⁸ Furthermore, those who needed protection the most were often those excluded from coverage under existing provisions. Although a further extension in coverage by the sickness funds was badly needed, the outbreak of World War II forced Torp to abandon such plans. Instead, Norwegians had to turn their full attention to the struggle for survival.

2. War Occupation and Joint Reconstruction Programme

Norway was badly prepared for the war: "The air-raid sirens and angry noises woke us up."⁶⁹ Having maintained neutrality during World War I, Norwegians had no recent experience to draw on for their mobilisation. Evacuation of the sick and the numerous casualties suffered during the war exposed many of the weaknesses in the existing health care system.

During the occupation, Nazi sympathisers had appointed a National Assembly under the leadership of Vidkun Quisling: "Most Norwegians were opposed to Nazism and throughout the occupation maintained a strongly anti-Nazi front."⁷⁰ When the Nazi regime arrested the Secretary General of the Norwegian Medical Association and appointed a Nazi commissary, 80 per cent of the members withdrew from the organization.⁷¹ Norwegians were subdued physically, but never morally. Civil resistance prevailed throughout the war.

Prime Minister Nygaardsvold formed a Norwegian Government-in-exile in London. The 'London-Regime' was "at times resentful and even bitter over Sweden's neutrality."⁷² Nygaardsvold declared in a speech in London that a union among the Nordic states was

⁶⁵ Personal communication with Ottar Lund, Assistant Secretary of Social Affairs in 1955. Supported through personal communication with Hans Johnsen, committee member from the National Insurance Institution to the expert working group drafting the Sickness Insurance Law of 1955.

⁶⁶ Norway, "Innstilling om en Lov om Syketrygd."

⁶⁷ Urdal, *Syketrygden*, 288.

⁶⁸ Urdal, *Syketrygden*, 292.

⁶⁹ Einar Gerhardsen, *Fellesskap i Krig of Fred: Erindinger 1940-45* (Oslo: Tiden Norsk Forlag, 1970): 9.

⁷⁰ Axel Stroem, "Lægeforeningen under okkupasjonen" *Tidsskrift for Den Norske Lægeforening* 11(1 June 1961): 712.

⁷¹ Stroem, "Social insurance," 712.

⁷² Marquis W. Childs, *Sweden: The Middle Way on Trial* (New Haven: Yale University Press, 1980): 126.

"not part of Norway's postwar plans."⁷³ Despite such sentiments, those who remained in Norway often found neutral Sweden the only place where they could seek refuge.⁷⁴

When Nazi troops invaded Norway on 9 April 1940, human fellowship and the courageous Norwegian underground provided the best protection for the fleeing refugees and those who remained prey to the Nazi 'puppet regime': "In the shadows of prisons, concentration camps and execution centres, a brotherhood developed that we had been unaware of before."⁷⁵

The post-war Joint Reconstruction Programme had its origin during those difficult years. German forces began retreating from Norway in October 1944; liberation took place on 8 May 1945. On 25 June 1945, Einar Gerhardsen, who had spent most of the war in Norway and Sweden as well as in German concentration camps, became Prime Minister of the post-war Coalition Government.

All parties pledged support for a Joint Reconstruction Programme which gave birth to the Norwegian universal sickness insurance system.⁷⁶ The programme, 'Work for All', aimed to secure freedom, rebuild the economy with employment and security for all, create solidarity between the social classes and establish a new international order to secure peace for the future.⁷⁷ This was seen as the only way "to make Norway a secure and good home for all."⁷⁸

3. Parliamentary Decree

On 19 November 1948, the Labour Government, under the leadership of Einar Gerhardsen, announced in a parliamentary decree that the Joint Reconstruction Programme would include provisions for a comprehensive social security programme.⁷⁹ Later, the Ministry of Social Affairs revealed that such a programme would include universal entitlement to health care under compulsory sickness insurance. The proposal, reflecting the spirit of the national fellowship that existed immediately following the war, was supported by all political parties.⁸⁰

⁷³ Childs, *Sweden 1980*, 130.

⁷⁴ Gerhardsen, *Fellesskap*.

⁷⁵ Gerhardsen, *Fellesskap*, 149.

⁷⁶ Gerhardsen, *Fellesskap*, 161.

⁷⁷ Einar Gerhardsen, *Samarbeid og Strid: Erindringer 1945-55* (Oslo: Tiden Norsk Forlag, 1971): 32.

⁷⁸ Gunnar Ousland (Labour), C.A.R. Christensen (Right), Verdens Gang (Left) and Hans Holten (Farmers), the four "forefathers" of the joint reconstruction programme. Gerhardsen, *Fellesskap*, 150.

⁷⁹ The new Labour Government came to power on 5 November 1945, with a majority in Parliament. Norway "Stortingsmeldingen om fylketrygd," Stortingsmeldingen 58(1948); and Norway, "Folketrygden om pliktig syketrygd," 9.

⁸⁰ Gerhardsen, *Fellesskap*, 7.

Gerhardsen's years as a prisoner-of-war in German concentration camps had taught him the compassion for human suffering which the civilian population needed in the post-war period: "[He believed that] politics of social security, and especially social insurance, [was] solidarity in practice. Those who are healthy, help the sick and disabled, those who are employed, help the unemployed, those who are of working age, help the old."⁸¹

During the war, the sickness funds had been unable to meet the costs of health care and cash benefits, especially in the northern regions. By 1947, they had a deficit of 15 million Crowns. Although, the Department of Social Affairs had until then resisted going back to the "means-tested sickness benefits that existed before the war," the existing condition could not prevail much longer.⁸²

The Members of Parliament who had been in the war-time London Shadow Cabinet believed that social insurance and a modified Beveridge Plan could provide a solution to these difficulties: "The social security legislation should evolve with a view towards making poor relief superfluous. The social insurance programmes should be consolidated in order to establish a common insurance programme for sickness, disability, unemployment and old age."⁸³

Sven Oftedal, the Minister of Social Affairs who had been intimately involved with the proposed social reforms during the 1930s, became the driving force for the new social legislation. Assisting Oftedal in his task were R.G. Caspersen, Director of the National Association of Insurance Offices, and Knut Getz World, Permanent Secretary in the Department of Social Affairs.

There were many priorities, each seeming as important as the other: pensions, unemployment insurance, child benefits, disability insurance, accident insurance and sickness insurance. "During the war, Oftedal had helped relieve the suffering of fellow prisoners and save lives in various German concentration camps. Now in a free Norway he had to secure his countrymen their life and health. No one could have been better suited for [the job]."⁸⁴

When Sven Oftedal died in 1948, he had finished most of the preliminary work for the future plan. His successor Aaslaug Aasland presented a draft for a unified social insurance programme to Parliament on 19 November 1948.⁸⁵ The health provisions called

⁸¹ Gerhardsen, *Samarbeid*, 167.

⁸² Urdal, *Syketrygden*, 319; and Urdal, *Syketrygden*, 324.

⁸³ Urdal, *Syketrygden*, 325. Supported by personal communication with Ottar Lund and Rakel Seweriin.

⁸⁴ Gerhardsen, *Samarbeid*, 165.

⁸⁵ Norway, "Stortingsmeldingen om fylktrygd" and Urdal, *Syketrygden*, 325.

for compulsory sickness insurance for all Norwegians. This would include health care, hospital treatment, transportation, drugs and the usual cash benefits. Other benefits would be added later in response to local needs and initiatives.

Workers, employers, the municipalities and the state would finance the new programme. It would be administered by National Insurance Institute which would use existing sickness funds as local agents.⁸⁶ Extending the previous programme to all Norwegians was estimated to cost 325 million Crowns.⁸⁷

To avoid a conflict with the medical profession, doctors would be paid on a fee-for-service basis rather than a capitation fee or salary. Hospitalisation would remain completely free of charge, financed largely through the local municipalities. There would be a charge for prescriptions although essential medications would be available at as low a cost as possible.

Public reaction to the legislation was anticlimactic: "One cannot deny that the public reaction or rather near total lack of reaction to the announcement [was] somewhat of a disappointment for those of us who have worked on it."⁸⁸ The Norwegian Medical Association considered the parliamentary proposal an 'important document' which it felt could form the basis for further efforts to develop a sickness insurance programme.⁸⁹ Only the National Association of Insurance Offices, whose independence was threatened, objected to a tax-based system of financing and to the new central role of the National Insurance Institution which would collect the finances and distribute the benefits of the new programme.⁹⁰

The Social Affairs Standing Committee immediately began drafting the legislation for the social insurance reform⁹¹ and the more specific sickness insurance reform.⁹² In 1951, a committee was assigned the task of examining and unifying the existing social security system, including voluntary and means-tested compulsory sickness insurance.⁹³

4. Social Insurance Committee Report No. I

Nils Hoensvald, a Member of Parliament, became the Chairman of the Social Insurance Committee. Its members included R.G. Caspersen, the Director of the

⁸⁶ The problem of collecting contributions from the self-employed and other non-employed remained unsettled.

⁸⁷ Urdal, *Syketrygden*, 327.

⁸⁸ Urdal, *Syketrygden*, 333.

⁸⁹ Norwegian Medical Association quoted in Urdal, *Syketrygden*, 336.

⁹⁰ Urdal, *Syketrygden*, 334.

⁹¹ The Committee was Appointed in 23 February 1951. Norway, "Folketrygden" *Innstilling st.* 265(1952).

⁹² Norway, "Folketrygden om pliktig syketrygd."

⁹³ The sickness funds covered 70 per cent of the population in 1945 and nearly 90 per cent of the population by the mid-1950s.

National Association of Insurance Offices, and Dr. Axel Stroem, the President of the Norwegian Medical Association. Both Caspersen and Stroem felt that many people could not afford to insure themselves and that there was a strong desire for collective protection: "The first and most important task will be to ease the social needs of groups that cannot care for themselves.... A natural consequence of solving this mentioned and most important task will be that ... the cost [of social needs] will be collectively divided among the working portion of the population."⁹⁴

The first report of the Social Insurance Committee recommended that Norway introduce universal entitlement to social security, "compulsory for the whole population, with no consideration for either contributions or income."⁹⁵ The programme would provide the working population with comprehensive benefits: sickness insurance, accident insurance, workmen's compensation and old age pensions. The report concluded that coverage for sickness insurance should be expanded to include "all the population without regard to contribution or income."⁹⁶

Workers, employers, the state and the local municipalities would finance the new programme with contributions being collected at source together with ordinary income taxes. Every capable person would contribute to the programme: "It is necessary to build a security system for people that are not capable of caring for themselves and who require a collective support from the working population."⁹⁷

The leaders of the Labour Government hoped that a contributory programme which would pay for itself would avoid putting an added burden on the treasury. Based on an estimate that the social security system had cost 390 million Crowns in 1947-48, the Committee projected that under existing separate provisions the system would cost 747 million Crowns in 1952-53. Under the proposed integrated system, the cost would only increase to 765 Crowns for 1952-53.⁹⁸ Seweriin, later Minister of Social Affairs, however warned that the cost might be 'considerably more'.⁹⁹

The first report emphasised that those not covered under existing provisions were often those in greatest need. The excluded group included the self-employed, unemployed, older people, pensioners, those covered under public assistance and perhaps

⁹⁴ Norway, "Folketrygden," 1.

⁹⁵ Norway, "Folketrygden," 1; and Norway, "Folketrygden om pliktig syketrygd," 9. The terms of reference of the Committee had been to examine the principle of coordinating and developing a comprehensive social security programme for Norway.

⁹⁶ Norway, "Folketrygden," quoted in Urdal, *Syketrygden*, 339.

⁹⁷ Norway, "Folketrygden," quoted in Urdal, *Syketrygden*, 338.

⁹⁸ Norway, "Folketrygden," quoted in Urdal, *Syketrygden*, 340.

⁹⁹ Rakel Seweriin quoted in Urdal, *Syketrygden*, 342.

most importantly, those who previously were in too poor health to qualify for membership with the sickness funds. All depended on the state for financial support.

Although, Norway was undergoing its "biggest and richest expansion in the history,"¹⁰⁰ The mid-1950s (Torp years) represented a tumultuous time in Norwegian politics, marked by internal political strife and economic difficulties.¹⁰¹ The Chairman of the Committee, Nils Hoensvald, recommended delaying introduction of the planned social reforms until after post-war economic recovery to avoid it becoming a financial nightmare for the State. Oscar Torp, who had replaced Gerhardsen as Prime Minister, likewise feared that his Government would have to bear the brunt of discontent if the Treasury incurred a deficit which would worsen inflation. Reforms through contributory social insurance were therefore seen as a safer route than the Labour Party's traditional call for the financing of public programmes through general revenues.

Finn Alexander, later Director of the National Sickness Insurance institution, felt that if the local sickness funds took over all responsibility for social security the programme would avoid contributing to the financial burden of the state. He therefore recommended that a sickness insurance should be given priority attention, since it would provide a the basis for other social reforms.¹⁰² Seweriin supported this view.¹⁰³ "Norway is one of those countries in the world where public sickness insurance has become a truly popular institution."¹⁰⁴

5. Committee Report No. II

The parliamentary debates on social security included discussions on sickness insurance on 6 and 7 November 1952. Over the next two years, the details of the programme took form. The second report of the Social Insurance Committee, published on 9 February 1954, dealt exclusively with the sickness insurance question: "The Committee recommends that compulsory universal sickness insurance should be introduced as soon as possible."¹⁰⁵

¹⁰⁰ Mons Lid, Minister of Finance in 1955, quoted in Gerhardsen, *Samarbeid*, 1972.

¹⁰¹ Helle, *Oscar Torp*.

¹⁰² Personal communication with Finn Alexander, former Director General of the National Insurance Institution. Urdal, *Syketrygden*, 337.

¹⁰³ Seweriin replaced Aaslaug Aasland on 2 November 1953 as Minister of Social Affairs in the new Oscar Torp Labour Regime (19 November 1951 to 22 January 1955).

¹⁰⁴ Rakel Seweriin speaking to Parliament during the November 1952 parliamentary debates, quoted in Urdal, *Syketrygden*, 341.

¹⁰⁵ Norway, "Folketrygden om pliktig syketrygd," Preface. Dr. Axel Stroem, President of the Norwegian Medical Association, was a member of the Committee. He ensured that the views of the medical professions were heard by the reformers.

Before the reform was carried out, however, regulations had already extended the compulsory sickness insurance to include all employees and their families, irrespective of their income.¹⁰⁶ Anyone else could join on a voluntary basis. Life-saving and indispensable medications were covered for the first time. The time-limit for hospital treatment had been removed. Finally, midwifery and medical attention during pregnancy were a part of standard benefits. By the time the second report was presented to Parliament in 1954, extending existing provisions for universal entitlement was no longer seen as a major reform.¹⁰⁷ "The Committee now feels that the time has come to take the step and introduce sickness insurance for all."¹⁰⁸

During the years following the war, the costs of administering the hospital sector had risen sharply. The growing hospital deficit was financed mainly through general revenues from the county councils and local municipalities. Not surprisingly, the different local authorities hoped that universal entitlement to ambulatory care might decrease the demand for hospitalisation from the segment of the population that could not afford private care.

In 1950, the Department of Social Affairs even suggested that social insurance should be used to make the financing of hospitals more self-sufficient: "The Department found such an arrangement reasonable in that a significant portion of the expenses of hospital sector would be covered by insurance."¹⁰⁹ This proposal was unanimously approved by the Departmental Standing Committee on Social Affairs and Parliament.

Based on estimates of the financing of the existing system, the Department estimated that 25 million Crowns could be collected from employers' premiums, 45 per cent from workers, 25 per cent from the municipalities and 20 per cent from the state. To control costs, doctors' fees would be determined through negotiations between the Norwegian Medical Association, the Department of Finance and the National Pricing Board.¹¹⁰ This strategy met with immediate, though short-lived success. Both Dr. Axel Stroem, President of the Norwegian Medical Association, and Finn Alexander, Director of the National Insurance Institute, hoped that the favourable terms proposed by the reform would encourage doctors to work in rural regions.

¹⁰⁶ Norway, "Folketrygden om pliktig syketrygd," 9. These regulations were passed on 17 July 1953.

¹⁰⁷ Norway, "Folketrygden om pliktig syketrygd," 9. Around the same time period, Sweden had only attained a membership rate of 53 per cent of its population.

¹⁰⁸ Norway, "Folketrygden om pliktig syketrygd," 10.

¹⁰⁹ Urdal, *Syketrygden*, 350.

¹¹⁰ Urdal, *Syketrygden*, 351.

6. Compulsory Universal Sickness Insurance Law of 1956

To finalise the reform, Seweriin appointed an expert working committee of senior civil servants to draft the new Compulsory Universal Sickness Insurance Law. F.W. Ohldieck, the Chairman, worked as Assistant Director of the National Insurance Institution. S. Amble and Hans Johnsen, also from the National Insurance Institution, helped him with this task.¹¹¹ Ottar Lund, Assistant Secretary of Social Affairs, and Per Ramholt, Government actuary, represented the Department of Social Affairs.

The expert working committee, which reported in March 1955, used the 1909 and 1930 sickness insurance laws as the basis for drafting the new legislation. Although the National Insurance Institution had originally wanted to conduct a more thorough revision of the whole sickness insurance system, the Department of Social Affairs wanted to "keep the existing law, with the changes and additions that [were] necessary to extend coverage of the insurance."¹¹² They feared that a more radical reform would only lead to added costs and further delays.

A renewed estimate of existing membership under the old system showed that 90 per cent of the Norwegian population was already covered in 1954.¹¹³ Those excluded from the previous programme were the self-employed, pensioners, the occupationally inactive and those receiving other forms of public assistance.¹¹⁴ "There [was] no doubt that the greater part of those who [were] excluded ... [needed it], to some extent more than many of those who [were] covered by the programme."¹¹⁵ The proposed programme on the other hand would cover all Norwegians: employees, self-employed, families, public servants, seamen overseas, military personnel, fishermen and prisoners.¹¹⁶

Benefits in kind would include medical treatment by doctors, dental treatment, physiotherapy, speech therapy, life-saving medications, medications necessary at the time of accidents, hospital treatment and maternity treatment. Hospitalisation, however, referred only to curative medicine, not chronic nursing care.¹¹⁷ Benefits in cash would include sick pay, maternity pay, cost of home help for seamen, subsidies for non-home ambulatory treatment and burial benefits.¹¹⁸ Sick pay, of up to 90 per cent of previous income, would be available to all contributing workers. The self-employed and others who had an income could qualify for similar cash benefits by making a special voluntary

¹¹¹ Norway "Innstilling til Lov om Syketrygd," *Innstilling* from Sosialdepartementet (1955).

¹¹² Norway "Lov om Syketrygd" *Forhandlinger i Stortinget* 12(14 February 1956): 1.

¹¹³ Norway, "Innstilling til Lov om Syketrygd," 6.

¹¹⁴ Personal communication with Ottar Lund.

¹¹⁵ Norway, "Innstilling til Lov om Syketrygd." Personal communication with Hans Johnsen.

¹¹⁶ Norway, "Innstilling til Lov om Syketrygd," 8, 9, 12, 18, 19 and 82-85.

¹¹⁷ Norway, "Innstilling til Lov om Syketrygd," 44-45.

¹¹⁸ Norway, "Innstilling til Lov om Syketrygd," 43-44.

contribution.¹¹⁹ Doctors would still work on a fee-for-service basis, with patients being reimbursed for the charges.

Workers, employers, municipalities and the state would finance the programme.¹²⁰ Seweriin, now Minister of Social Affairs, supported this arrangement: "I feel that the proposed law will introduce a just distribution of the expenses for sickness insurance. I think that it is reasonable that workers and employees should share this burden."¹²¹ The estimated cost of the new programme was revised upward from 375 million to 470 million Crowns. Income from premiums were estimated at 470 million Crowns.¹²²

Dr. Gudmund Harlem, the next Minister of Social Affairs, had the honour of presenting the sickness insurance proposals to Parliament on 19 June 1955.¹²³ The spokesman for the Minister of Social Affairs, Kjell Bondevik, called it "a milestone in Norwegian social legislation ... the largest reform in the past lifetime."¹²⁴ Seweriin emphasised that the important contribution made by the new law was the inclusion of the final 10 per cent of the population who had been without coverage.¹²⁵

The organizations and departments that submitted opinions on the legislation all reflected the mood of national unity that prevailed following the war.¹²⁶ The Directorate of Health, represented on the expert working group by Jon Bjoernsson, supported the new law: "The extension of the existing sickness insurance system to include the whole population represents an end, and an especially happy one, to a long toil."¹²⁷ The Directorate hoped that the new system would lead to an improvement in both the standards of medicine and standards of life in Norway.

The Norwegian Medical Association, which pleased with the existing sickness insurance system, welcomed an extension of this system:¹²⁸ "In contrast to many other

¹¹⁹ Norway, "Innstilling til Lov om Syketrygd," 45.

¹²⁰ Norway, "Innstilling til Lov om Syketrygd," 61.

¹²¹ Norway, "Lov om Syketrygd og Endringer i Lov om Ufoertrygd for Militære," *Forhandlinger i Odelstinget* 12(14 February 1956): 98.

¹²² Norway, "Innstilling til Lov om Syketrygd," 33. The estimated cost of the programme was later revised to 482 million Crowns, while the initial income under the programme was 493 million Crowns. Urdal, *Syketrygden*, 360.

¹²³ Following the return to a Gerhardsen Government in January 1955, Dr. Gudmund Harlem became the new Minister of Social Affairs on 1 August 1955. Norway "Innstilling fra Sosialkomitéen 1) Om Lov om Syketrygd. 2) Om Lov om Endring i Lov om Ufoertrygd for Militærpersoner av 19 July 1953 m. fl. Lov" *Ot. prp.* 52(19 June 1955).

¹²⁴ Kjell Bondevik speaking during parliamentary debates on 14 February 1956. Norway, "Lov om Syketrygd og Endringer," 86. Expecting no opposition to the proposed reform, the Minister of Social Affairs, Dr. Gudmund Harlem, was busy with a North-Norway Development Project and therefore did not attend the opening day of the debates on 14 February 1954. Norway, "Lov om Syketrygd og Endringer," 86.

¹²⁵ Norway, "Lov om Syketrygd og Endringer," 97.

¹²⁶ Norway, "Lov om Syketrygd," 1.

¹²⁷ Urdal, *Syketrygden*, 360. Personal communications with Ottar Lund.

¹²⁸ Jens Bjoerneboe, "Endringer i Lov om Syketrygd" *Tidsskrift for Den Norske Lægeforening* 1(1 January 1954): 18.

countries, there has been little resistance to sickness insurance among doctors in Norway.... Nor have the doctors had fundamental objections to the extension of the sickness insurance to cover the whole population."¹²⁹

The Association, however, echoed the concerns expressed by doctors in other countries that such reforms should be introduced gradually, citing an eastern proverb to support their claim: "One should not march faster than the camel can follow."¹³⁰ Furthermore, the Association criticised the law for having created a sharp distinction between curative and preventive medicine, claiming that it would have been preferable to develop the two branches simultaneously.¹³¹

The National Insurance Institute responded to allegations of the Norwegian Medical Association by pointing out that sickness insurance was a short-term solution, with improved health as the long-term goal. It agreed that health care and prevention were both important issues that required further reform in the future.¹³² The sickness funds and other insurance organizations, which would act as agents for the National Insurance Institution, supported the principles of the legislation.¹³³

The parliamentary debates took place on 14 and 17 February 1956 with minimal discussion.¹³⁴ The law was passed by both Houses without amendments: "I cannot recall any opposition at all ... our sickness insurance system was accepted by all -- both the public and medical [profession] wanted to extend its coverage."¹³⁵ The legislation passed into law on 2 March 1956, and as planned universal entitlement to health care was implemented on 2 July 1956.¹³⁶

The reform completed the incremental policy process in sickness insurance that had been in progress over the previous 50 years. It represented an important symbolic landmark in Norwegian social reform legislation: "The basis of Norwegian National Insurance is that it is a right, not a privilege granted at the discretion of someone else to receive support from society when one's welfare is impaired by disease, pregnancy, old age, unemployment or the like."¹³⁷

¹²⁹ Dr. Axel Stroem, the President of the Norwegian Medical Association in 1948-51. Axel Stroem, "Social insurance in Norway," *Tidsskrift for Den Norske Lægeforening* 10(30 May 1970): 15. Supported by personal communication with Dr. Johan W.R. Haffner, President of the Norwegian Medical Association from 1954-57.

¹³⁰ Bjoerneboe, "Endringer i Lov om Syketrygd," 19.

¹³¹ Urdal, *Syketrygden*, 362.

¹³² Urdal, *Syketrygden*, 362.

¹³³ Hans Asphaug, "Proposisjon om syketrygd for alle" *Social Trygd* 10(October 1955): 317-18.

¹³⁴ Norway, "Lov om Syketrygd og Endringer;" and Norway, "Lov om Syketrygd."

¹³⁵ Personal communication with Dr. Gudmund Harlem, Minister of Social Affairs who introduced the act in 1955.

¹³⁶ F.W. Ohldieck, I. Litleré and H. Rygh, *Lov om Syketrygd: Av 2 Mars 1956 med Senere Endringer of Tillegg, Sist ved Lov av 22 Januar 1960* (Oslo: Sem & Stenersen, 1960).

¹³⁷ Harold, *Choices for Health*, 51.

Although the 1956 law did not introduce radical new ideas, in the aftermath of the Second World War, Norwegians rightly prided themselves on their "slow revolution [which] had not cost a single person his life."¹³⁸ The Compulsory Universal Sickness Insurance Law would remain in force for years. "When I look back on the developments which occurred 50 years ago, I am struck with amazement and respect for our ancestors. The framework of the law has not changed in all these years."¹³⁹

C. BARRIERS TO UNIVERSAL ENTITLEMENT

1. Civil Defence Health Plan

World War II had exposed many weaknesses in the Norwegian civil defence system, including its health care systems. Determined not to get caught off-guard again, O.C. Grundersen, the Minister of Justice, asked his Department on 11 November 1946 to initiate a review of the country's preparedness should another war ever occur. The Departmental Civil Defence Legislation Standing Committee, under the Chairmanship of Judge Carl Johan Fleischer, began its work on 16 December 1949.

The Committee, which reported in 1952, recommended that the old Civil Defence Law of 1930 be replaced by new legislation.¹⁴⁰ "Modern warfare demands that one not only has a military but also civilian defence. The civilian part of the total defence can be said to include all citizens that must be mobilised so that a country can defend itself."¹⁴¹ The resulting Norwegian Civil Defence Law was passed in 1953.¹⁴²

The Minister of Social Affairs, Rakel Seweriin, asked the Standing Committee of the Department of Social Affairs to examine the health provisions contained in the Civil Defence Law. The Committee, then under the Chairmanship of Kjell Bondevik, presented its report in 1955.¹⁴³ Few people, however, recognised that the proposal "represented a desire for a universal and improved health care system."¹⁴⁴

The legislation was presented to Parliament on 25 March 1955. It went through the two Houses of Parliament with little debate and few amendments. It was ignored by both

¹³⁸ Olav Larssen quoted from his book *The Slow Revolution* by Gerhardsen, *Unge År*, 355.

¹³⁹ Gudmund Harlem, Minister of Social Affairs who introduced the act to Parliament in 1955. Quoted in Urdal, *Syketrygden*, 369.

¹⁴⁰ Norway "Lov om Siviltforsvaret," *Ot. prp.* 28(1953).

¹⁴¹ Norway, "Lov om Siviltforsvaret," 5.

¹⁴² Norway, "Lov om Siviltforsvaret."

¹⁴³ Norway, "Innstilling fra Sosialkomitéen om Lov om Helsemessig Beredskap," *Ot. prp.* 39(1955).

¹⁴⁴ Personal communication with Reidar S. Bang, Assistant Deputy General of the Directorate of Health, who worked as a lawyer in the Directorate during the 1950s.

the press and the Norwegian Medical Association.¹⁴⁵ The resulting Civil Defence Health Plan, which passed on 2 December 1955 contained no peace-time provisions.

A war-time programme would cover institutional care, materials, public health, health care personnel and other health-related items. In particular, its provisions included hospital, infirmaries, convalescent homes, health resorts, maternity hospitals, orphanages, old age homes, laboratories, vaccination and full health personnel (doctors, dentists, apothecaries, pharmacists, nurses, physiotherapists, masseurs, midwives, students and any other personnel in health institutions).¹⁴⁶ It provided for the "availability of adequate medical care and nursing facilities at the time of war."¹⁴⁷

To initiate the programme, the Government allocated a grant of 12 million Crowns for capital construction. In the event of war, however, "expenditure incurred through the implementation of the provisions laid down in this act, or which are a consequence of instructions or provisions issued pursuant to this act, [would] be defrayed by the Government."¹⁴⁸

Seweriin, having been in London during the World War II, was well aware that Norway could have introduced a service like the British National Health Service, rather than a mere extension of the existing sickness insurance system.¹⁴⁹ "In Britain ... they have a programme that is somewhat more comprehensive than the sickness insurance programme that we have here at home [in Norway]."¹⁵⁰ A similar war-time civil defence health plan had played a significant role in the creation of the National Health Service in Great Britain.

Norwegians, anxious to put behind them the grim memories of the war, failed to realise the broader potential scope of their civil defence plan: "We hope that we will never need the law that we have dealt with today."¹⁵¹ Instead, the country followed the time-tested, less comprehensive, sickness insurance approach as the basis for financing health care.¹⁵²

¹⁴⁵ Personal communication with Dr. Johan W.R. Haffner, President of the Norwegian Medical Association from 1954-57.

¹⁴⁶ Norway, "Lov om Sivilforsvaret," 1-4, para. 2-9.

¹⁴⁷ Norway, "Lov om Sivilforsvaret," 1, para. 1.

¹⁴⁸ Norway, "Lov om Sivilforsvaret," 4-5, para. 12.

¹⁴⁹ Personal communication with Rakel Seweriin, Minister of Social Affairs, at the time of the introduction and passing of the Civil Defence Health Legislation.

¹⁵⁰ Norway, "Lov om Syketrygd og Endringer," 98.

¹⁵¹ Grundersen speaking in Parliament on 5 April during the debates on the Civil Defence Law, quoted in Gerhardsen, *Samarbeid*, 74.

¹⁵² Thirty years later another working committee advocated a similar plan which once again "concerns defence-related action and has little or no bearing upon the general national health care programme." Personal communication with Kaare Salvesen, Deputy Director-General, Norwegian Ministry of Social Affairs. Personal communication Dr. Gustav Vig, Chairman of the Civil Defence Plan Working Group 1983. Periodic reviews

2. Health For All

There were advantages and disadvantages to the slow introduction of universal health care through sickness insurance in Norway. "The fact that social insurance in Norway has developed over a period of more than 70 years has meant that the speed could be adapted to the country's economic capacity and the necessary mental adjustment could take place. It has not been necessary to make such sudden and radical changes as in other countries with the shock-effects that these have often led to. But the step-by-step development has, on the other hand, had the disadvantage that the individual insurance programmes have not been well coordinated."¹⁵³

The organizational shortcomings of the sickness insurance system of financing, the fee-for-service system of paying for doctors and the reimbursement system of offering benefits to patients soon emerged, especially in rural areas. Medical services varied considerably from one municipality to another, and there was an uneven distribution of general practitioners: "Until now too much of health service planning has been carried out separately for the different parts of the health service."¹⁵⁴ Patients often received treatment and care in hospitals "not because they need the highly specialised services that only the hospitals [could] provide, but because the primary health care services in many parts of the country [did] not have sufficient capacity to treat the patients outside institutions."¹⁵⁵

These difficulties became more apparent during the 1960s and early 1970s. General practitioners were dwindling, and there was no system to ensure an equitable geographic distribution of doctors throughout the country.¹⁵⁶ Norway tried to deal with these problems through an increase in the number of Medical Officers of Health, hoping in this way to offer a better service to rural regions: "Only then can we proceed towards the stated aim of the health services of high quality on an equal basis to every citizen, irrespective of where he lives and of his financial situation and social status."¹⁵⁷

Over the years, the county municipalities slowly increased their jurisdiction. These responsibilities extended to psychiatric hospitals in 1961, general hospitals in 1969, mental

have been carried out on the Norwegian civil defence plan since the 1950s. Norway, Helsedirektoratet (H), *Katastrofe-Planlegging ved Sykehus* (Oslo: Helsedirektoratet og Norske Kommuners Sentralforbund, 1972); and Norway, Helsedirektoratet og Norske Kommuners Sentralforbund (HNKS), *Planlegging av Helsetjenesten for Katastrofer og Krig* (Oslo: Helsedirektoratet og Norske Kommuners Sentralforbund, 1980).

¹⁵³ Stroem, "Social insurance," 14.

¹⁵⁴ Torbjoern Mork "Health services in Norway," Special Issue of "Sykehuset" on the 21 International Hospital Congress in Oslo, June 24-29, *Journal of the Norwegian Hospital Association* 4(1979): 254.

¹⁵⁵ Mork, "Health services," 253. Present Director General of the Norwegian Directorate of Health.

¹⁵⁶ Evang, "Public Health Services," 1143.

¹⁵⁷ Mork, "Health services," 254.

retardation in 1979, child welfare in 1980, comprehensive health care and prevention in 1982, and public dental services in 1984.¹⁵⁸

By 1982, however, institutional care remained fully financed through public funds while ambulatory care still relied significantly on private financing.¹⁵⁹ Although, in principle, universal entitlement exists for all inhabitants as a 'paper right', in practice, charges created an income barrier for ambulatory care, and poor distribution of resources limited access to services.

The Municipal Health Services Act of 1984 was intended to correct many of these deficiencies in the Norwegian sickness insurance system. The new Health Act, which came into effect 1 January 1984, made provisions for both salaried District Health Officers and a guaranteed wage for clinical doctors. The local Medical Officers of Health became employees on contract to the municipalities rather than appointed and paid for by the state. The improved basic wage for clinical doctors hoped to reduce the importance of previous fee-for-service payments: "With the addition of this guaranteed wage, today's fees will be dropped by about 40 per cent."¹⁶⁰

Norway claims that the new focus of its health policy is 'Health for All' not just universal sickness insurance.¹⁶¹ The complete elimination of sickness insurance from the financing of health care in 1986 may open the way for more radical reforms in this direction. It is too early to know, however, if these recent reforms are sufficient to overcome the historical problems created by financial infrastructures developed through the uncoordinated sickness funds.

¹⁵⁸ Salvesen, "Norwegian health administration," 5.

¹⁵⁹ Alexander S. Preker, "Public finance and provision of health care services in Québec: An international perspective," *Brief*, presented to the Commission of Enquiry into the Health and Social Services of Québec [Chairman Jean Rochon] (London: IIHS, December 1986): 27; and Organization for Economic Co-operation and Development (OECD), *Measuring Health Care 1960-1983: Expenditure Costs and Performance*, OECD Social Policy Studies No. 2 (Paris: OECD, 1985): 68-69 and 72-73.

¹⁶⁰ Hauge, "Norwegian Medical Association," 33.

¹⁶¹ Norway, *Health for All by the Year 2000: Norwegian Contribution to an ad hoc Meeting on Health for All in Industrialized Countries, Geneva, 1-2 May 1980* (Oslo: Directorate of Health, 1980).

CHAPTER 9. SWEDEN

All services needed by the individual should be offered free of charge at the time of treatment ... the community [will] deliver this by means of an extended and regulated organization, public health, hospital care, preventive medicine on an individual basis and ambulatory medical care.¹

Axel Höjer, 1948

A. FINANCIAL INFRASTRUCTURES

1. Swedish Sickness Funds

Sweden was slow to industrialize compared with other Western countries: "At the close of the nineteenth century, Sweden ranked as one of the backward nations of Europe."² Although the sickness funds were equally slow to develop, local governments had a long history of financing health care. The first paragraph of the Constitution of Sweden's Parliamentary monarchy underscores the importance of such local self-government: "Swedish democracy ... shall be realised through a representative and parliamentary polity and through local self-government."³

In 1863 the county councils and later the municipal councils assumed substantial taxation powers, including the right to levy income taxes.⁴ Their health-related responsibilities developed later.⁵ These included the provision of local hospitals, small provincial hospitals, sanatoria and special hospitals for the infectious diseases. Such hospitals became public institutions at an early stage, financed through the local governments.⁶

¹ Sweden, Inrikesdepartementet (I), "Den öppna läkarvården i Riket: Utredning och förslag av Medicinalstyrelsen," *Statens Offentliga Utredningar* 14 (Sweden: Iduns Tryckeriaktiebolag, 1948): 14, translated by Uncas Serner, "Swedish health legislation: Milestones in reorganization," in *The Shaping of the Swedish Health System*, Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 101.

² Agne Gustafsson, *Local Government in Sweden*, Sweden Books (Stockholm: The Swedish Institute, 1983): 11.

³ Sweden, "The Instrument of Government Act," (Stockholm: Parliament, 1974): Art. 1.1.

⁴ Three years later, in 1866, a bicameral parliamentary system replaced the old parliamentary system of four estates: nobility, clergy, burghers and peasants. In 1871, the system became unicameral with the King acting as an official figurehead with no powers. Eric Lindström, *The Swedish Parliamentary System: How Responsibilities are Divided and Decisions are Made* (Stockholm: The Swedish Institute, 1983): 12.

⁵ Gunnar Heckscher, *The Welfare State and Beyond: Success and Problems in Scandinavia* (London: Crom Helm, 1980): 23.

⁶ Edgar Borgenhammar, *Hälsans Pris: En Hälsokontroll av Sjukvården* (Stockholm: Studieförbundet Näringsliv och Samhälle, 1982): 14.

A lack of financial security in private practice meant that there were few private practitioners even in the larger cities. Provincial doctors, who served both as medical officers of health and general practitioners in rural regions, first appeared in the 1700s but remained scarce.⁷ Although a position as a district medical officer of health offered more security than fee-for-service private practice, both were less honoured than work in hospitals.⁸ These two groups of doctors were, therefore, unable to meet the medical needs of Sweden's population of 5,136,441, which at the turn of the century was scattered over the country's 410,929 square kilometers of northern regions.⁹

Hospitals doctors were salaried by the institutions in which they worked, but supplemented their incomes through fee-for-service consultations in out-patient departments. The county councils encouraged this practice to reduce the occupancy of hospitals, thereby saving money for their residents. This habit would later be difficult to break.

From the sixteenth century onward, tradesmen's guilds began providing limited sick pay for their members.¹⁰ As there were few doctors in private practice, and salaried district medical officers of health were scarce, the independent sickness funds, which began appearing in the mid-eighteenth century, offered mainly cash support during illness.¹¹

These circumstances lead King Oscar II of the joint Swedish-Norwegian Kingdom to encourage the Swedish Parliament to examine Bismark's model of sickness insurance.¹² In 1884, S.A. Hedin, a Swedish Member of Parliament, asked the Government to appoint a Workers' Insurance Commission. The terms of reference of the Commission were to enquire into old age pensions and workers' accident insurance.¹³

The combination of late industrialization, few doctors in private practice and the liberal self-help philosophy which prevailed during the nineteenth century, led the

⁷ Their original function was to prevent the spread of venereal disease among soldiers. Borgenhammar, *Hälsans Pris*, 13.

⁸ State pensions were especially attractive to the Medical Officers of Health. Gottfrid Törnell, *Svenska Provinsiällläkareföreningens Historia 1906-1930* (Stockholm: Svenska Tryckeriaktiebolaget, 1930); and Hirobumi Ito, "Health insurance and medical services in Sweden and Denmark 1850-1950," in *The Shaping of the Swedish Health System*, edited by Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 63.

⁹ The population for 1900 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962), 280 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 1132.

¹⁰ Gösta Lindeberg, *Den Svenska Sjukvårshistoria* (Lund: Carl Bloms Boktryckeri, 1949): 7.

¹¹ Lindeberg, *Sjukvårshistoria*, 26.

¹² Norway, *Social Insurance in Norway* (Stockholm: National Insurance Administration, 1984): 5

¹³ The Government appointed the Commission in 1885. Edvard Tegendal, "Den Svenska sjukvårslagstiftningen 1891-1931," in *Den Svenska Sjukvårshistoria* edited by Gösta Lindeberg (Lund: Carl Bloms Boktryckeri, 1949): 286.

Commission to recommend voluntary sickness insurance plan when it reported in 1889.¹⁴ The question of compulsory sickness insurance did arise for the first time during these deliberations.

The Sickness Fund Law of 30 October 1891 defined the conditions which voluntary sickness funds had to meet in order to qualify for state registration and a small public subsidy.¹⁵ Because the subsidies contributed less than 10 per cent to the sickness funds finances, most of the organizations did not bother to apply for registration. Their benefits remained unregulated, offered only limited coverage and had long initial waiting periods.¹⁶

Hjalmar Branting, a Member of Parliament (later Prime Minister), called for compulsory sickness insurance as early as 1900: "A country ... that leaves its injured workers helpless for the first two months [following an accident] ... will soon be forced to have compulsory sickness insurance."¹⁷ Reforms were subsequently slowly introduced. In 1908, Edvard Wawrinsky, a Member of Parliament, presented a motion to introduce maternity benefit insurance. By 1912, such insurance was available separately through many of the voluntary sickness funds.¹⁸

An amended Law on Registered Sickness Funds, appeared in Parliament in 1909; it passed into law on 4 July 1910 and came into effect on 1 January 1911. During the parliamentary debates, James J. Gibson, a Member of Parliament tried unsuccessfully to persuade Government to introduce a compulsory plan.

The 1911 law refined the criteria necessary for official registration and increased the subsidies offered by the state. Recognised sickness funds were required to have at least 100 members and to reimburse patients for the cost of medical treatment, hospitalisation and drugs.¹⁹ The small subsidies offered by the Government were still insufficient to act as an incentive for the sickness funds to attract a large membership.²⁰ Their benefits continued to consist mainly of income support during illness not treatment by doctors.

¹⁴ Ernst Michanek, *Sukförsäkring för Alla* (Stockholm: Tidens Förlag, 1953): 12.

¹⁵ Limited workmen's compensation was introduced in 1901. Tegendal, "Sjukkasslagstiftningen 1891-1931," 286-87.

¹⁶ Rolf Broberg, *Så Formades Tryggheten: Socialförsäkringens Historia 1946-1972* (Stockholm: Försäkringkassaförbundet, 1973): 12.

¹⁷ Hjalmar Branting quoted by Michanek, *Sukförsäkring*, 12.

¹⁸ Tegendal, "Sjukkasslagstiftningen 1891-1931," 315.

¹⁹ Tegendal, "Sjukkasslagstiftningen 1891-1931," 310-313.

²⁰ Up until 1930, benefits in kind comprised less than 3 per cent of total benefits covered by the sickness funds. Ito, "Health Insurance," 61.

To gain greater control over the activities of the sickness funds, the Board of Social Welfare became responsible for supervising their activities in 1912. The Commercial Collegiate and the Sickness Fund Bureau had previously filled this function.²¹

In 1915, A. Lindstedt was appointed Chairman of a Social Insurance Commission.²² The terms of reference of the Commission were to conduct a detailed examination of social insurance, including superannuation, invalidity benefits, maternity benefits, sickness insurance and accident insurance.²³ The Commission, which reported in October 1919, recommended a means-tested compulsory sickness insurance for workers. It also recommended that the Government introduce the programme through a comprehensive social security package, which would include old age pensions.²⁴

Although the Scandinavian countries managed to stay out of World War I, Sweden did not escape the war's economic consequences: "The depression that followed the end of the First World War affected Sweden profoundly."²⁵ One third to one half of the labour force was unemployed. In this context, the Ministry of Finance for the Conservative Government in power was unwilling to consider the expensive social reforms recommended by the Social Insurance Commission. Instead, the Minister of Social Affairs, Bernhard Eriksson, appointed an expert committee, under the Chairmanship of A. Jochnick, to explore other options. This latter committee, however, never reported.²⁶

By 1928, seventeen European countries had introduced compulsory sickness insurance, leaving Sweden significantly behind.²⁷ In March 1929, a new committee conducted yet another inquiry into sickness insurance under the Chairmanship of L.A.V. Rydin. Its report of 11 October 1929 once again called for compulsory hospital insurance.²⁸

After fifty years of voluntary sickness insurance and extensive debate, Eriksson finally had the Ministry of Social Affairs draft a law which would lead to compulsory sickness insurance in Sweden. The new Sickness Fund Law passed in Parliament on 26 June 1931, coming into effect on 1 January 1933.

²¹ Later, on 1 January 1938, the Board of Pensions assumed the administrative responsibility for the sickness funds and other social insurance programmes, except for unemployment insurance. Tegendal, "Sjukkasslagstiftningen 1891-1931," 373 and 1982.

²² The Accidents Insurance Law was passed in 1916. Cash support during incapacity due to short-term injuries would be paid through ordinary sickness insurance.

²³ Tegendal, "Sjukkasslagstiftningen 1891-1931," 317.

²⁴ Tegendal, "Sjukkasslagstiftningen 1891-1931," 319. Michanek, *Sukförsäkring*, 13-14.

²⁵ Marquis W. Childs, *Sweden: The Middle Way on Trial* (New Haven: Yale University Press, 1980): 15.

²⁶ Tegendal, "Sjukkasslagstiftningen 1891-1931," 330; and Broberg, *Tryggheten*, 3.

²⁷ The Sickness Fund Federation and its Chairman Gösta Lindeberg supported such an extension in sickness insurance. Lindeberg, *Sjukasserörelsens Historia*, 218-231.

²⁸ Tegendal, "Sjukkasslagstiftningen 1891-1931," 358.

The new law offered means-tested compulsory sickness insurance with improved maternity benefits and full reimbursement of the cost of medical care. It reorganized the existing sickness funds into twenty-one geographically-based central sickness funds that would oversee local organizations. The reform aimed to unify the Swedish sickness insurance system.

The Swedish Medical Association voiced little protest against these early reforms for several reasons. First, private doctors, the main members of the Association, supported the voluntary sickness insurance reforms which offered them an added source of income.²⁹ Secondly, over 60 per cent of doctors held public posts which were unaffected by the sickness insurance debate and were not members of the Association. Finally, the hospital appointments of the younger doctors depended on their maintaining a good relationship with the senior doctors, a system which discouraged dissension. The Swedish Younger Doctors' Association (SYLF) formed a conservative branch of the parent Swedish Medical Association that advanced few radical policies of its own during the 1930s and 1940s.³⁰

By 1930, only 21 per cent of eligible adults were covered by voluntary sickness insurance.³¹ Eriksson hoped that compulsory means-tested membership and increased state subsidies would overcome some of the shortcomings of the previous voluntary system.³² The outcome was disappointing: there were few doctors in private practice, state subsidies remained low and membership with the sickness funds remained low.³³

To fill the gap where no other care was available, legislation was passed to extend the health care responsibilities of county councils and local hospitals. By the 1930s, these responsibilities expanded to cover non-institutional care such as district nurses, midwives, maternity, pediatric care and dental care. Provision by the county councils of ambulatory clinics in hospitals, however, did not become mandatory until 1958 and ambulatory community care not until 1961.

²⁹ Negotiations over the fee schedule and interference with the doctor-patient relationship, however, caused recurrent conflicts between the doctors and the sickness funds.

³⁰ Personal communication with Professor Olle Johansson, President of the Younger Doctors' Association from 1951-60 and later Chairman of the Swedish Medical Association from 1966-1968. SYLF was created in 1921.

³¹ Lindeberg, *Sjukvårshistoria*, 257.

³² Before 1930, 65 per cent of the sickness funds incurred deficits on a regular basis. Ito, "Health Insurance," 65.

³³ By the mid-1940s, only 30 per cent of the population were members of a sickness fund. Lindeberg, *Sjukvårshistoria*, 257. Personal communication with Rolf Broberg, former Director General of the Swedish National Social Insurance Board.

2. Social Democratic Party

The inadequacy of the new compulsory Sickness Insurance Law of 1931 became obvious almost as soon as the law was passed. More radical reforms were needed to extend the benefits of pre-paid health care to larger segments of the population. The Social Democratic Party, which formed a Coalition Government in 1932, was committed to introducing such reforms.

Karl Hjalmar Branting founded the Swedish Social Democratic Party in 1889. Much later, he briefly led Social Democratic Governments in 1920, 1921 and 1924 by 'cultivating the Liberals'.³⁴ The 1920s and early 1930s were politically unstable times with much economic hardship in Sweden. There was a change in leadership and Government almost every year, resulting in fragile coalitions composed of right-centre parties. The Social Democrats were often forced to choose 'the middle way' to remain partners in these Coalition Governments.³⁵

In a world polarised between fascism and communism, the Swedish Social Democratic Party followed a reformist path, rejecting a policy of revolution from the onset. Radical reform proposals such as nationalization were rarely advocated. Instead, the party allowed private enterprise to continue unhampered as long as its adherents were willing to contribute to the cost of society.

In 1932, the Social Democratic Party formed a Coalition Government with the Agrarian (Farmers) Party which would last through World War II. Per Albin Hansson, the new Prime Minister, wanted to end the thirty years of *laissez-faire* social policies of the previous Conservative, Liberal and Agrarian Governments.³⁶

Hansson believed that the state should satisfy "those programmes [accident, sickness and maternity insurance], ... that one cannot do without, if one truly wants the population to have some feeling of security and comfort in its own country."³⁷ He became known to his fellow countrymen as the "archetype of the moderate socialist leader ... an assurance of peace and prosperity."³⁸

³⁴ Branting and Hansson, both journalists, supplemented their incomes by acting as parliamentary correspondents for *The Daily News* during the early days. Anna Lisa Berkling, *Från Fram till Folkhemmet: Per Albin Hansson som Tidningsman och Talare* (Falköping: Metodica Press, 1982): 23.

³⁵ Childs, *Sweden 1980*, 19; and Marquis W. Childs, *Sweden: The Middle Way* (New Haven: Yale University Press, 1935).

³⁶ The following name changes occurred in the Swedish political parties: the Conservative Party became the Moderate Party in 1969, the Liberal Party became the People's Party in 1934, the Agrarian Party became the Centre Party in 1958, the Communist Party became the Left Party Communists in 1963. The Christian Democrats appeared in 1964.

³⁷ Per Albin Hansson, "Sverige åt Svenskarna," Valbroschyr, [1926] quoted in Anna Lisa Berkling, *Från Fram till Folkhemmet: Per Albin Hansson som Tidningsman och Talare* (Falköping: Metodica Press, 1982).

³⁸ Childs, *Sweden 1980*, 16.

His Minister of Finance, Ernst Wigforss, was Albin's opposite: "An intellectual, an ideologue ... witty, brilliant, with an absorbing interest in the people of every kind and class, was to become a kind of Social Democratic saint."³⁹ Wigforss felt that a demand for equality was normal in society that had "need side by side with plenty."⁴⁰

Wigforss believed that free competition was an appalling squandering of resources. After 1932, he quickly put his beliefs into practice by expanding public works and introducing a progressive tax structure. His long period in office as Minister of Finance allowed him to successfully alter the economic policy of his country.

Sweden was the first industrialized nation to use such Keynesian deficit spending strategies with success. The business sector flourished, giving the Government the economic means to introduce reforms aimed at easing poverty, unemployment and social inequity. This unexpected economic growth during the 1930s was, envied by other countries that were still suffering from the Great Depression.

The country's economic prosperity allowed Gustav Möller, the Minister of Social Affairs, to lay the groundwork for a comprehensive social welfare reform, 'The People's Home'.⁴¹ It introduced subsidies for housing construction and special unemployment insurance in 1934, pensions in 1935, means-tested maternal benefits in 1937 and two-week paid vacations in 1938.⁴²

The Social Democrats build their political platform on a social humanism which maintained that the ills of a free society can be cured and that injustices are intolerable, "a pragmatic belief acknowledging the frail nature of the human condition."⁴³ To achieve this goal, their social security reform focused on two separate mechanisms: an expanded social insurance system which would pay for new benefits, including universal entitlement for sickness insurance, and an expanded public sector which would provide such services.

³⁹ Wigforss was the Minister of Finance from 1932 to 1949. Childs, *Sweden 1980*, 16.

⁴⁰ Ernst Wigforss, *Frihet och Gemenskap: Essayer*, Socialistisk Bokklubb (Stockholm: Tidens Förslag, 1962): 52.

⁴¹ This was the Swedish forerunner of Beveridge's "From the Cradle to the Grave." Stig Hadenius, *Swedish Politics During the 20th Century* (Stockholm: The Swedish Institute, 1985): 41; and Tage Erlander, *Tage Erlander 1901-1939* (Stockholm: Tidens Förlag, 1972): 273. On 1 October 1937, at Möller's request, Tage Erlander (later Prime Minister) joined the Department of Social Affairs to help him with this task. Erlander, *1901-1939*, 231.

⁴² Hadenius, *Swedish Politics*, 41.

⁴³ Childs, *Sweden 1980*, 3.

B. LANDMARK LEGISLATIVE REFORMS

1. Social Security Commission of 1938

Before the outbreak of World War II, the Minister of Social Affairs, Gustav Möller, appointed Bernhard Eriksson as Chairman of a Parliamentary Commission on Social Security.⁴⁴ The terms of reference of the Commission were to explore the health responsibilities of the county councils and examine how to unify their diverse functions under one administration. The war, however, soon caused a shift in priorities, and the country's attention turned to maintaining its neutrality.

The Social Democrats constituted a four-party Coalition Government on 1 December 1939 which included the Liberals, Agrarians (later Centre) and Conservatives. Hitler humiliated the Prime Minister, Per Albin Hansson, on several occasions by forcing him to make a series of concessions to Germany which violated Sweden's pledge of neutrality. One of the more publicised events occurred in 1941 when Sweden allowed Germany to transport its armed Engelbrecht division from occupied Norway to Finland on Swedish railways, having previously refused the Allies and Finland similar advantages.⁴⁵ There were few illusions about the strains that events like these would place on the Nordic Union following the war.

Both Ernst Wigforss and Gustav Möller wanted Sweden to accept refugees seeking asylum.⁴⁶ Others, however, felt that humanitarian aid would compromise the country's economic standing with Germany: "Given the close ties in trade with Germany, the pressure from Hitler's Reich to come in on the German side was intense.... The German connection, as it had existed during the years of rearmament and then during the war, deeply troubled the Swedish conscience."⁴⁷

The Swedish Medical Association advocated a protectionist manpower policy during the war, claiming that since Sweden had a surplus of doctors. It maintained that Sweden should refuse demands for immigration from non-Swedish refugee doctors: "As long as the present difficult conditions for young doctors persist in our country, no action should be taken which could lead to a further worsening of the chances of young doctors to earn a livelihood."⁴⁸ The Social Democrats and others critical of this stance used international standards to show that Sweden on the contrary had a shortage of doctors. Dr. Karl Evang

⁴⁴ Bernhard Eriksson, who was Minister of Social Affairs in the early 1920s, later served as a County Governor.

⁴⁵ Wigforss wanted to refuse Germany the right to send German troops through Sweden to Finland which had retained close ties to Sweden since its independence in 1909.

⁴⁶ Tage Erlander, *Tage Erlander 1940-1949* (Stockholm: Tidens Förlag, 1973): 109.

⁴⁷ Childs, *Sweden 1980*, 120.

⁴⁸ Arnold J. Heidenheimer, "The debate over 'surplus or shortage'," in *The Shaping of the Swedish Health System*, edited by Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 71.

of Norway, addressing the Karolinska Institute in March 1933, exclaimed that it was "absurd for the Swedes to talk about the dangers of 'overproducing' doctors."⁴⁹

These troubled times had an important influence on the work of the Parliamentary Commission on Social Security which anticipated a period of economic hardship following the war. When the Commission finally presented its report on sickness insurance in April 1944 it recommended a complete reorganization of the Swedish social security system which would include universal entitlement to health care through sickness insurance.⁵⁰ Its report on pensions was issued in 1945, unemployment insurance in 1948 and workmen's compensation in 1951.⁵¹

The proposed sickness insurance programme called for both medical treatment and cash benefits during incapacity due to illness.⁵² Medical benefits would include visits to doctors' offices and hospitalisation (365 day limit).⁵³ Income support would be limited to 730 days.

The new county council boundaries created by the local government that was taking place at the same time would strengthen public control over the administration of the programme. Each new region would have central offices responsible to the Board of Pensions to ensure that each county had its own local insurance office.⁵⁴ The sickness funds would be allowed to continue to act as agents in administering the new sickness insurance benefits locally. Members of recognised sickness funds would automatically qualify for membership under the new system. Those who had no previous protection would be given the names of new local organizations to join. In this way, the programme intended to cover all residents in Sweden.

Workers' and employers' contributions as well as a central government subsidy would finance the programme. Employers would collect their employee's contributions at source. The anticipated annual cost of the programme was 235 million Crowns per year, with central government subsidies financing a third of this cost.⁵⁵

⁴⁹ Arnold J. Heidenheimer, "Conflict and compromises," in *The Shaping of the Swedish Health System*, edited by Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 121. At the time of the address, Dr. Karl Evang was head of the Norwegian Socialist Doctors' Association (later Director General of the Norwegian Board of Health).

⁵⁰ Sweden, Inrikesdepartementet (I), "Utredning och förslag ang. Lag om Allmän Sjukförsäkring," *Statens Offentliga Utredningar* 15 (Sweden: Iduns Tryckeriaktiebolag, 1944); and Sweden, Inrikesdepartementet (I), "Kostnadsberäkningar ang. Lag om Allmän Sjukförsäkring," *Statens Offentliga Utredningar* 16 (Sweden: Iduns Tryckeriaktiebolag, 1944).

⁵¹ Broberg, *Tryggheten*, 3.

⁵² Cash benefits excluded civil servants, pensioners, those already on social assistance and those with inherited wealth.

⁵³ Broberg, *Tryggheten*, 4.

⁵⁴ Konrad Persson was the Director General of the Board of Pension in 1944.

⁵⁵ Broberg, *Tryggheten*, 34.

During the war there was little opposition to the proposed reform in the sickness insurance system. The sickness funds fully endorsed it in their yearly congress held in Göteborg in 1945.⁵⁶ "The [medical] profession as a whole did not seem to be aware of the trend until the late 1940s."⁵⁷ The Swedish Medical Association favoured a continuation of the existing system, but raised no protest to the reform.⁵⁸ The report of the Parliamentary Commission on Social Security was accepted by most Swedes in a spirit of national unity.

2. Sickness Insurance Law of 1947

During the war, the Social Democratic Party continued to strengthen its popular base. In the 1940 general election, the Social Democrats won an absolute majority of 54 per cent of the vote, the largest ever. In the 1948 election, they won 46.1 per cent of the vote, while the Liberals won 16 per cent and the Conservatives and Agrarians won 12 per cent each. When the war-time Coalition Government dissolved in 1945, the Social Democrats were left with a majority in the Parliament. This enabled them to carry out their planned social security reforms which included universal entitlement to health care through sickness insurance.

With the sudden death of Per Albin Hansson in 1946, Tage Erlander became Prime Minister. Although Erlander was not widely known in the party or to the public, his years in the Department of Social Affairs under Gustav Möller had prepared him for implementing the recommendations of the Parliamentary Commission on Social Security. It was also largely through the support of Möller that Erlander became Prime Minister: "It was lucky for me to have had Gustav Möller as supervisor and close friend."⁵⁹

To secure a strong Government, Erlander formed a Coalition Government with the Agrarian Party (later Centre) led by Gunnar Hedlund in 1951.⁶⁰ Hedlund became Minister of the Interior, responsible for both the Board of Health and county councils. The chairmen of the County Council Federation, Erik Fast and Fridolf Thapper, were both Social Democrats.

The Universal Compulsory Sickness Insurance Law was presented to Parliament in 1946. The law intended to extend coverage under sickness insurance to the whole

⁵⁶ Broberg, *Tryggheten*, 39.

⁵⁷ In 1945 there were only six articles on sickness insurance in the *Svenska Läkartidningen*, the journal published by the Swedish Medical Association, and in 1946 there were none. Ito, "Health Insurance," 63.

⁵⁸ Svenska Läkartidningen, "Lagen om Allmän Sjukförsäkring: Sveriges Läkeförbunds yttrande över socialvårdskommitténs betänkande," *Svenska Läkartidningen* 40(6 October 1944), 2372. The voluntary insurance system had attained a membership of only 53 per cent of the population by 1945.

⁵⁹ Erlander, *1901-1939*, 266 and 266.

⁶⁰ Gunnar Hedlund, a lawyer and farmer, led the Agrarian Party. Tage Erlander, *Tage Erlander 1949-1954* (Stockholm: Tidens Förlag, 1974): 267-272.

population. Benefits would include reimbursement of 75 per cent of the cost of medical treatment by doctors, free transport to and from hospitals and free medications. The county councils would receive a state subsidy to help them finance hospital care at a nominal charge to patients. Although it became law on 3 January 1947 without major opposition, it was never implemented in its original form.

Enactment of the law, which was planned for 1 July 1950, was postponed on several occasions. First, the date of implementation was delayed to allow for the preparation of the concomitant local government reform.⁶¹ The latter led to the formation of larger municipalities, based on a population of 2,000 or more, which was considered a more appropriate economic unit.⁶² On 20 April 1950, the Prime Minister announced another delay, fearing that Sweden was heading for a period of post-war economic depression.⁶³ A further indefinite delay, announced on 8 December 1950, no longer surprised anyone.

Sweden's policy of neutrality during the war spared its industry from destruction, obviating expensive physical reconstruction. The context in which the original act had been conceived, therefore, changed rapidly. Following World War II, instead of facing an economic depression as anticipated, the country entered a period of rapid growth and inflation. As a result, on 28 December 1951, the Under Secretary of State of the Ministry of Social Affairs, Per Eckerberg, headed a working group to re-examine the social security reform in light of these changes, including its sickness insurance provisions.

The terms of reference of the new investigation were to minimise the cost of sickness insurance and to integrate workmen's compensation into a comprehensive programme. Relying heavily on earlier recommendations made by the Parliamentary Commission on Social Security, the group published a Social Security Report in 1951 and a Social Insurance Report on 4 November 1952. Eckerberg's working group recommended that sickness insurance and workmen's compensation be coordinated but treated under different laws.

3. Höjer Report of 1948

While pressing ahead with the new sickness insurance law, Möller also wanted to explore the possibility of more radical reforms in health care: "Left-wingers in the party were contemptuous in the mid-1940s of what they said was merely a social insurance

⁶¹ Sweden, *Allmänna Sjukförsäkringen* No. 1 (Sweden: Svenska Sjukförsäkringsförbundet, 1947).

⁶² In 1962 a further reform created new economic, geographic and cultural units with populations of at least 8,000. By 1983 most of these municipalities had populations of at least 20,000.

⁶³ Erlander, *1949-1954*, 287.

system that left a few wealthy families in control of industry."⁶⁴ The Universal Compulsory Sickness Insurance Law of 1947 belonged to such social insurance.

In 1943, Möller appointed Dr. Axel Höjer, the Director General of the Swedish Board of Health, to head a seemingly benign Commission to examine out-patient regulations in hospitals.⁶⁵ Following an informal meeting with the Minister, Höjer interpreted the terms of reference of the Commission as demanding an extensive review of the whole Swedish health care system.⁶⁶

Höjer's experience as a district medical officer for deprived areas in Stockholm and Malmö had taught him the limitations of the existing system. This exposure combined with his socialist political views led him to favour an increased emphasis on primary care rather than a further expansion of the traditional institutional sector:

All [health care] services needed by the individual should be offered free of charge at the time of treatment ... the community [should] deliver this by means of an extended and (comprehensively) regulated organization, [including] public health, hospital care, preventive medicine on an individual basis and ambulatory health care.⁶⁷

If the system develops in the projected way, there should be by 1960 or 1970, only a very few physicians employed at the hospitals who would not be willing or obliged to enter the civil service compensation system.⁶⁸

He expressed these views in his final report.⁶⁹ First, he recommended the development of an effective primary care plan in tandem with the evolving hospital sector. Health centres would provide both preventive and curative treatment. Secondly, he wanted to increase the total number of doctors in Sweden, including district doctors. Finally, he envisaged a change in the status of doctors from that of independent contractors to that of public employees on salaries.

The report was revolutionary. The manpower and remuneration issues posed a direct threat to the lucrative fee-for-service practices enjoyed by a few privileged and influential consultants in hospitals. Regionalisation would require extensive administrative reform in local government and the county councils.

Sweden, however, having based its welfare state on a moderate socialism rather than revolution and radical nationalization, found the Höjer Report too radical. Many years

⁶⁴ Childs, *Sweden 1980*, 43.

⁶⁵ Dr. Axel Höjer occupied the post as Director-General of the Swedish Board of Health between 1935 and 1952.

⁶⁶ Serner, "Swedish health legislation," 101.

⁶⁷ Sweden, I, "Den öppna läkarvården," 14.

⁶⁸ Sweden, I, "Den öppna läkarvården," 316.

⁶⁹ Sweden, I, "Den öppna läkarvården."

would pass before some of the principles in his proposal would be accepted and implemented.⁷⁰

4. Swedish Medical Association

With the election of Dr. Dag Knutson as Chairman in 1947, dramatic changes took place within the Swedish Medical Association. Knutson immediately introduced new regulations all members of the medical profession to participate in local and national organizations.⁷¹ This policy resulted in a sharp increase in membership and a strengthening of the political influence of the Association.

Knutson and Höjer had previously engaged in heated debates on "whether doctors should continue to be members of a free profession" or become civil servants.⁷² Knutson, whose support came mainly from private practitioners and senior hospital doctors, defended the free medical profession: "My main interests were education -- further training ... and preservation of the freedom of physicians as professionals."⁷³

The previously unassertive medical profession and other vested-interest groups reacted with horror to Höjer's report.⁷⁴ By the time the Government released the Report, Knutson had prepared doctors for the worst: "We must refuse to cooperate with the Medical Director. He is dangerous and must be removed from post as soon as possible."⁷⁵

The Swedish Medical Association scored an early success by influencing the Government to abandon the recommendations in the report: "By defeating the reform proposals of Axel Höjer, [the Swedish Medical Association] won the first round of the postwar struggle, unlike their British colleagues who had to accept a National Health Service."⁷⁶ This early success of the Swedish Medical Association was deceptive, however, since later events would support Höjer's vision of the Swedish health care system.

⁷⁰ Sweden, National Board of Health and Welfare (NBHW), *The Swedish Health Services in the 1990s* (Stockholm: National Board of Health and Welfare, 1985): 64-67.

⁷¹ Ito, "Health Insurance," 57.

⁷² Ito, "Health Insurance," 63.

⁷³ Dr. Dag Knutson, quoted by Bo Hjern, "Commentary on part three," in *The Shaping of the Swedish Health System*, Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 174. Personal communication with Dr. Hjern, the present Director General of the Swedish Medical Association.

⁷⁴ Borgenhammar, *Hälsans Pris*, 15. The Socialist Doctors Federation was one of the few organizations to support Höjer's proposed reforms in 1948.

⁷⁵ Höjer describing Knutson's reaction to their meeting in 1937. J. Axel Höjer, *En Läkares Väg* (Stockholm: Bonniers, 1976): 192. Translated by Heidenheimer, "Conflict and compromises," 122.

⁷⁶ Heidenheimer, "Conflict and compromises," 121.

5. Sickness Insurance Law of 1953

The new Minister of Social Affairs, Gunnar Sträng, accepted the revised sickness insurance reforms as proposed. The amended compulsory sickness insurance law was presented to Parliament on 27 March 1953 and passed on 19 June 1953, following a lively debate. On 1 January 1955, Sweden finally introduced universal entitlement to health care through national sickness insurance.⁷⁷ "To a great extent ... it was Gunnar Sträng in collaboration with Per Eckerberg, then State Secretary in the Department of Social Affairs, that formulated and pushed through the new sickness insurance legislation."⁷⁸

The amended Sickness Insurance Law called for compulsory economic protection against illness for all Swedes over 16 year of age, children being included under their parents. The programme would cover 7.1 million people, all of the Swedish population.⁷⁹ A total of 31 central and 630 local registered sickness funds would administer the benefits of the programme. These organizations, in turn, would be administered by the National Health Insurance Institution.

The law provided for cash benefits during illness, free hospital care financed through the county councils and reimbursement for 75 per cent of doctors' fees. Hospital insurance would finance part of the cost of hospitalisation and pre-hospital transport. Health care would include dental care and free choice of doctor.⁸⁰ Income support would apply to gainfully employed people with a minimum income or full-time housewives during part of the duration of an illness.⁸¹ The law limited cash benefits following hospitalisation to 730 days following a waiting period of three days.⁸²

The revised cost of the programme was 738 million Crowns.⁸³ Workers would contribute 44 per cent, employers 27 per cent and the state 29 per cent to the financing of the programme. Employers could contribute to both sickness insurance and workmen's compensation. Employers would deduct their employees' contributions at source together with income taxes for non-pensioners earning a minimum of 1,200 Crowns. The Director General of the Swedish Sickness Funds Federation, Erik Malm, welcomed this

⁷⁷ Sweden, Riksdag Propositionen Nr. 569 of 19 June 1953 quoted in Rolf Broberg, Ingvar Lindell and Yngve Samuelsson, *Den Allmänna Sjukförsäkringen: Redgörelse för den År 1955 Genomförda Sjukförsäkringsreformen* (Stockholm: Norstedt & Söners Förlag, 1956): 13.

⁷⁸ Erlander, *1949-1954*, 289.

⁷⁹ Broberg, Lindell and Samuelsson, *Allmänna Sjukförsäkringen*, 22.

⁸⁰ General health care comprised only 15 per cent of the expenditure of sickness funds by 1950. Ito, "Health Insurance," 54.

⁸¹ Eligibility for cash benefits continued to be means-tested.

⁸² For recipients of old age pensions the duration would be 90 days.

⁸³ A review of the actual cost of the programme for 1955 was 800 million Crowns, very close to the original estimate.

simplification: "Under the [new] system it will be much easier to control the registration of members in the proper sickness funds."⁸⁴

The Sickness Insurance Law was only one of several reforms in health insurance introduced between 1947 and 1953.⁸⁵ A separate compulsory workmen's compensation insurance was passed on 14 May 1954, coming into effect on 1 January 1955.⁸⁶ Additional voluntary insurance became available to the self-employed, housewives and students.⁸⁷ On 21 May 1954, a separate law integrated maternity benefits and general sickness insurance under the same programme.⁸⁸ Finally, on 4 June 1954, the cost of medications became subsidised if prescribed by a doctor or dentist.⁸⁹

In 1958, the new Minister of Social Affairs, Torsten Nilsson, established a working Commission under Axel Strand to examine the whole area of pensions, sickness insurance and invalidity benefits. The Commission, reporting in 1961, recommended that pensions and sickness insurance should be integrated into a single plan.

On 1 January 1963, the National Insurance Act unified the National Health Insurance Act with other social insurance programmes to complete the long process of integration. The new act converted the sickness funds into new social insurance offices. Each county council would have an insurance office with its own local branches.⁹⁰ Under supervision of a National Insurance Board.

C. BARRIERS TO UNIVERSAL ENTITLEMENT

Two interrelated circumstances prevented the sickness insurance system from providing truly universal entitlement to health care in Sweden. First, there was an overemphasis on the unevenly distributed institutional sector. Secondly, there was persistent shortage of medical doctors in the primary care. The Seven Crown's Reform, which created a salaried doctor service, was intended to correct some of the barriers to universal entitlement created by the financing of health care through sickness insurance.

⁸⁴ Erik Malm, "En översikt över Sjukförsäkringslagens huvudbestämmelsen," in *Föredrag I Sjukkasfrågor 1953-56*, edited by the Svenska Sjukkasförbundet (Stockholm: Svenska Sjukkasförbundet, 1957): 9.

⁸⁵ Broberg, Lindell and Samuelsson, *Allmänna Sjukförsäkringen*, 11-15.

⁸⁶ Sweden, *Lag om Yrkesskadeförsäkring*, No. 243 (Stockholm: Svenska Sjukkasförbundet, 1954).

⁸⁷ Sweden, *Lag med Särskilda Bestämmelser om Frivillig Sjukpenningförsäkring i Allmän Sjukkas*, No. 774 (Stockholm: Svenska Sjukkasförbundet, 1954).

⁸⁸ Sweden, *Lag om Moderskapshjälp*, No. 266 (Stockholm: Svenska Sjukkasförbundet, 1954).

⁸⁹ Sweden, *KF Angående Kostnadsfria eller Prisnedsatta Läkemedel*, No. 519 (Stockholm: Svenska Sjukkasförbundet, 1954).

⁹⁰ Broberg, *Tryggheten*, 49-52. Rolf Broberg was the first General Director.

1. Regional Hospital Plan of 1958

The institutional sector flourished when Dr. Arthur Engel, an internist and Chief Medical Officer of Health with liberal political views, became Director General of the Board of Health in 1952, replacing Höjer who became Director of the Board of Social Welfare. Following the controversy created by the Höjer Report, Engel tried to reassure Prime Minister Tage Erlander that he envisaged his role as an 'unpolitical adviser'.⁹¹ In the same breath, he quickly tabled the blueprint for a regionalised hospital system which gained him a reputation as the 'father' of the Swedish regional health care system.⁹²

While Engel was planning his regional health care system, Erlander appointed Richard Sterner as Chairman of a Commission on Regionalism. Its terms of reference were to examine the broad direction of the Swedish health care system. In his report of 1958, Sterner recommended an expansion in ambulatory care by increasing the number of salaried district and regional medical officers, increasing the facilities for medical education, stimulating the hospital sector and focussing on prevention.⁹³

The recommendations affecting the institutional sector were quickly put into place with the county councils forming new hospital management regions.⁹⁴ Fridolf Thapper, Chairman of the County Councils Federation, felt that such reforms would optimise coordination of health services and thereby lead to greater cost efficiency. The personal links between the Engel and Thapper guaranteed success for Engel's plans: "I have for many years had the pleasure and the privilege of counting myself as one of Arthur Engel's good friends."⁹⁵ Engel presented his regional plan as a national programme for combating the "rising costs of hospital care and shortage of medical personnel and especially doctors and nurses."⁹⁶

He felt that local health centres should "integrate their activities as closely as possible with the nearest district hospital" so that the hospital districts would become the core of

⁹¹ Heidenheimer, "Conflict and compromises," 125. Personal communication with Dr. Arthur Engel.

⁹² His plan was based on the existing French regional system. Borgenhammar, *Hälsans Pris*, 14. A similar proposal had been suggested by a Swedish Commission in 1930. Arthur G.W. Engel, "Planning and spontaneity in the development of the Swedish health system," Paper presented at the 1968 Michael M. Davis Lecture at the Chicago Centre for Health Administration Studies, Graduate School of Business, University of Chicago (1968): 6.

⁹³ Sweden, Inrikesdepartementet (I), "Regionsjukvården," *Statens Offentliga Utredningar 26* (Sweden: Iduns Tryckeriaktiebolag, 1958): 15. It led to the Hospital Law of 1959.

⁹⁴ Sweden, I, "Hälsovård och öppen sjukvård."

⁹⁵ Fridolf Thapper speaking about Dr. Arthur Engel. Fridolf Thapper, "The Regional Plan," in *Regional Hospital Planning*, edited by Malcolm Tottie and Bengt Janzon (Stockholm: National Board of Health, 1967): 13.

⁹⁶ Arthur Engel, "The Swedish Regionalized Hospital System," in *Regional Hospital Planning*, edited by Malcolm Tottie and Bengt Janzon (Stockholm: National Board of Health, 1967): 14.

the Swedish health care system.⁹⁷ "I nourish the hope of having our health centres staffed, in the future, with physicians who are specialists (in internal medicine, pediatrics, obstetrics, gynecology and psychiatry)."⁹⁸

By 1963, the county councils had assumed full responsibility for the financing, organization and administration of both in-patient and out-patient care in hospitals.⁹⁹ This fulfilled the recommendations of Dr. C.J Ekströmer, Director General of the National Health Services in 1846, who had advocated that the county councils should be given full control of local state hospitals: "The State should be responsible for the over-all planning only and fulfill an advisory and supervising function."¹⁰⁰

Dr. Bror Rexed, Engel's successor, continued the emphasis on institutional care following his appointment in 1965: "In principle everybody working in the health system should be exposed to a successively more specialised, continued training throughout his whole working life."¹⁰¹ Rexed's skill as a negotiator led to an expansion in the budget for the Ministry of Social Affairs until it consumed 25 per cent of the national budget: "The value placed on health and medical care is generally very high and it is my opinion that politicians have a duty to encourage citizens to pay for what they want and need."¹⁰²

Instead of controlling cost as initially intended, there was a rapid rise in cost of the Swedish health care system during the 1960s.¹⁰³ "Every self-respecting central hospital included in its plans new clinics for thoracic surgery, neuro-surgery ... concerned with fairly uncommon diseases."¹⁰⁴ The hope of controlling costs through economies of scale such as institutional care had backfired.

Gunnar Sträng, the Minister of Finance, felt that the county councils had reached their financial limits.¹⁰⁵ Thapper, who had previously had great faith in the Engel Regional Plan, now shared this concern: "From an economic point of view, the late 1950s and early 1960s were record-breaking years. The growth rate was higher than ever before."¹⁰⁶

⁹⁷ Engel, "Planning and spontaneity," 10.

⁹⁸ Engel, "Planning and spontaneity," 11.

⁹⁹ They financed a significant part of the cost through autonomous taxation. Responsibility for psychiatric hospitals was transferred from the state to the county councils in 1967.

¹⁰⁰ Dr. C.J. Ekströmer, Director-General of Swedish Hospital Services in 1846, quoted by Dr. Arthur Engel. Engel, "Planning and spontaneity," 1.

¹⁰¹ Bror Rexed, "Public policy and medicine," in *The Swedish Health Services System: Lectures from the A.C.H.'s Twenty-Second Fellows Seminar Stockholm 1969*, edited by the American College of Hospital Administrators (Chicago: ACHA, 1969): 34. The Board of Health became part of the Board of Social Welfare in 1968.

¹⁰² Rexed, "Public policy and medicine," 217.

¹⁰³ Borgenhammar, *Hälsans Pris*, 14-15. Personal communication with Professor Edgar Borgenhammar, Economist and Professor of Health Administration.

¹⁰⁴ Thapper, "Regional Plan," 10.

¹⁰⁵ He was responsible for introducing a sales tax (later transformed into a value-added tax, VAT). This trend has continued until today when the Swedish VAT accounts for 25 per cent of the central government income.

¹⁰⁶ Hadenius, *Swedish Politics*, 93.

Health expenditure grew 231 per cent in a decade from 1950 to 1960 and 346 per cent from 1960 to 1968.¹⁰⁷

In 1967, Sven Aspling, the new Minister of Social Affairs, emphasised that preventive care was "at least as important as care in the case of illness.... [requiring] a more intimate collaboration between hospitals, home care and social care."¹⁰⁸ Universal entitlement had become increasingly limited by lack of access to the highly specialised institutional facilities which were often the sole providers of health care.

2. Swedish Younger Doctors' Association

Although the belligerent posture of the Swedish Medical Association under the leadership of Knutson lasted until 1962, the Swedish Younger Doctors' Association had by then become impatient with the practice of patronage in hospitals and the poor opportunities for future advancement. With no advancement in sight, the younger doctors' fear of displeasing senior consultants disappeared. From then on, they simply bypassed the Swedish Medical Association in their collective negotiations with the Government.

This revolt happened at a time when both local governments and the state were experiencing problems with the senior hospital consultants. The county councils had become acutely aware that the hospital sector was a costly way to provide ambulatory care and the Social Democratic Party Government was embarrassed by consultants who flaunted their high incomes.¹⁰⁹

Hospital consultants continued to overcharge patients under the insurance reimbursement system, resulting in in-patient care being cheaper than out-patient care. Hospital appointments remained more highly honoured than work as district medical officers or clinic doctor. This discouraged the younger doctors from pursuing training in primary care and seeking non-institutional posts. Although, ambulatory care was thought to offer a cheap alternative to institutional care, available posts were nearly impossible to fill.

Both the county councils and the Government felt that abuses under the fee-for-service insurance system in the out-patient departments were responsible for many of their problems: "One way to improve the chances for other sectors within the

¹⁰⁷ Mack Carder and Bendix Klingeberg, "Towards a salaried medical profession: How 'Swedish' was the Seven Crowns Reform," in *The Shaping of the Swedish Health System*, edited by Arnold J. Heidenheimer and Nils Elvander (London: Croom Helm, 1980): 148.

¹⁰⁸ Sven Aspling, "Forward," in *Regional Hospital Planning*, edited by Malcolm Tottie and Bengt Janzon (Stockholm: National Board of Health, 1967): 9.

¹⁰⁹ Such out-patient departments handled 40 per cent of medical consultations in 1963.

health care system to compete for physicians would be to deny physicians additional incomes from out-patient work, in other words to integrate out-patient work into those service duties that are compensated for by salaries."¹¹⁰

Dr. Bo Hjern, the Chairman of the Younger Doctors' Association (later Director of the Swedish Medical Association), had long advocated that the Association abandon its free medical profession model and adopt a collective bargaining role which would give greater recognition to the plight of the younger doctors.¹¹¹ Other influential leaders, such as Åke Lindgren and Nils Ternér, supported this view.¹¹² "Without embarrassment, we call ourselves a trade union."¹¹³ By infiltrating both the general assembly and the executive of the Association, the Younger Doctors' Association slowly succeeded in its goals. "We ... wanted to turn the association into something more like a modern trade union. When Knutson realised that there were many members of the Association who wanted a new Chairman, he resigned."¹¹⁴

3. Seven Crowns Reform of 1969

Over the years, the Social Democratic Party had promoted several distinct policy platforms. During the early years, it focused on political democracy. Later, during the 1940s and 1950s, it built the Swedish welfare state. In the 1960s, a new platform based on employment equality led to the Seven Crowns Reform. Under this reform Swedish doctors became salaried state employees.

The Social Democratic Party's margin for exercising power had continued to decrease following World War II. After the 1956 general election, the Coalition Government, composed of Social Democrats and Agrarians, continued to lose popular support. In the 1966 local elections, the Social Democrats suffered the worst setback since the war, winning only 42 per cent of the popular vote. They badly needed a new political platform to boost their popularity. Further increases in the cost of the health care system and hostility from the powerful county councils worsened their political position.

Finding a stimulating election platform formed the basis for the Party Congress in 1967.¹¹⁵ "They needed a new issue that could rekindle the enthusiasm of the labor

¹¹⁰ Sweden, Inrikesdepartementet (I), "Sjukhus och öppna vård," Statens Offentliga Utredningar 21(Sweden: Iduns Tryckeriaktiebolag, 1963): 165; and Carder and Klingeberg, "Salaried medical profession," 147.

¹¹¹ Personal communication with Dr. Bo Hjern, present Director General of the Swedish Medical Association.

¹¹² Personal communication with Dr. Åke Lindgren.

¹¹³ Bo Hjern, "The Swedish Medical Association and its role in Swedish health care," in *Scandinavian Health Care: Report of an Estes Park Conference*, edited by Richard C. Bates (Englewood, Colorado: Estes Park Institute, 1983): 55.

¹¹⁴ Hjern, "Commentary," 1975. Personal communication with Dr. Bo. Hjern.

¹¹⁵ Tage Erlander, *Tage Erlander 1955-1960* (Stockholm: Tidens Förlag, 1976): 256-262.

movement and encourage a new belief in change."¹¹⁶ To make matters worse, just before the 1968 general elections, the county councils decided to increase in-patient fees to draw public attention to their plight -- an awkward event for the Government.

The post-war economic boom had allowed the Swedish welfare state to develop without radical challenges to private industry. This had been an affront to the more radical factions of the Social Democratic Party. To regain its more radical constituents, the party decided to focus on equality among workers as its new political platform.¹¹⁷ "Its most important purpose was to generate enthusiasm among Social Democratic precinct workers and to draw a clear line between their party and the non-socialists."¹¹⁸

The September 1968 elections witnessed a voter turnout of 89 per cent and led the Social Democratic Party gain over 50 per cent of the popular vote, a rare event in a multi-party political system.¹¹⁹ The Party's income equality platform, the personal popularity of Tage Erlander, who had become a cult father figure, and the economic success of two decades of growth contributed to the landslide election victory.

Following the elections, the Ministry of Social Affairs and County Council Federation meet to discuss the necessary measures to implement the Government's election promises. Both felt that eliminating the disproportionately high incomes of some doctors would serve as a symbolic showpiece of their commitment to income equality. By December, an *ad hoc* working committee rushed through an analysis of various proposals, which they "presented as a binding agreement to the respective parties ... passed and implemented virtually unchanged" in what would become the Seven Crowns Reform.¹²⁰

The Government informed the medical profession in February that the county council hospitals would take over the full responsibility of collecting patient fees, thereby eliminating all direct financial transactions between doctors and patients. The executive of the Swedish Medical Association, agreeing with the principles of the reform, advised its membership that the Association had no jurisdiction over the determination of the mode of remuneration of doctors.¹²¹

When the Government introduced its memorandum containing the Seven Crowns Reform in March 1969, the Association accepted what they understood as the principles

¹¹⁶ Hadenius, *Swedish Politics*, 125.

¹¹⁷ A Myrdal, *Towards Equality: The Alva Myrdal Report to the Swedish Social Democratic Party* (Stockholm: Prisma, 1971): 24; and Tage Erlander, *Tage Erlander 1960-talet* (Stockholm: Tidens Förlag, 1982): 218. Such wage equality was the terms of reference for the Low Income Commission that had just reported.

¹¹⁸ Hadenius, *Swedish Politics*, 126.

¹¹⁹ Hadenius, *Swedish Politics*, 128.

¹²⁰ Carder and Klingeberg, "Salaried medical profession," 149.

¹²¹ Carder and Klingeberg, "Salaried medical profession," 160 quoting the *Svenska Läkartidningen* 66(1969): 978.

of the reform. Their main objection was the rushed manner in which the Government introduced the proposal: "The proposals should be improved considerably and backed with documentations and data on the important issues."¹²²

Bo Hjern then hosted a dinner for members of the Government during which he proposed that the medical profession negotiate the terms of its involvement through collective bargaining. During this and other closed meetings, he and the leaders of the Medical Association became aware of the Government's underlying intentions to create a salaried service. The executive decided, however, not to inform the membership, fearing that this would give opponents time to mount a protest. Instead they "allowed the reform to progress unhindered."¹²³

This course of action reflected the deep division that existed within the Swedish medical profession at the time. Junior doctors resented how a few privileged consultants enjoyed great financial advantages over them, usually at their expense. Doctors with comfortable incomes found that long hours of work often made little difference in terms of real income. When the general membership realised the full extent of the reform during the October and November parliamentary debates, many doctors were well on the road to accepting the notion of salaries if they were "combined with regulation of working hours."¹²⁴

The Seven Crowns Reform succeeded in equalising the incomes of medical doctors who became salaried employees of the state. In return, doctors gained normal working hours, and the Swedish Medical Association took on a new role as a professional trade union. The Reform abolished the fee-for-service system of remuneration and established a new flat-rate user fee of 7 Crowns collected by the county councils. This excluded doctors from all direct financial transactions with patients. The nominal in-patient users-fees was doubled to discourage over-use of hospitalisation where adequate ambulatory care was available.¹²⁵

The decrease in patient contributions led to an annual out-of-pocket saving of 4 million Crowns. The corresponding increase in the cost of out-patient care to the county councils was 121 million Crowns.¹²⁶ Employer contributions on wages were increased from

¹²² Swedish Medical Association Brief to the Seven Crowns Reform Memorandum from the Ministry of Social Affairs, U 91/69,(20 April 1969): 17, Mimeograph. The idea of a salaried health service was far from new. Højer proposed it in 1948, and the Royal Commission on Health Insurance debated its merits in 1963.

¹²³ Carder and Klingeberg, "Salaried medical profession," 169.

¹²⁴ Hjern, "Commentary," 175.

¹²⁵ The Royal Commission on Insurance in 1967 had recommended the introduction of free health care with an abolition of all in-patient fees.

¹²⁶ Patients contributed 7 Crowns, while the sickness funds contributed 31 crowns. Under the previous system, patients often contributed more than 7 Crowns, depending on what the doctors charged.

2.6 to 2.9 per cent to provide the additional finances required by the National Insurance Fund. This allowed the Government to eliminate entirely all employee contributions.

4. Health Policy for the 1990s

In Sweden, the introduction of public financing for universal entitlement to health care occurred slowly. There were no major milestones transforming the system through a single radical piece of legislation. The evolving public system of hospitals, financed and run by the county councils, has remained the backbone of its health care system.

Swedes slowly realised the shortcomings of the social insurance system for the financing of ambulatory care. The reimbursement system of sickness insurance, doctors over-charging patients and the over-emphasis on the institutional care all created barriers to universal access. The Seven Crown's Reform, which created a salaried health service, attempted to correct these shortcomings by encouraging a more even distribution of primary care services.

The Public Health Service Act of 1981 obliged the county councils to provide a full range of health care services. It completed the health-related responsibilities of local authorities. Under the act, the county councils became responsible for general health care, public health services, hospital care, public dental care, care for the mentally retarded, family counselling and children's homes. The local municipalities became responsible for social welfare, housing, sanitation, environment and health protection, and emergency and fire protection.

Today the county councils spend 75 per cent of their budget on health care. Taxation revenues finance 60 per cent of this outlay, while state grants-in-aid and direct charges account for an additional 15 per cent each.¹²⁷ The municipalities have powers to levy their own taxes to finance their expenses.¹²⁸ Following further reforms in 1986, contributory social insurance was eliminated as one of the sources of financing for health care.¹²⁹

Höjer envisaged the present primary health care system in 1948.¹³⁰ His supporters had waited with impatience: "To my joy, I find modern scholars studying Höjer's vision of how the health care system should evolve."¹³¹ This completed a process that he had begun

¹²⁷ Figures based on data for 1981. See Gustaffson, *Local Government*, 110.

¹²⁸ Sweden, "The Instrument of Government Act," Art. 1,7.

¹²⁹ Since 1986 the county councils no longer receive a contribution from the National Insurance Board toward the finance of health care.

¹³⁰ Sweden, National Board of Health and Welfare (NBHW), *The Swedish Health Services in the 1980s* (Stockholm: National Swedish Board of Health and Welfare, 1976); Sweden, Ministry of Health and Social Affairs (MHSA), *Health in Sweden HS 90: Swedish Health Service in the 1990s* (Stockholm: Swedish Ministry of Health and Social Affairs, 1982); and Sweden, NBHW, *Health Services in the 1990s*.

¹³¹ Erlander, *1960-talet*, 275.

thirty-five years earlier, which "aimed not only at equal health care for all, but good health for all as well."¹³²

¹³² Barbro Westerholm, "The Swedish National Health Services: Goals, organization and problems," in *Scandinavian Health Care: Report of an Estes Park Conference*, edited by Richard C. Bates (Englewood, Colorado: Estes Park Institute, 1983): 51.

CHAPTER 10. FINLAND

Social legislation in our country has come a long way in many fields but still suffers from shortcomings [in health care] that are not worthy of a modern welfare state.¹

Carl Olof Tallgren, 1962

A. FINANCIAL INFRASTRUCTURES

1. Early Health Provisions

Ravaged by wars and civil strife, "Finns lived for centuries in the shadow of other nations."² The early organization of health care services reflected 800 years of Swedish and Russian domination which ended when Finland finally gained its full independence in the wake of the Russian civil war which followed the 1917 Bolshevik Revolution.³ "Being Nordic is more than a matter of will to us Finns: it is an inseparable part of our history."⁴

During the early years of the nineteenth century, the Finnish Lutheran Church provided some outdoor relief to the poor. The communes assumed this responsibility when the administration of parishes and secular communes separated into two branches in 1836. From this stage onward, provision of medical care was seen as an "obligation of the society and their utilisation as a natural right of the citizen."⁵

Institutional care followed the same course. Hospices for lepers and those suffering from infectious diseases date back to the fourteenth century, while asylums or Holy Spirit houses, under parish supervision, remained available for containment, isolation and social control of the undesirable. Later, as the running costs of the parish hospitals rose, the state assumed their financing. With the growth of local government, the communes slowly took over this task.⁶

¹ Finland, "Yleistä sairausvakuutusta koskevan esityksen antamisesta," *Valtiopäivät Liitteet IX-XII A*. Toiv. al. No 678 (Helsinki: 6 March 1962): 1867.

² Finnish Medical Association, "Finnish Medical Association and Medical Profession in Finland," *Monograph* (Helsinki: Finnish Medical Association, 1986): 3.

³ Although Finland became an autonomous Grand Duchy under the Russian Empire in 1809, Finnish did not become the official language until towards the end of the 19th century.

⁴ Urho Kekkonen, *A President's View* (London: Heinemann, 1982): 84.

⁵ Finland, National Board of Health (NBH), Department of Planning and Evaluation (DPE), "The health services system of Finland: Description," *Memorandum* (Helsinki: NBH, DPE, 1972): sec. 1.1.

⁶ Unlike in other Nordic countries, this did not occur until the early 1950s. Esko Kalimo, "The relationship between trends in health expenditure and the type of organization of health care: National Monograph of Finland," *Research Institute for Social Security Publication M:31* (Helsinki: Social Insurance Institution, 1979): 4.

Early forms of sickness insurance started with the trade guilds in the 18th century.⁷ The Crafts Order Act of 1720 established the basic rules for these organizations: "If some master of a trade, not through his own fault, becomes poor or ill he should receive help from the 'Craft Box'.⁸ When a member regained his working capacity he had to pay back what he received during the period of his illness.

The Royal Order on the Foundries Act of 1766 established the practice of 'iron boxes' for foundry workers. Under the provisions of this act, blacksmiths who were unable to work for a week received a cash benefit from his employer and the foundry 'benefit box'.⁹ Later, Finlayson and Co., a cotton factory, established the first sickness fund in 1846. Under the plan, the employers offered medical treatment at work and paid a cash benefit to workers during illness.¹⁰

The provision of sickness funds were rudimentary during the nineteenth century. Since they were not under public supervision, their standards varied and their benefits were often inadequate. Furthermore, since there were few doctors, benefits aimed at economic support during illness, not medical treatment or health care.¹¹

2. Finnish Medical Association

During the nineteenth and early twentieth centuries, most Finnish doctors worked in hospitals as public employees on a salary.¹² As in Sweden, fee-for-service private practice offered little financial security and was less honoured than hospital work. The few doctors who kept such private practices worked in isolation with little collaboration from their colleagues.¹³

From the 1750s onwards, the local communes, which became responsible for the provision of health care, employed district doctors to carry out both public health and clinical duties.¹⁴ These doctors supplemented their basic salary with fee-for-service for

⁷ Finland, "Sairausvakuutuskomitean mietintö," *Valtioneuvoistolle*, translated by Helle Satälä (Helsinki: 15 April 1959): 7.

⁸ From the Crafts Order Act quoted in Finland, "Sairausvakuutuskomitean 1959," 7.

⁹ The foundry benefit funds ceased to exist in 1854. In 1868, Parliament abolished the other trade guilds, replacing them with workers' and craftsmen's funds. Finland, "Sairausvakuutuskomitean 1959," 7.

¹⁰ Employers also supplied the personnel for the secretariat of the sickness funds. Finland, "Sairausvakuutuskomitean 1959," 7.

¹¹ The first hospital with nine beds was established in Turku in 1759. Finland, "Sairausvakuutuskomitean 1959," 8.

¹² The first Finnish Collegium Medicum was similar to its counterpart in Stockholm, and the first Professor in the Faculty of Medicine at the University of Turku was Swedish.

¹³ The wealthy upper class used foreign doctors for their medical needs. Finland, "Sairausvakuutuskomitean 1959," 3.

¹⁴ The first district doctor post was established in 1749.

clinical work.¹⁵ While the number of district doctors did grow slowly, the increase was too small to provide adequate health care for the Finnish population of 2,712,562 which, at the turn of the century, was scattered over 304,623 square kilometers of lake-covered northern regions.¹⁶

Finland's doctors created the Finnish Medical Association as a professional syndicate and political lobby in 1910.¹⁷ "The founding of the Finnish Medical Association was based on the idea of a common professional association, which would take care of the physicians' economic interests and numerous obligations to society, such as expertise in developing health care and turning in reports to the legislator."¹⁸

Five hundred of the country's 523 doctors immediately joined the association. Meetings often focused on "health policy and the improvement of health care ... government bills and reformatory measures."¹⁹ Through their Association, Finnish doctors began influencing policy through 'quiet diplomacy', much as they did in the other Nordic countries.²⁰

3. Public Involvement

In 1888, the Finnish Diet appointed Senator A.L Gripenberg as Chairman of a Sickness Insurance Committee to examine the function, organization and shortcomings of the existing sickness funds. This ended the *laissez-faire* period during which the voluntary sickness funds had escaped public supervision and regulation.²¹ The committee, which reported in 1892, recommended the creation of a Medical Supervisory Board to oversee the activities of the sickness funds.

Based on the recommendations of the committee, Parliament introduced a Workers' Benefit Fund Act in 1897, which offered specific groups of workers cash support during times of incapacity due to industrial accidents. Although the Law recognised the sickness

¹⁵ Kalimo, "Trends in health expenditure," 4.

¹⁶ The population for 1900 is based on United Nations (UN), Statistics Office (SO), Department of Economic and Social Affairs (DESA), *Demographic Yearbook 1962*, 14th Edition (New York: UN, 1962): 277 and the area is based on John Paxton, ed., *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World for the Year 1986-1987*, 123rd Edition (London: MacMillan Press, 1986): 464.

¹⁷ Swedish doctors had earlier established a Finnish Medical Society in 1835 whose members were mainly Swedish. Finnish-speaking doctors later established the Finnish Medical Society Duodecim to promote their own language.

¹⁸ Finnish Medical Association, "Medical Profession," 5.

¹⁹ Finnish Medical Association, "Medical Profession," 6.

²⁰ The number of communal doctors never rose beyond 1000. Finnish Medical Association, "Medical Profession," 6.

²¹ Finland, "Sairausvakuutuskomitean 1959," 8.

funds, it did not call for means-tested compulsory sickness insurance as recommended by a minority report of the Gripenberg Committee.²²

The Senate and Governor General assumed the responsibility of establishing "pensions and sickness funds for certain groups of workers ... and ratifying their rules, directives and regulations."²³ The sickness funds which applied for official registration with the County Council Boards were eligible for small public subsidies.

Public subsidies were too low, however, to entice a significant number of the sickness funds to seek official registration. As a result, a new committee was created to examine the role of the sickness insurance system. This committee concurred with the minority opinion of the first committee, calling for a means-tested compulsory sickness insurance for all workers.²⁴ The Senate, feeling that such a programme would be too expensive, ignored its recommendations.²⁵

4. Multi-Party Politics

In Finland, both social class structure and politics determine the popularity of political parties. The tradition of proportional representation, characteristic of all Nordic countries, has led to a multi-party system of five major parties: the Conservatives, Liberals, Agrarian/Centre, Social Democrat and Left Socialist/Communists.²⁶

Among the Nordic countries, Denmark led the way in the evolution of political parties. Norway and Sweden were next with Finland was last. The Finnish working class felt less threatened by external Russian rulers than by threats of cultural assimilation from the Swedish-speaking upper class.²⁷ Finland was, therefore, the last Nordic country to shed the four-estate political structure of the Diet -- the nobility, the clergy, the burghers and the peasants. Although enfranchisement and a uni-cameral representative assembly were finally introduced in 1906, the Russian Tsar, who dominated its Government and Senate, continued to maintain the power of veto.

During the latter part of the nineteenth century, the conservative bourgeois parties at the right, the liberal parties in the centre and the Labour Party at the left appeared. The

²² Jaakko Pajula and Esko Kalimo, "Social security in Finland," *International Social Security Review* 32(1979): 161.

²³ A Senate directive of 1892 quoted in Finland, "Sairausvakuutuskomitean 1959," 8.

²⁴ A. Ramsayn was appointed its Chairman.

²⁵ Finland, "Sairausvakuutuskomitean 1959," 9.

²⁶ Juhani Mylly, "The emergence of the Finnish multi-party system: A comparison with developments in Scandinavia, 1870-1920," in *Political Parties in Finland: Essays in History and Politics*, edited by Juhani Mylly and R. Michael Berry, Series C:21 (Turku: University of Turku, 1984): 9.

²⁷ Mylly, "Finnish multi-party system," 13.

agrarian/centre parties, Communist Party and socialist parties appeared later during the early twentieth century.²⁸

Since many doctors in Finland at the turn of the twentieth century were Swedish, the medical profession was more sympathetic to Swedish-speaking right-wing bourgeois conservative parties than Finnish-speaking counterparts. The Finnish-speaking division of the Medical Association supported the more complex central political parties.²⁹ Evolution in social policy and health care appeared only after further political reforms had taken place.

5. First Parliamentary Proposal

In 1917, the Government appointed a new Sickness Insurance Committee with Onni Hallstenin as Chairman. Its terms of reference were once again to review the existing sickness insurance system. Before the committee reported, however, a faction of the Finnish labour movement formed the 'Red Guards' and unsuccessfully attempted a military *coup d'état*.

The Finnish Social Democratic Party (SDP), founded on a belief in peaceful social and economic reform, rejected calls for armed uprising.³⁰ Their leader, Väinö Tanner, ousted the communists who continued to support violent insurrection. This action won him strong popular support, resulting in a gain by the Social Democratic Party of 80 of the 200 seats in the 1919 parliamentary elections.³¹

Despite this strong showing by the SDP, the Conservative Government rejected the Sickness Insurance Committee's proposal for a means-tested old age pension and compulsory sickness insurance in 1921.³² When Väinö Tanner formed a short-lived Social Democratic Party Minority Government in 1926, he was equally unsuccessful in introducing the legislation. The Conservatives, now in the Opposition, had convinced Parliament that the introduction of old age pensions took precedence over sickness insurance.³³

²⁸ Mylly, "Finnish multi-party system," 10.

²⁹ The Finnish Party split into the Young Finnish Party (later Liberal Party) which joined the Centre Party during the 1980s) and the Old Finnish Party (later Conservative Party). The Agrarian Party became a Centre Party, while the Finnish Labour Party split into a Social Democratic Party and a Communist Party.

³⁰ The Finnish Labour Party, formed in 1899, changed its name to the Social Democratic Party in 1903. Tapani Paavonen, "The Finnish Social Democratic Party since 1918," in *Political Parties in Finland: Essays in History and Politics*, edited by Juhani Mylly and R. Michael Berry, Series C:21 (Turku: University of Turku, 1984): 137; and Mylly, "Finnish multi-party system," 17.

³¹ The Conservatives wanted to create a constitutional monarchy while the centre and left wanted a Republican-Democratic Constitution. Paavonen, "Finnish Social Democratic Party," 138.

³² Finland, "Sairausvakuutuskomitean 1959," 9.

³³ Finland, "Sairausvakuutuskomitean 1959," 9.

In 1934, the Conservatives, who now formed another Coalition Government, appointed a Sickness Benefit Fund Committee with Councilor Niilo A. Mannion as Chairman. This committee recommended that old age pensions should be introduced before sickness insurance. The National Pensions Act of 1937 followed these recommendations.³⁴ The committee also recommended that means-tested compulsory sickness insurance should cover urban workers, while a voluntary programmes should be made available for the rest of the country.

After the defeat of the Social Democratic Party Minority Government during the 1920s, the party was forced to accept more gradual social reforms as partners in Conservative and Central Party dominated Governments. As a result, prior to World War II, the Finnish Social Democratic Party failed to pursue "the principles of [Keynesian] anti-depression fiscal policies, for which its Nordic sister parties would become so famous."³⁵

B. LANDMARK LEGISLATIVE REFORMS

1. Governmental Proposal to Parliament of 1954

After World War II, the Social Democratic Party called for a major social reconstruction similar to that of the other Nordic countries: "There would be a planned economy, full employment, a general social insurance scheme, redistribution of income via tax reform, industrial democracy, wage bargaining on a basis of equality with the employers, etc."³⁶ Its political platform, passed at the Party Conference of 1945, stressed such welfare programmes.³⁷

The war had, however, left Finland in economic ruins. "Wars had sucked the country's economy dry, foreign trade had come to a standstill, and there were shortages of everything. Lapland lay in ruins and had to be reconstructed. The war indemnity which we were required to pay under the terms of the armistice agreement was so large that economists considered it impossible to accomplish."³⁸

Niilo A. Mannion was once again appointed Chairman of a Sickness Insurance Committee whose terms of reference were to enquire into compulsory sickness insurance.

³⁴ Finland, "Sairausvakuutuskomitean 1959," 10.

³⁵ Paavonen, "Finnish Social Democratic Party," 140.

³⁶ Paavonen, "Finnish Social Democratic Party," 141.

³⁷ Timo Soikkanen, "Changing bourgeois parties in a changing Finnish society," in *Political Parties in Finland: Essays in History and Politics*, edited by Juhani Mylly and R. Michael Berry, Series C:21 (Turku: University of Turku, 1984): 83.

³⁸ Kekkonen, *President's View*, 37.

Its majority report of 1949 proposed a gradual introduction of compulsory sickness insurance in larger factories, a recommendation similar to that made in the reports during the 1930s. The committee also felt that a more extensive programme was impossible, given Finland's scarce economic resources and limited health care facilities.³⁹ Two minority reports were notable. First, Tyyne Leivo-Larsson proposed universal entitlement under compulsory plan.⁴⁰ At the same time, Mauri Ryömä proposed financing sickness insurance entirely through employer contributions and a state subsidy.⁴¹

The Social Democratic Party supported the recommendations of the minority reports, while the Conservative Party favoured the recommendations of the majority report. A new balance of political power, however, had emerged in Parliament. The new Agrarian Coalition Government had banned the right-wing Fascist Party, while allowing the Finnish Communist Party to re-enter the political arena. Finland had become acutely aware of its delicate position between the East and West.

As a result of these changes, the conservative policies which had dominated the political scene before the war were soon dropped. This allowed Finnish social reformers to become more aggressive in rebuilding the country's economic base and finally establishing a comprehensive social security infrastructure.

2. Sickness Insurance Committees

The seemingly endless proposals for expanding the Finnish sickness insurance system continued. On 15 April 1955, the Government appointed another Sickness Insurance Committee "to work on a proposal for a sickness insurance law, taking into account that the insurance must cover the whole population except possibly those which already benefit from some other type of social insurance."⁴²

Tauno Jylhä, a department head at the National Pensions Board, became the Chairman of the committee. Erkki Mäkelä, Senior Government Secretary at the Ministry of Social Affairs, became its secretary. Other prominent members included Niilo Pesonen, Director of the National Medical Board, Erkki Jäämeri, representing the Finnish Medical Association, Erkki Canth, representing the Ministry of Finance, and Martti Vihma, representing the Ministry of Social Affairs. Many other organizations also had members on the committee: trade unions, employer's union, agricultural unions, benefit funds association, town and city associations, rural boroughs and professional unions.

³⁹ Finland, "Sairausvakuutuskomitean 1959," 10.

⁴⁰ This was the first proposal to include contributions from the self-employed.

⁴¹ Finland, "Sairausvakuutuskomitean 1959," 11.

⁴² Finland, "Sairausvakuutuskomitean 1959," Forward.

When the committee reported in 1959, its majority report outlined the sorry state of collective financing of health care in Finland. Apart from state and commune-owned hospitals, which received public financing at an early stage, collective provisions for both financial support and treatment during illness remained minimal. By 1957, after sixty years of debate, sickness insurance remained voluntary and restricted to industrial employment. The 254 sickness funds covered only 145,000 of the country's 4 million citizens.⁴³

In comparison to social security programmes throughout the world, the committee felt that the existing lack of comparable provisions in Finland was an embarrassment to the country.⁴⁴ To correct these shortcomings, the majority report recommended that the Government should introduce a Compulsory Sickness Insurance Law as soon as possible.

The committee prepared a draft legislation calling for universal entitlement under compulsory sickness insurance.⁴⁵ Benefits would include health care, maternity care, drugs, transportation to hospital, cash support during illness and maternity benefits. Every person in Finland, including those who for one reason or another did not contribute, would enjoy the benefits of the new insurance system. Workers' and employers' contributions as well as subsidies from the local communes and the state would jointly finance the programme. Membership contributions would depend on taxable income. A new central insurance organization would oversee the programme, while local authorities, using the private sickness funds as agents, would administer the benefits.

Several members of the committee, once again, submitted important minority reports. Uuno Hiironen and Niilo Jeminen, representing the trade unions, felt that the majority report had placed the financial burden of the programme directly on workers: "In our view the insured's proportion is too high in comparison with that of other contributors."⁴⁶ They therefore recommended that state financing be increased.

Dr. Niilo Pesonen warned that despite the laudable recommendations of the committee, it would be difficult to implement the proposed sickness insurance programme because "at the moment there are few doctors in comparison with the populations, and they [are] inequitably distributed throughout the country."⁴⁷

⁴³ Ninety per cent of the existing 36,794 beds were already under state or local authority ownership, financed through the public sector. Finland, "Sairausvakuutuskomitean 1959," 11-14.

⁴⁴ Finland, "Sairausvakuutuskomitean 1959," 116-27.

⁴⁵ Finland, "Sairausvakuutuskomitean 1959," 71-92.

⁴⁶ Finland, "Sairausvakuutuskomitean 1959," 131.

⁴⁷ Finland, "Sairausvakuutuskomitean 1959," 135-36. Personal communication with Professor Niilo Pesonen, Director-General of the Finnish National Board of Health in the late 1950s and early 1960s. He was a member of the Sickness Insurance Committee of 1955 and Chairman of another committee in 1961.

The infrastructure of Finland's health care system had been slow to develop. In 1961, the country had 12 hospital beds per 10,000 population and one doctor per 1,516 people.⁴⁸ This compared poorly with Sweden's 15.1 beds per 10,000 and one doctor per 1,000 population.⁴⁹ In the northern regions, the dearth of health care services was even more pronounced.

Pesonen therefore recommended that the new Sickness Insurance Law initially be restricted to the workers and only later be extended to cover the whole population: "In my view the law should be put into operation in two stages, during the first stage it would cover only those in employment and in the second stage it would cover the whole population."⁵⁰ This would give the country time to expand its health care services and sickness insurance slowly in parallel.

Others, such as Mäkinen, also felt that the committee had gone too far in its recommendations for universal entitlement: "The committee has included less important support which will increase the total cost too rapidly for the total programme to be put into force." He feared that this would "delay the realisation of support given to those suffering from long-term illness."⁵¹

The Government appointed a Legislative Committee to prepare the Sickness Insurance Law on 26 October 1961. Erkki Mäkelä, who had submitted a minority report in 1959, became the Chairman of the Committee. Dr. Niilo Pesonen, who submitted a minority report, and Jaakko Pajula, later Director General of the National Pensions Institution, were members of the committee.

The Legislative Committee reported on 28 November 1961.⁵² Relying heavily on the majority report of the 1959 committee, the Legislative Committee warned that the programme needed to be economically feasible: "None can be of a different opinion that sickness insurance is needed quickly.... When this question is examined, however, the society as a whole needs to be considered and how it would affect its economic

⁴⁸ There was one doctor per 755 people in the large cities, and one per 4,290 people in the country.

⁴⁹ Finland, "Regeringens proposition till Riksdagen med förslag till Sjukförsäkringslag och Vissa Därtill Anslutna Lagar," *Handlingar* Part 3 (Helsinki: Statsrådets Tryckeri, 1962): 2. By today's standards, both would be considered high.

⁵⁰ Finland, "Sairausvakuutuskomitean 1959," 136.

⁵¹ Finland, "Sairausvakuutuskomitean 1959," 133.

⁵² Tallgren in parliamentary debates during the introduction of the Sickness Insurance Law. Finland, "Yleistä sairausvakuutusta," 1867. Personal communication with Professor Niilo Pesonen and Jaakko Pajula, members of the 1961 Sickness Insurance Legislative Committee.

development."⁵³ It nevertheless recommended that the new law "should include [the] whole population."⁵⁴

The committee also reminded the Government that social expenditures was taking up an increasing proportion of the country's GDP. It therefore recommended that the sickness insurance should be introduced gradually and that the proposed law should apply primarily to ambulatory care, since institutional care was already financed by the state and local governments. The committee concluded by warning the Government against overloading existing services which might compromise treatment of the seriously ill.⁵⁵

3. Social and Political Transformation

Several new circumstances finally broke the vicious circle of aborted attempts to expand coverage under sickness insurance from the 1920s to 1950s. First, Finland transformed from an agricultural to an industrial community during the late 1950s and early 1960s.⁵⁶ People who moved into the cities could no longer rely on the security of the land and family networks during times of unemployment and illness. The social hardships and needs created by this industrialization were similar to those experienced by other countries during the nineteenth and early twentieth centuries.

Secondly, despite the absence of a national health care system during the 1950s, social legislators had begun to expand health care facilities in a piecemeal fashion.⁵⁷ Within a few years, the public sector built 19,000 new general hospital beds and 11,000 mental hospital beds. Three new medical schools appeared, and educational grants encouraged the training of doctors abroad.⁵⁸ These events countered some of the fears expressed by Dr. Niilo Pesonen in his minority report of 1959.

Thirdly, although the public sector had financed hospitals since the nineteenth century, treatment by doctors and ambulatory care were still outside the means of most people.⁵⁹ The wealth generated through increased industrialization and completion of the repayment of war-time debts allowed the Finnish economy to improve. As resources

⁵³ Finland, "Hallituksen esitys eduskunnalle sairausvakuutuslaiksi ja eräiksi siihen liittyviksi laeiksi," *Valtioneuvoston*, translated by Helle Satälä (Helsinki: 15 November 1961): 1-3.

⁵⁴ Finland, "Yleistä sairausvakuutusta," 1867.

⁵⁵ Finland, "Hallituksen esitys," 3.

⁵⁶ Esko Kalimo, "Planning and evaluation of national health insurance in Finland," *Research Institute for Social Security Publication M:32* (Helsinki: Social Insurance Institution, 1979): 2.

⁵⁷ Kalimo, "Planning and evaluation," 5.

⁵⁸ Finland, Ministry of Social Affairs and Health (MSAH), "Health policy report by the Government to Parliament," *Report*, translation by the Medical Translation Office (Helsinki: Ministry of Social Affairs and Health, 1985): 10. By 1966, 90 per cent of financial resources used for health care were spent on hospital care, while only 10 per cent was spent on ambulatory care. Kalimo, "Trends in health expenditure," 4.

⁵⁹ Kalimo, "Planning and evaluation," 2.

became more visible, there was increasing political pressure to bring health care services within the reach of the ordinary person.

Finally, as a result of weak Coalition Governments and internal power struggles within the political parties during the 1950s, the bureaucracy of the administrative branches of the Government controlled much of Finnish policy-making. To influence this bureaucratic process, political parties had tried to be represented on administrative boards and committees of inquiry. Even parliamentary committees now had such party representation: "Institutions and organizations which had traditionally remained outside the domain of party politics were also affected by this development."⁶⁰ The 1959 majority and minority committee reports reflected this trend.

The multi-party system had led to a process of convergence and revisionism. The series of unstable and short-lived Coalition Governments that had existed up until the 1960s, had polarised the five major parties into two camps: the centre coalition (Centre, Liberal and Swedish People's Parties) and the left (Social Democratic Party and Finnish People's Democratic League -- communist offsprings).

Only policies that were acceptable to all the parties in a Coalition Government could be implemented. Lack of unanimous support for a given policy within a political party often led to internal strife. Fragile coalitions, therefore, avoided introducing radical social reforms for fear not only of provoking a conflict which would lead to a defeat of the Government, but also a breakup of parties themselves. Although this made achieving radical reforms difficult to impossible, it engendered a 'middle-of-the-road' political process similar to that which had evolved in Sweden.

The Social Democratic Party, although a firm supporter of an expanded social security system, had on repeated occasions compromised its principles in exchange for remaining a partner in Coalition Governments. Unlike its Scandinavian counterparts, the Finnish Social Democratic Party had to compete with a strong Communist Party. Anti-communist sentiments engendered by the Cold War were especially pronounced in Finland. This complicated a reconciliation among the left-wing political parties and forced the Social Democratic Party into a close alliance with the Agrarian Party (later Centre). With the right holding a majority in Parliament and the Agrarian Party holding balance of power in the Government, the range of movement for the Social Democratic Party was restricted.⁶¹

⁶⁰ Onni Rantala, "Changing features in the Finnish party system from the 1960s to the present: An overview," in *Political Parties in Finland: Essays in History and Politics*, edited by Juhani Mylly and R. Michael Berry, Series C:21 (Turku: University of Turku, 1984): 35.

⁶¹ Paavonen, "Finnish Social Democratic Party," 144.

The subordinate position of the Social Democratic Party, moreover, excluded it from important decision-making. In 1952, the party finally dropped its emphasis on class conflict, replacing it with a new 'Principles Programme'. This programme followed the guidelines of the 1951 Socialist International Programme which sought a planned economy and opposed communism. The adoption of the compromise stance led to a split between the Parliamentary representatives of the Social Democratic Party and the non-elected trade unionists who supported more radical reforms.

When Tanner won the election as Party Chairman in 1957, the faction headed by the previous Party Chairman, Emil Skog, walked out in protest. The result was a complete breakdown in party unity. In defiance of the party leadership, the 'Skogite' minority proposed its own candidates to become members of the Agrarian-led Government of V.J. Sukselainen in 1957. The expulsion of the 'Skogites' led to a near total disintegration of the Social Democratic Party.⁶²

The Agrarian Party, which dominated the Coalition Governments following the war, was also experiencing internal discord. Although the party consolidated its power in 1950 when Urho Kekkonen became Prime Minister (later President), this did not prevent it from suffering the political repercussions of the social upheaval of industrialization. It had previously represented the rural centre in Finnish politics. It stood for "a mixed economy, small and medium-scale industry, intensive regional policies, decentralisation, promotion of the rural way of life and an anti-bureaucratic, humane environment."⁶³ As Finland industrialized and urbanized during the 1960s, the younger generation which moved from the country into the cities voted for other parties.⁶⁴

In 1962, to adapt to the realities of the times, the Agrarian Party moved away from its previous emphasis on agrarianism toward a more central platform.⁶⁵ At the Party Conference of 1965, it changed its name to the Centre Party. Although this secured some support from the political centre in urban areas, the change also estranged the party's traditional rural constituencies.

President Kekkonen, nevertheless, became a strong national figurehead who believed that cooperation among the political parties was crucial for Finnish society. He

⁶² Paavonen, "Finnish Social Democratic Party," 145.

⁶³ Juhani Mylly, "The Agrarian/Centre Party in Finnish politics," in *Political Parties in Finland: Essays in History and Politics*, edited by Juhani Mylly and R. Michael Berry, Series C:21 (Turku: University of Turku, 1984): 114-115.

⁶⁴ A similar phenomenon had occurred in the Scandinavian countries at an earlier stage.

⁶⁵ In 1950, 50 per cent of the labor force was still engaged in agricultural activities; in 1980, only 13 per cent remained in this sector. Mikko Vienonen, "How to plan the resource allocation," HEDC 86 Section 3, paper presented by the Working Group on primary, secondary and tertiary health care (Helsinki: National Board of Health, 28 August 1986): 2.

encouraged the partners of Coalition Governments to cooperate with each other in an attempt to increase their period in office. He also managed to improve Finland's relations sufficiently with the Soviet Union: "Thus our geographical location makes it essential for us to arrange our relations with our neighbours in a satisfactory manner."⁶⁶ Kekkonen shared this feeling with his predecessor, President J.K. Paasikivi: "The most important thing for Finland is and will always be the preservation of good relations with Russia. Geography and history dictate that so it must be."⁶⁷

All these circumstances broke the long deadlock caused by political instability that had prevented previous Governments from introducing significant social reforms necessary to public financing of health care.

4. Sickness Insurance Act of 1963

On the 6 March 1962, Carl Olof Tallgren set the legislative machinery in motion in Parliament: "Social legislation in our country has come a long way in many fields but still suffers from shortcomings that are not worthy of a modern welfare state."⁶⁸ He described how Governments since 1927 had unsuccessfully presented repeated proposals for improved sickness insurance.

During the same debate, the Government insisted that Finland's social security system had evolved into a near comprehensive system, comparable with those found in other Western developed nations. Others supported this opinion: "Particularly as a result of developments over the past 20 years, Finnish social security is of a standard comparable to that of the other industrialized countries of Europe."⁶⁹

The Government, however, conceded that despite general improvements in other areas of social insurance, sickness insurance had lagged behind; the voluntary sickness funds offered inadequate protection for those who needed help the most. The explosive increase in the cost of institutional care during the late 1950s and early 1960s was of added concern to the Government: "The introduction of sickness insurance is, therefore, of the most immediate importance to us, and the most pressing socio-political task."⁷⁰

⁶⁶ Kekkonen, *President's View*, 17.

⁶⁷ J.K. Paasikivi quoting the present President Mauno Koivisto in *Landmarks: Finland in the World* (Helsinki: Kirjayhtymä, 1985): 39. The original quote appeared in a 1955 summer edition of a Swedish daily, *Dagens Nyheter*. "Finlandisation" is a term used to describe a country that has "fared badly by cultivating such a friendly relations with the Soviet Union." Finns would argue, however, that they have not sacrificed their "independence in order to appease a large neighbour." Koivisto, *Landmarks*, 20 and 138.

⁶⁸ Tallgren during parliamentary debates on the Sickness Insurance Law. Finland, "Yleistä sairausvakuutusta," 1867.

⁶⁹ Pajula and Kalimo, "Social security," 160.

⁷⁰ Finland, "Regeringens proposition," 1.

Kyllikki Pohjala, the Minister of Social Affairs, had the Secretary-General of the Ministry, Aarne Tarasti, initiate negotiations with the Finnish Medical Association, the trade unions and other interest groups. Public opinion was indirectly reflected through extensive coverage in the press.⁷¹ "The establishment of the [Sickness Insurance] scheme in 1964, followed a typical Finnish pattern, in which a social reform, on the basis of prior political negotiations, was considered necessary and a parliamentary committee was formed for the preparation of the draft legislation."⁷²

As a result, by the time Pohjala presented the Sickness Insurance Bill to Parliament on 9 December 1962, negotiations were well on the road to securing full support for the reform, despite compromises along the way. The Government notably had little difficulty obtaining the collaboration from the medical profession. "The Finnish Medical Association is delighted about the recent action for sickness insurance. General sickness insurance which covers the whole population will greatly increase the possibilities for health care for the whole population, but particularly for the poorest members of the society who live in the countryside."⁷³

The medical profession regarded the proposals for out-patient care as important because "being sick at home is so expensive that people chose hospital care to avoid such treatment even when it was possible."⁷⁴ Furthermore, they recommended that the new sickness insurance programme should support prevention and rehabilitation: "Doctors in Finland are ready to give their assistance in planning a good sickness benefit system"⁷⁵

The doctors, however, did object to several of the specific issues raised by the proposed legislation. Fearing abuses, they felt that it was important to start the new system in stages, allowing for a simultaneous growth in the health care system and the training of new doctors. They also supported a continuation of the sickness funds which they felt would allow them to carry on in private practice.⁷⁶

The universal compulsory Sickness Insurance Act was passed in Parliament on 4 July 1963 and would be implemented on 1 April 1964: "Every person resident in Finland [would] be insured against sickness under this Act."⁷⁷ Persons between the ages of 16 and

⁷¹ Kalimo, "Planning and evaluation," 5.

⁷² Kalimo, "Planning and evaluation," 5.

⁷³ Finland, "Eduskunnan sosiaalivaliokunnalle," *Hallituksem Pöytäkirja Liite D S 13* ptk 3, translated by Helle Satälä (Helsinki: 1963): 1.

⁷⁴ Finland, "Eduskunnan sosiaalivaliokunnalle," 2.

⁷⁵ Finland, "Eduskunnan sosiaalivaliokunnalle," 3.

⁷⁶ Personal Communication with Professor Martti J. Karvonen, Secretary General of the Finnish Medical Association in 1963.

⁷⁷ Finns serving overseas and seamen would also be covered. Finland, "Sickness Insurance Act," translated by the National Pensions Institute, Law No. 364 (Helsinki: Parliament, 4 July 1963): sec. 1.1.

65 were eligible for the specified cash benefits during illness or incapacity because maternity, based on their previous income.⁷⁸

The new programme offered benefits in cash not in kind: "An insured person shall be entitled on the grounds of sickness to compensation for expenses on necessary health care to a daily allowance on account of incapacity for work due to sickness and on the grounds of pregnancy and confinement."⁷⁹ Such reimbursable health care included treatment from doctors, laboratory investigations, radiology exams, drugs, dental treatment and travel expenses during illness.⁸⁰

The programme would reimburse 60 per cent of doctors' fees based on an established fee-schedule.⁸¹ A similar fee-schedule would likewise determine the rate of reimbursement for other services that were prescribed by doctors.⁸² This '60 per cent solution' was the result of the political compromises that had taken place during the process of negotiations.⁸³

The programme divided the country into sickness insurance administrative districts and areas. Each district would have a board of five members who were familiar with the insured person's conditions, consisting of the Chairman appointed by the National Pensions Institution, a doctor appointed by the county and three others, at least one of which had to be a woman. The National Pensions Institution would "supervise the determination, the assessment, the collection and the rendering of accounts of the insured persons' sickness contributions."⁸⁴

Workers and employers as well as a state subsidy would finance the programme. All insured persons would pay a sickness insurance contribution based on income. Employers would be responsible for submitting their employees' contributions.⁸⁵ The same rule applied to the self-employed. Those receiving national pensions or who did not pay taxes for lack of an income, would make no contributions but would still benefit from the programme.⁸⁶

⁷⁸ Finland, "Sickness Insurance Act," sec. 2.16.

⁷⁹ Finland, "Sickness Insurance Act," sec. 2.4.

⁸⁰ Finland, "Sickness Insurance Act," sec. 2.5.

⁸¹ The law delayed the financing of doctor services by two years, and excluded medical prosthesis, dressings and other medical accessories. Finland, "Sickness Insurance Act," sec. 2.7.

⁸² Finland, "Sickness Insurance Act," sec. 2.8.

⁸³ If doctors charged above the recommended schedule, the reimbursed portion would fall below the 60 per cent coverage. This became a major cause of erosion in the original principles of the reform.

⁸⁴ Since 1937, the National Pensions Institution (later called the Social Insurance Institution) serves as an autonomous public institution for the administration of national pension benefits. Finland, "Sickness Insurance Act," sec. 2.39.

⁸⁵ Finland, "Sickness Insurance Act," sec. 3.32.

⁸⁶ Finland, "Sickness Insurance Act," sec. 3.34 and 3.35.

The state would cover any deficit incurred through the programme through general revenues, therefore, guaranteeing the solvency of the sickness funds.⁸⁷ The estimated income from all sources was 7.9 billion Marks from the insured, 7.9 billion Marks from employers and 3.9 billion Marks from the state.⁸⁸

The cost of the resulting sickness insurance programme compared favourably with the estimated costs. "There were some 'experts' who believed ... it would lead to escalating cost of health care but no such phenomenon was found."⁸⁹ The reform succeeded in stimulating private practice in the urban setting; its shortcomings in the rural regions and the erosion in coverage under the reimbursement system soon became apparent.

C. BARRIERS TO UNIVERSAL ENTITLEMENT

Several interrelated circumstances prevented universal entitlement under sickness insurance from providing truly universal health care. As in Sweden, there was an overemphasis on an unevenly distributed institutional sector; the growth of private practices was mainly in urban areas; and medical doctors in the primary care sector refused to respect the established fee schedules. Instead, the Public Health Act of 1972, which established a network of multi-disciplinary health centres with salaried doctors, paved the way for true universal entitlement in Finland, where the social insurance model had failed.

1. Beyond Social Insurance

To examine and evaluate the successes and failures of the new Sickness Insurance Act, the Social Insurance Institution established a Research Institute for Social Security in 1964.⁹⁰ The legislators who formulated the Sickness Insurance Law of 1963 sought to advance two major social reforms: compensate for economic losses during illness and increase the use of ambulatory health services.⁹¹ Following a review of the outcome of the reform, the Institute concluded the following: "The Scheme contributes to social security through economic means only, [that is], by lowering the price for health services and by compensating for the loss of income. The scheme does not directly affect the supply of health services and their distribution over various population groups."⁹²

⁸⁷ Finland, "Sickness Insurance Act," sec. 6.58 and sec. 6.59.

⁸⁸ Finland, "Regeringens proposition," 6.

⁸⁹ Personal communication with Dr. Esko Kalimo, Director of the Research Institute for Social Security of the National Insurance Institution.

⁹⁰ It has later expanded its function to include the pensions plan and health-related studies. Kalimo, "Planning and evaluation," 10.

⁹¹ Kalimo, "Planning and evaluation," 12.

⁹² Kalimo, "Planning and evaluation," 2.

A nationwide survey showed that the gap between stated needs and care obtained had narrowed, with only a small increase in general utilisation following introduction of the 1963 Sickness Insurance Law: "However, the results suggest that financial arrangements, [that is], health insurance, must be accompanied by other measures (in Finland an increase in the supply of ambulatory health services) if the objectives of health policy are to be obtained on a more satisfactory scale."⁹³

The first policy objective of the Social Insurance Law was to compensate people for their direct financial losses because of illness. Such financial barriers were partially removed by the new sickness insurance: "The purpose of social insurance is to protect the population against loss of income in the event of sickness, invalidity, old age, the death of the family provider, maternity and unemployment. It also aims at alleviating the burden of medical expenses incurred as a result of sickness."⁹⁴

The programme, however, failed to equalise the burden of expense between the sick and healthy, and between the rich and poor: "Since the supply of physician services in ambulatory care did not increase markedly between 1964 and 1968, the impact of sickness insurance could only mean a redistribution of the services among the population groups. After this redistribution, acutely ill respondents in the lower-income categories visited a physician more often than previously, whereas older chronically ill persons decreased their use."⁹⁵

The second policy objective of the Sickness Insurance Law was to increase the use of ambulatory health services by making such services more available to the public, thereby making institutional services less important. Although the 1963 Sickness Insurance Law represented "the most important measure in Finnish health policy in the 1960s," it failed to affect the geographic distribution of health care resources.⁹⁶ "It became clear ... that the use of health services was decisively dependent on the supply of health services."⁹⁷

From 1960 to 1967, Finland had a 17 per cent growth in health care expenditures. The main reason for this growth was the cost of the hospital sector. The institutional sector comprised 85 per cent of total cost of health care and was financed through the state and local communes, not sickness insurance. Increases in hospital construction which had occurred during the 1950s was largely responsible for this trend.⁹⁸ The original decision to postpone the introduction of sickness insurance for ambulatory care in favour of

⁹³ Tapani Purola et al., "National health insurance in Finland: Its impact and evaluation," *International Journal of Health Services* 3(1973): 69.

⁹⁴ Villa Kopra, "Social insurance in Finland," *Bank of Finland Monthly Bulletin* 11(1981): 1.

⁹⁵ Purola et al., "National health insurance," 78.

⁹⁶ Purola et al., "National health insurance," 70.

⁹⁷ Kalimo, "Planning and evaluation," 13.

⁹⁸ The Central Hospital Construction Act Nr 337/50 initiated this building programme.

increased public expenditure on institutional care made it difficult for the former to catch up even when financing became available through the new programme.⁹⁹

Finally, the reimbursement principle of paying for services stimulated private out-patient care: "It was argued that the development of out-patient care would reduce the use of hospital services and that in fact the increased costs of out-patient care could be covered by savings in hospital expenditure."¹⁰⁰ In practice, this failed to occur, and institutional care continued to increase. Moreover, the real level of reimbursement dropped as doctors charged above the official fee-schedule on which the reimbursements were based.

The Sickness Insurance Law, therefore, eliminated only some of the financial hardship associated with illness. The cost of medical treatment was not the only expense for those unable to lead productive lives because of chronic illnesses. Uneven geographic distribution of resources among subgroups of the population remained a problem.¹⁰¹ "In 1968, an average of six families out of 100 had been obliged to finance some of their sickness expenses from loans or monetary aid from relatives or social welfare authorities."¹⁰²

When the socialists gained a majority in Parliament during the mid- to late-1960s, the shortcomings of the sickness insurance system became politically intolerable: "As the SDP and the labour movement began to resolve their internal conflicts and to rise to a dominant position in the new industrial society, the Centre Party found itself increasingly on the defensive and hard-pressed to develop a programme in tune with the rapid changes Finnish society was undergoing."¹⁰³

2. Public Health Act of 1972

Under the leadership of Prime Minister Rafael Paasio, the Social Democratic Party overcame its disarray and internal strife, improving both its relations with President Kekkonen and the Soviet Union. A new era in Finnish politics began in 1966 with the

⁹⁹ Tapani Purola, Esko Kalimo and Kauko Nyman, "Health services use and health status under national sickness insurance: An evaluative resurvey [sic] of Finland," Research Institute for Social Security Publication A:11 (Helsinki: Social Insurance Institution, 1974): 247.

¹⁰⁰ Pekka Sirén, "The growth of health expenditure in Finland 1960-80 and prospects for curbing its future growth," in *Improving Cost Effectiveness in Health Care*, Studies and Research No. 19 (Geneva: International Social Security Association, 1983): 32.

¹⁰¹ Esko Kalimo, "Determinants of health care utilization," Research Institute for Social Security Publication, E:11(Helsinki: Social Insurance Institution, 1969); and Purola et al., "National health insurance."

¹⁰² Purola, Kalimo and Nyman, "Health services use," 235. In rural regions this rate was 1 out of 10, and it was even higher for low-income groups.

¹⁰³ Mylly, "The Agrarian/Centre Party," 115.

election of a left-wing majority to Parliament.¹⁰⁴ The Sickness Insurance Law became a clear target for reform.

The new socialist-dominated Coalition Cabinet, called the 'Popular Front', included the Social Democratic Party, the People's Democratic League (Communists), the Social Democratic League (Social Democratic Party splinter group) and the Centre Party (Former Agrarians). Rafael Paasio was Prime Minister from 1966-68. Mauno Koivisto, who succeeded him from 1968-70, later became President.

Finland's new political stability and economic prosperity led the Social Democratic Party to initiate several overdue social reforms. The expansion of health care, introduction of a comprehensive education system and guarantee of employment security became priority issues: "The reforms in the educational and health care systems were introduced, however, only after overcoming resistance from a majority of teachers and medical doctors who have traditionally identified with the political Right."¹⁰⁵

The work of the two earlier sickness insurance committees had already paved the way for the health care reforms. On 11 October 1960 the Ministry of Social Affairs appointed Dr. Niilo Pesonen as Chairman of a committee on Public Health. The terms of reference of the committee, which reported on 5 October 1965, were "to examine the possibility of improving the effectiveness of public health services," within the context existing legislation and regulations.¹⁰⁶

Later, on 18 January 1967 the Ministry of Social Affairs appointed O. Blomqvist as Chairman of another Committee on Public Health. The terms of reference of this second committee were "to study the [previous] 1965 report compiled by the Public Health Committee ... with the aim to ... recommend ways to introduce the proposal ..., to put forward its own proposal ..., [and] to examine the basis for a new Public Health and Hospital network."¹⁰⁷ Its report of 21 May 1969 formed the basis for the Public Health Act of 1972.¹⁰⁸

Both committees emphasised the failings of the Sickness Insurance Law in meeting growing manpower shortages, and expressed a loss of confidence in the capacity of the institutional sector as the basis for solving all health care problems. The committee

¹⁰⁴ After 1966, with minor exceptions, the same Coalition Government ruled Finland up until 1987. Rantala, "Changing features," 52.

¹⁰⁵ Paavonen, "Finnish Social Democratic Party," 148.

¹⁰⁶ Finland, "Kansanterveyskomitean mietintö," *Valtioneuvostolle*, translated by Helle Satälä (Helsinki: 5 October 1965).

¹⁰⁷ Finland, "Kansanterveyskomitean 1965."

¹⁰⁸ Finland, "Kansanterveystoimikunnan Mietintö," *Valtioneuvostolle*, translated by Helle Satälä (Helsinki: 21 May 1969).

recommended the establishment of a new health system to serve the whole population with a network of publicly financed health centres. Such centres would offer general practitioner services, public health nurses, dentists, physiotherapists, dieticians, psychologists and social workers.

The team of public health nurses, midwives and communal doctors aimed to "strengthen primary health care services, and to shift the point of gravity from hospital-oriented secondary and tertiary health care into ambulatory services."¹⁰⁹ Local governments would be responsible for administering the new system, reflecting the Nordic Countries' tradition for local self-government: "The responsibility of the local health care in the public sector is based on the responsibility of local authorities to organize the delivery of services."¹¹⁰

On 23 October 1971, the Minister of Social Affairs and Health, Pekka Kuusi, introduced a Public Health Bill. He relied heavily on the work of Aarne Tarasti, the Secretary-General of the Ministry (1964) in preparing the new legislation.¹¹¹ The reform finally passed into law on 28 January 1972, under a new Minister, Alli Lahtinen, following extensive debates and conflicts with the Finnish Medical Association.¹¹²

"[What is meant] by primary care is ... health care directed at the individual and his or her environment, and the health care of the individual as well as activities associated with these and having the object of maintaining and promoting the state of health of the population."¹¹³ The new law hoped to improve the coordination between the institutional sector and primary care sectors through joint five year resource allocation and strategic planning cycles.¹¹⁴ "The National Board of Health shall draw up each year a national plan for the arrangement for the following five calendar years of the primary care referred to in this Act."¹¹⁵

The communes became responsible for both the financing and administration of the new programme, providing the following services: health education including family

¹⁰⁹ Viononen, "Resource allocation," 6.

¹¹⁰ Arto Niemi, "Community involvement in primary health care in Finland," paper presented at the Interregional Meeting on Community Involvement for Health in Brioni, Yugoslavia (9 to 14 June 1985): 1.

¹¹¹ Personal communication with Esko Tainio, Budget Officer, Ministry of Social Affairs and Health. The Public Health Act of 1972, the Public Health Act of 1972 and the National Health Act 1972, all refer to the same Act.

¹¹² Personal communication with Dr. Mårten Kvist, Assistant Secretary General of the Finnish Medical Association. Mårten Kvist, "Presentation of the Nordic countries and their primary health care: Part 2. Finland," *Scandinavian Journal of Primary Health Care* 1(1983): 88-92.

¹¹³ Finland, "Primary Health Care Act," (Helsinki: Parliament, 28 January 1972): sec. 1.1. Personal communication with Dr. Mikko Viononen, Acting Deputy Director of the Department of Primary Health Care, Finnish National Board of Health.

¹¹⁴ The two sectors operate under different legislation, different managements and different financial systems.

¹¹⁵ Finland, "Primary Health Care Act," sec. 2.3. The plans originally covered only the primary care sector, expanded in 1974 to include secondary and tertiary care and in 1984, to include the social sector.

planning, health care supervised by a doctor, transport, dental treatment and school health.¹¹⁶ "The commune shall have a health centre for the functions referred to above."¹¹⁷ Such health centres, depending on their size, included hospital beds. A medical doctor determined the level of treatment needed at the health centres and decided which patients to refer to larger centres for more advanced treatment.

The communes, in turn, depended on local taxation powers, including income tax and state grants, to finance the services which they offered. State grants ranging from 39 to 70 per cent of the total cost of the programme supplemented the communes' finances.¹¹⁸ Only curative treatment would have a user-fee, while "services devolving [from] the commune and referred to above ... shall be free of charge to their consumers."¹¹⁹

Unlike the Seven Crown's Reform in Sweden, doctors in Finland who participated in the Public Health Act of 1972 were still allowed to maintain private offices. The National Pensions Institution continued to reimburse 60 per cent of doctors fees as established in 1963. Any monies collected directly from a patient living in a commune or through the Sickness Insurance Act were, however, deducted from the amount that the commune could use in the calculations for state subsidies. This gave the communes a powerful incentive to establish effective health centres.¹²⁰

To prevent abuse and control costs, the state demanded the right to approve the plans for all new health centres before offering financing through the public sector. Only costs arising out of activities carried out by the health centres were eligible for subsidies.¹²¹ The popularity of the health centres allowed them to become a successful alternative to the private sector.¹²² Demand for services unfortunately increased more rapidly than anticipated: "This led to queuing in the public sector and presumably also to under-utilisation of resources in the private sector."¹²³

The estimated cost of the previous system for the year 1972 was 170 million Marks. The estimated increase in state expenditure was 62 million Marks.¹²⁴ Eliminating direct

¹¹⁶ Finland, "Primary Health Care Act," sec. 2.

¹¹⁷ Finland, "Primary Health Care Act," sec. 3.15.

¹¹⁸ The level of state subsidies was based on a solvency classification. Finland, "Primary Health Care Act," sec. 4.27.

¹¹⁹ Finland, "Primary Health Care Act," sec. 4.21.

¹²⁰ Forty per cent of the medical profession, nevertheless, still engage in part-time private practice in 1986. Personal communication with Dr. Mårten Kvist.

¹²¹ Finland, "Primary Health Care Act," sec. 4.36.

¹²² Pertti Kekki, "Analysis of relationships between the availability of resources and the use of health services in Finland: A cross-sectional study," *Medical Care* 18(December 1980): 1238.

¹²³ Sirén, "Growth of health expenditure," 33.

¹²⁴ Finland, National Board of Health (NBH), Department of Planning and Evaluation (DPE), "Government's general argumentation," *Memorandum* (Helsinki: NBH, DPE, 1972): 8.

charges to patients cost the state an additional 25-30 million Marks. The reformers hoped, however, to make savings through a reduced need for curative services.¹²⁵

Even the Public Health Act of 1972, therefore, did not solve all the problems in the Finnish health care system since it led to a skewed growth in health care services at the expense of the social services. This hampered the development of services for the elderly, chronic care patients and those with physical problems stemming from social maladjustment such as alcoholics.¹²⁶ These imbalances led to a call for further reforms during the 1980s.

3. Finnish Health for All by the Year 2000

Through the construction of health centres, out-patient care expanded rapidly during the 1970s. By the mid-1970s, the use of the ambulatory sector had increased, while that of the hospital sector decreased.¹²⁷ The personnel employed in health centres doubled, and there was less disparity among population subgroups groups.¹²⁸ The national sickness legislation of 1963 had aimed to alleviate the financial burden of illness. The Public Health Act of 1972 tried to improve coordination of such health care and to promote regional equalisation.¹²⁹

To complete the process of public sector financing for universal entitlement to health care, Finland has gone one step beyond that of most other countries by fully embracing the World Health Organization's 'Health for all by the year 2000'. Through this programme, Finland has tried to shift the emphasis from secondary and tertiary hospital care to primary care:¹³⁰ "Exchange of information and experience, especially in the World Health Organization, is particularly important for a small country like Finland."¹³¹

The basic aim of Finnish health policy today is to promote both the health and welfare of its citizens:

Adding years to life -- This means that premature death rates will be reduced and the mean life expectancy thus increased.

¹²⁵ Finland, "Primary Health Care Act," 9.

¹²⁶ Finland, Ministry of Social Affairs and Health (MSAH), "The national 5-year planning system for social welfare and health care: Its main principles and its role in the management of national health policies," *Report* (Helsinki: MSAH, 18 March 1985): 2.

¹²⁷ Some public health centres are, however, in reality small hospitals, have as many as 120 beds.

¹²⁸ Esko Kalimo et al., "Need, use and expenses of health services in Finland 1964-1976," English summary, *Research Institute for Social Security Publication A:18* (Helsinki: Social Insurance Institution, 1982): 476.

¹²⁹ Finland, National Board of Health (NBH), Department of Planning and Evaluation (DPE), "Development of primary care services in Finland," *Memorandum* (Helsinki: NBH, DPE, 1972): 1.

¹³⁰ Vienonen, "Resource allocation," 1.

¹³¹ Finland, MSAH, "Health policy report," 58.

Adding health to life – This means that in the future people will have more healthy and active years. People will have fewer illnesses and accidents than before.

Adding life to years – This means promotion of health so that as many people as possible will feel healthy in every way throughout their lives, will manage their everyday activities well, and will experience their life as rich and varied.

Finland, which views itself as a developing country, continues to emphasise the importance of primary care.¹³² "Health can only be attained if the basic needs of life are satisfied."¹³³ Since the activities of the individual determine his lifestyle, the programme encourages active consumer participation. To achieve the above goals, the country has continued to set aside an increase in funds for programmes in the social sector.¹³⁴ It has pledged to double the commitment of public financing in this area in the coming years.

To achieve its goals within affordable limits, Finland's health policies also attempt to focus its attention on the target groups needing medical attention the most: "Primary attention must be given to the needs of underprivileged individuals and population groups and to equality among citizens so that financial considerations do not prevent appropriate use of health services."¹³⁵ Today, the country claims to have achieved many of these objectives. It uses fewer financial resources than most other industrialized countries, yet has managed to increase life expectancy and quality of treatment more rapidly than most.

¹³² Today primary care receives 40 per cent of the funds allocated to health care. Finland, MSAH, "Health policy report," 11.

¹³³ Finland, MSAH, "Health policy report," 7.

¹³⁴ Finland, MSAH, "Health policy report," 58.

¹³⁵ Finland, MSAH, "Health policy report," 9.

PART III. DISCUSSION

CHAPTER 11. ANALYSIS

The public sectors of all western developed countries have become increasingly involved in financing health care during the past century through regulations, subsidies and direct provision of services. In 1938, New Zealand became the first country with a market economy to introduce compulsory participation and universal entitlement to a comprehensive range of health services, financed largely through general revenues. By now, thirteen OECD countries have passed landmark legislation offering similar coverage for their population.¹ The discussion that follows will first attempt to clarify some of the issues relating to the various complex concepts in health care financing. A descriptive analysis of the historical profiles of eight of these countries and subsequent quantitative analysis of all OECD countries gives rich insights into *why*, *how* and *to what effect* their governments introduced such policies, while the others restrict compulsory participation and entitlement to a targeted sub-group of the population.² Finally, theories will be proposed about processes that have occurred in health care financing over the past decades.

Figure 11.1 Issues, Policies and Hypotheses

Objective:	Clarification of issues and policy options in health care financing
<i>Mechanisms</i>	Direct charges versus prepayment
<i>Participation</i>	Voluntary versus compulsory
<i>Entitlement</i>	Restricted versus universal
<i>Services</i>	Basic versus comprehensive
<i>Linkages</i>	Risk-rated versus open-ended
Hypotheses:	Government involvement in health care financing
<i>Why</i>	Socio-economic, political processes, bureaucratic structures, market failure
<i>How</i>	Allocation, redistribution and stabilisation
<i>Effects</i>	Growth, debt, opportunity, displacement, backlash, expenditure, equity

A. CLARIFICATION OF CONCEPTS

Western countries were separated into two groups in this study based on similarities in policies relating to health care financing: Group I is characterised largely by compulsory participation and universal entitlement to comprehensive services, while the countries in

¹ The eastern European countries, Albania, Bulgaria, Czechoslovakia, Hungary, Poland, Romania and the USSR, as well as many developing countries have passed similar legislation. See Table 2.1 in the Appendix.

² The eight case studies were Australia, Canada, Denmark, Finland, New Zealand, Norway, Sweden and the UK.

Group II lack several of these characteristics. This is represented schematically in the following figure, where the presence of a dominant trait is indicated by a plus and its absence by a minus. Although these issues and policy options were not readily quantifiable in their historical context, scaling ratios could be constructed from the degree of voluntary versus compulsory participation and restricted versus universal entitlement with data on the OECD dating from the early 1980s. Subsequent cluster analysis confirmed that there is a dichotomy in policies relating to these key issues in health care financing and that western countries can be divided into two groups based on this information.

Figure 11.2 Groups of Countries and Clusters of Policy Options

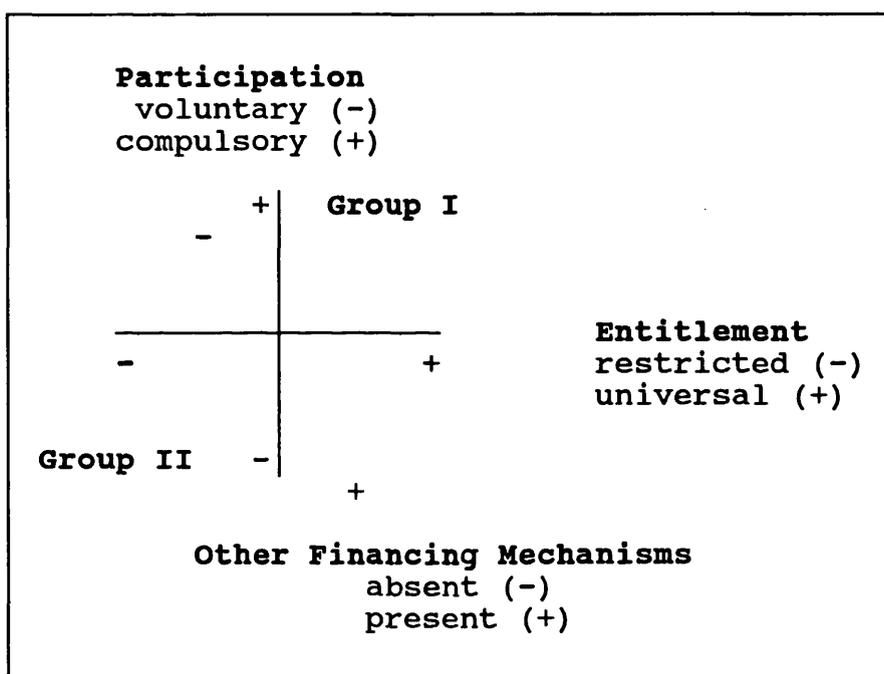
Dominant Characteristics Based on Cluster Analysis				
Participation Entitlement	1 Voluntary 2 Restricted		3 Compulsory 4 Universal	
	Group I		Group II	
Clustering	1234		1234	
Present (+) Absent (-)				
	Australia	-++	Austria	++-
	Canada	-++	Belgium	++-
	Denmark	-++	France	++-
	Finland	-++	Germany	++-
	Greece	-++	Ireland	++-
	Iceland	-++	Japan	++-
	Italy	-++	Luxembourg	++-
	New Zealand	-++	Netherlands	++-
	Norway	-++	Switzerland	++-
	Portugal	-++	Turkey	++-
	Spain	-++	United States	++-
	Sweden	-++		
	UK	-++		

Detailed narrative and linguistic analysis of the eight case studies indicated that there is a great deal of confusion about basic concepts relating to health care financing.³ Despite similarities within each of the two groups of countries noted above, a number of significant differences and transformations occurred over time in the terminology, content, scope, boundaries and units-of-measurement. In a perfectly uniform situation, policy options 1 and 2 would be absent, while 3 and 4 would be present for Group I countries, and the opposite true for Group II countries. This was not the case. Instead, there was an overlap of some characteristics between the two groups. Similarly, if all definitions had been identical everywhere and well polarised, Group I countries would have fallen into the anterior part of the upper right quadrant in the figure below, and

³ Past comparative analysis of health care financing has suffered greatly because authors have not examined the key issues being investigated in the language of the country in question.

Group II countries would have fallen into the posterior part of the lower left quadrant. Once again, this was not the case. Definitions differed from country to country, so there was no true dichotomy between opposing policy options and no homogeneity in the formulation of any one concept. To avoid the classification of countries into two groups being misconstrued as an oversimplification, these inconsistencies will be explored in detail before shedding light on possible determinants, programme features and outcomes of compulsory participation and universal entitlement to health services.

Figure 11.3 Axes of Key Issues in Health Care Financing



1. Financing Mechanisms

Elimination of financial barriers to health care and financial protection against the risks of illness were key objectives of the reforms leading to compulsory participation and universal entitlement in each of the eight countries examined. Although many countries portrayed it as "free" services, direct charges continued to exist everywhere.⁴ New Zealand has never achieved complete prepayment for its general practitioner services because reimbursements to patients cover only a small part of the fee charged by doctors. Incomplete reimbursements exist in Australia, Norway and Finland. In Sweden, official co-payments were introduced on standard services under the Seven Crowns Reform in the belief that this would discourage excessive utilisation. In Canada, where such user

⁴ The terms user charges, fees, out-of-pocket payments, co-payments, cost recovery and *ticket modérateur* are used interchangeably and inconsistently for direct payments.

charges are illegal, more than 25 per cent of total health care expenditure involves the private purchase of medical goods and services that are not provided by the public sector.⁵ In the UK, symbolic charges for pharmaceuticals, private pay beds in public hospitals and an extensive range of private services have existed throughout the history of the British NHS. The debate on direct charges versus prepayment continues to plague all health care financing reforms currently taking place in western countries. Arguments in favour or against such charges, and their impact on efficiency and equity, will be discussed later in greater detail.

Health care has come to rely increasingly on general revenues, social insurance and various combinations of public and private health insurance for financing rather than on direct charges in all western countries. Unfortunately, the term health insurance is poorly differentiated and used generically to describe almost all forms of prepayment, including general revenues. In New Zealand, while political reformers talked specifically about 'health insurance' prior to 1938, bureaucrats made plans to finance the National Health Service (NHS) through general revenues. In Britain, Winston Churchill's 'magic of insurance' also turned out to be primarily general revenues, although national insurance did eventually play a small role in financing the British NHS. In Canada and Australia, Medicare and Medibank were both referred to as health insurance even though financing came mainly from earmarked tax levies and general revenues. Universal compulsory sickness insurance was transformed into a mixture of social insurance and general revenues, and since the early 1980s, the social insurance contribution towards health care financing has been dropped in Norway and Sweden. True risk-rated insurance is not used as a major source of revenue for health care financing in any western country, with the exception of the US. Instead, contributions to most health insurance schemes are non risk-rated and benefits are open-ended for at least part of the population.

Confusion in the use of the term insurance is compounded by a number of false premises. Health insurance is used almost synonymously with fee-for-services remuneration for doctors and retrospective reimbursements for hospitals. The idea of general revenues, on the other hand, immediately triggers an image of the British NHS with salaried doctors and global prospective hospital budgets. Closer analysis of the eight case histories, as well as of other western countries, indicates that these associations are excessively stereotyped. Countries such as Austria, Belgium, France, Germany, Japan and the Netherlands, depend on social insurance for health care financing. They rely on fees-for-service to pay their doctors in private offices, but use salaries to pay hospital doctors.

⁵ Public health, hospital care, doctors, medical education and capital investments are the main services provided by the public sector and financed through prepayment mechanisms; dentists, pharmaceuticals, medical supplies, chronic care institutions and different kinds of ambulatory services such as physiotherapy, laboratory services, home care and so on continue to be paid for largely with direct charges or voluntary supplemental insurance.

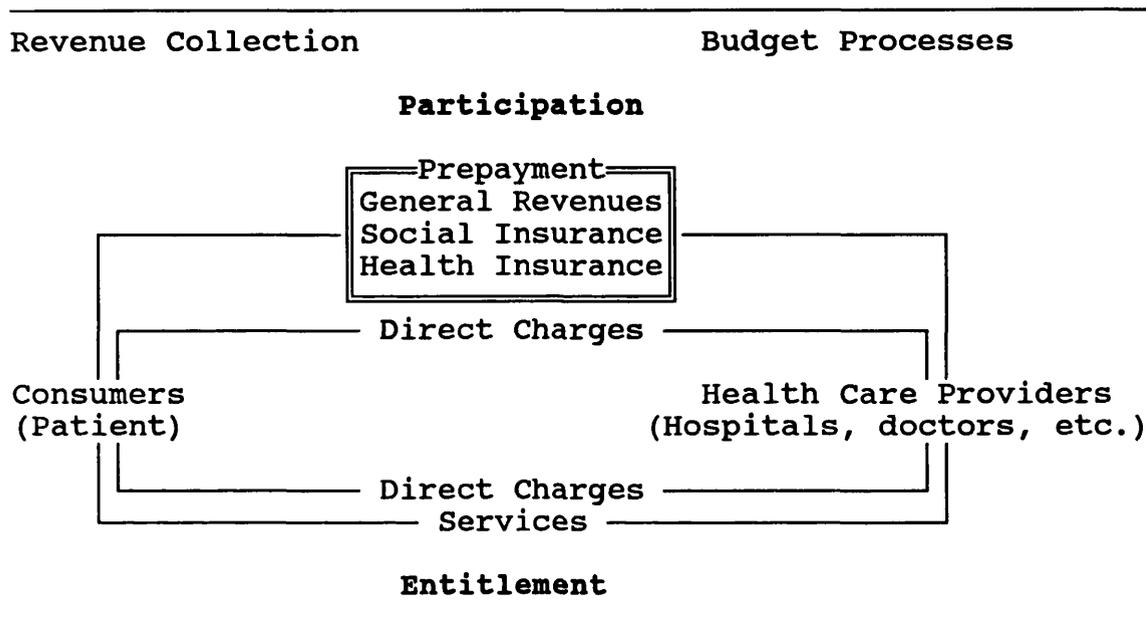
In Australia, Canada, Finland, Norway and New Zealand, where general revenues play a larger role, doctors in private offices still receive a fee-for-service. Only in the UK, Sweden and Finland, are non-hospital-based doctors paid a capitation payment or salary.⁶ Doctors working in public hospitals are almost always paid a salary, with the exception of the US, Canada and Australia where they continue to be paid a fee-for-service. Countries with a dominant general revenues component in health care financing are more prone to use global budgets to pay for hospitals; those with a dominant insurance component more frequently use itemised charges, per diem rates or Diagnostic Related Group (DRGs) activity reimbursements.⁷

The central issues in health care financing were even more confused because at times they referred to activities involving revenue collection, at other times, to budget processes or resource allocation and at still other times, to costs and expenditures. These processes are connected, but often not linked directly. Most prepayments through general revenues, social insurance and health insurance are pooled before they are spent on hospitals, doctors and other health care goods and services, or used to reimburse patients for their outlay. This gives the budget process some control over the flux in revenues through the system and the remuneration of health care providers. The flow of financial resources from direct charges is much more complex. Sometimes they are pooled with funds collected from prepayment schemes and are under budgetary control. At other times, they are paid directly to health care providers and are therefore outside budgetary control. In the latter case, patients are sometimes, but not always, given full or partial reimbursement for their outlay. Because these differences are in degree only, both Group I and Group II countries can be fitted into this schema.

⁶ Some doctors working in public clinics are paid a *vacation* (based on time) in Quebec.

⁷ The private sector generally relies more on fee-for-service for doctors and retrospective reimbursements for hospitals, but even this is not a hard fast rule. Some American Health Maintenance Organisations (HMOs) have salaried doctors and global budgets for their hospitals.

Figure 11.4 Flux in Health Care Financing in all Western Countries



Much of the striking variability in the health systems of western countries can be explained by the public/private mix in the financing, administration and ownership of the institutions that produce health care goods and services. They may produce public, private, mixed and merit goods.⁸ Just as the public sector may participate to varying degrees in the financing of health care through regulations, subsidies and the direct provision of services, so the production of health care in terms of its administration and ownership is often a mixture of public and private concerns. Private services may receive some of their revenue from public sources through subsidies or direct charges for services rendered. Public services may receive some of their revenue from private sources through direct user-fees and co-payments. Likewise, the allocation of the health care goods that are produced may occur through either the public or private sector. Most western countries have adopted an approach somewhere between pure market-oriented and centrally planned health care. The optimal, acceptable and feasible balance between these extremes remains the subject of endless disagreement.⁹

⁸ The distinction between these types of economic goods will be described in greater detail in the section on normative functions of governments.

⁹ Gordon McLachlan and Alan Maynard, *The Public/Private Mix for Health* (London: Nuffield Provincial Hospital Trust, 1982); and Antony J. Culyer and Bengt Jönsson, eds., *Public and Private Health Services: Complementarities and Conflicts* (Oxford: Basil Blackwell, 1986); Carol Propper and Alan Maynard, "Whither the private health care sector?" in *Competition in Health Care: Reforming the NHS*, by A.J. Culyer, A.K. Maynard and J.W. Posnett, eds. (London: Macmillan, 1990): 48-66.

Figure 11.5 Public/Private Mix

	Public		Private (Non-profit vs Profit)	
Financing	100%	< 50	>	100%
Production & Delivery	100%	< 50	>	100%
Ownership				
Administration				
Allocation	100%	< 50	>	100%

As a result of the overlaps that occur between direct charges and various forms of prepayment, and between private and public involvement in financing, production and allocation of health services, none of these criteria provided a good way to differentiate between possible policy options in health care financing. The following figure gives a typology of health care financing mechanisms.¹⁰ Most western countries have sub-components that fall into several cells at the same time. For example, the UK, New Zealand and the Nordic countries are dominant in cell A, but also have components of B and C, and J to L in their public sectors. Their private sectors include a range from D to L. Canada and Australia are dominant in B and C, but likewise include D to L in their private sectors. In Canada, J to L are prohibited by law for standard services in the public sector, but there are direct charges for above standard-services, pharmaceuticals and many other goods and services provided through ambulatory care. Some continental European countries dominate in cells D to F, but include A to C through the public sector for targeted services and populations. The comparative literature on health care financing does not make these distinctions clear. There are many studies that compare and contrast countries such as Australia, Canada, the US, France and Germany because they use health insurance. This approach is not helpful in clarifying the complex issues that arise relating to health care financing.

¹⁰ Adapted from Uwe E. Reinhardt, Working Paper, Princeton University, Princeton, 1989.

Figure 11.6 Typology of Health Care Financing

Production Ownership Delivery	Prepayment in Health Financing			Direct Charge
	Government	Statutory	Regulated	Competitive
	General Revenue	Social Insurance	Private Insurance	Out-of-pocket User fees
Purely Public	A	D	G	J
Private Non-profit	B	E	H	K
Private For-profit	C	F	I	L

2. Participation

The dispute over voluntary versus compulsory participation is a good example of how notions about individual rights and collective responsibilities were manipulated to suit the purposes of vested interest groups such as the medical profession, health insurance organisations and private hospitals as well as the governments in question and their oppositions. When doctors and hospitals had a difficult time making ends meet, or when local communities did not want to foot the bill for Poor Law provisions, there was little debate about compulsory membership in friendly societies or sickness funds to ensure participation of low-income earners. Later, when compulsory participation was extended to the whole population, there were claims that it represented state interference in the doctor-patient relationship, an individual sense of responsibility for health care, the just treatment of doctors and so on. The extreme example was in Australia where the medical profession challenged the government and won a legal test case on the grounds that forcing doctors to make prescriptions on official paper was unconstitutional being a form of civil conscription. Objections to compulsory participation was much more pronounced in English-speaking countries prior to the introduction of universal entitlement than in the Nordic countries, where there was almost no protest.¹¹ Arguments for and against individualism and collectivism were, therefore, different in different countries and of different times.

¹¹ The sickness funds did argue against a compulsory scheme when Denmark threatened to abolish them in the 1970s.

The meaning of voluntary and compulsory participation is open to interpretation. Denmark was credited with having achieved a remarkably high membership in the so-called voluntary sickness funds prior to the 1970s. However, only the upper echelons of a means-tested population could afford to opt out. Medium to low-income workers were not offered a choice, because failure to be a member in good standing in a sickness fund meant automatic loss of eligibility for a number of other social benefits such as pensions, unemployment benefits and so on. Canadian participation depends largely on provincial compliance because the federal government has no direct jurisdiction over most aspects of health care. When the government introduced its Medical Care Act in the late 1960s, Ontario was allowed to qualify for federal co-financing once it had achieved 90 per cent rate of voluntary participation even though the law called for 100 per cent participation. All other countries that have been classified as having compulsory participation offer some voluntary programmes through supplemental or private health insurance to cover above-standard services provided by both the private and public sectors. Only Australia and Denmark have in the past allowed those who participate in these programmes to opt out of their public programmes. Likewise, all the countries that have been classified in Group II have compulsory participation for part of their populations. Compulsory participation in this study therefore means compulsory for everyone.

3. Entitlement

Universal entitlement implies that the whole population is eligible for benefits irrespective of income, health status, membership in good-standing or other constraints. All Group I countries offer such benefits, while Group II countries restrict entitlement to a targeted portion of the population such as low-income earners, children, pensioners and other groups of the non-employed. Higher income groups may participate on a voluntary basis in a variety of ways that would give them similar entitlement. Many Group II countries that do not have legislative provisions for universal entitlement, such as France, Germany, Japan and the Netherlands, achieve extensive coverage through non-statutory arrangements.¹² Belgium achieves virtual universal entitlement through various pieces of legislation that require extensive compulsory membership in sickness funds and other insurance organisations. Most of the Nordic countries and the United Kingdom passed through a similar historical phase before extending coverage to the whole population. Because most western countries offer supplemental health insurance to cover higher standards of care, private accommodations in hospitals and so on, entitlement is a question of degree and open to interpretation as in the case of participation. The dates of the legislative reforms that introduced universal entitlement as interpreted in the eight case studies are given in the figure below.

¹² The Netherlands is planning to introduce compulsory participation and universal entitlement in 1993.

Figure 11.7 Legislative Reforms for Universal Entitlement

Country	Date Passed	Date Implemented
New Zealand	1938 (September 8)	1939 (April 1)
England/Wales	1946 (November 6)	1948 (July 5)
Sweden	1953 (June 19)	1955 (January 1)
Norway	1956 (March 2)	1956 (July 2)
Finland	1963 (July 4)	1964 (April 1)
Canada	1966 (December 21)	1968 (July 1)
Denmark	1971 (May 28)	1973 (April 1)
Australia	1974 (August 7)	1975 (July 1)

Furthermore, universal entitlement was meaningful only to the extent that access to services matched legal provisions. In practice, a lag occurs between the time that policies are formulated, legislation prepared and laws passed, and the date that programmes are implemented, services offered and entitlement exercised. Examination of resource allocation and access to services therefore provides a more subtle interpretation of restricted versus universal entitlement. Access to health care is difficult, and sometimes impossible, to achieve in all countries. Where geographical, financial, cultural and functional barriers exist, legal entitlement to health care has little meaning. This has remained a topic of heated debate in all countries that claim to offer universal entitlement. Additional reforms were required in many of the eight countries to deal with this problem following the legal provisions for universal entitlement. For example, compulsory universal health insurance in Sweden led to universal entitlement to health services in 1955. But it was the Seven Crowns Reform of 1969 that expanded and reorganised health services to permit universal access. Likewise, compulsory universal health insurance was introduced in Finland in 1964, but it was the Public Health Act of 1972 that extended access to the whole population.

The services offered through various forms of entitlement have changed greatly over time, and vary from one country to another.¹³ The minimum standards of health care provided through social security advocated by the ILO in 1952¹⁴ were much more limited than the more comprehensive requirements needed to satisfy the WHO.¹⁵ Even the core contents, such as health promotion, prevention, curative treatment, rehabilitation and chronic care, has changed over time. Each of the eight countries defined health services differently. The most clear-cut segmentation into limited and comprehensive services

¹³ See the discussion on methodology.

¹⁴ International Labour Office (ILO), *Social Security (Minimum Standards) Convention, No. 102* (Geneva: ILO, 1952).

¹⁵ World Health Organization (WHO), Regional Office for Europe (ROE), *Targets for Health for All: Targets in Support of the European Regional Strategy for Health for All* (Copenhagen: WHO, ROE, 1985): 23.

occurred in Canada. The National Hospital and Diagnostic Services Act of 1957 called for compulsory participation and universal entitlement to hospital care only. Treatment by doctors was not included until 1967 under the Medical Care Act.¹⁶

A full range of services exists in all western countries today, but only some provide them for the whole population. Populations that do not qualify for such benefits under the limited compulsory programmes in Group II countries have access to services through voluntary schemes, private insurance, direct out-of-pocket payment or simply by using them when seriously ill. In the US, where 30 million people still do not have adequate protection through any form of prepayment, the problems associated with restricted entitlement are much more dramatic.

¹⁶ Most other ambulatory services, dental care, chronic care, pharmaceuticals and so on were included under either piece of legislation.

B. HYPOTHESES (WHY, HOW AND TO WHAT EFFECT)

1. Determinants of Health Policy (why)

The best way to establish causal relationships is through combined regression and path analysis. Group II countries unfortunately do not have historical legislative landmarks that could be used as points of reference for comparison with Group I countries. Instead, to understand more fully *why* governments introduced compulsory participation and universal entitlement to health services, these policies will be analysed against existing theories on the determinants of the welfare effort: socio-economic development, political processes, bureaucratic structures and market failure. Chronological sequencing, historical breaks, thresholds and other developments in social policy will be used as supplementary, indirect evidence to support or contest hypotheses about various reforms that have occurred in health care financing. Determinants that have been identified by comparative studies in the social policy literature are relevant to developments in health care financing, but not directly transferable without prior empirical validation. Health care is a benefit in kind with many features that are different from most social security cash benefits. Furthermore, the relative significance of determinants change over time. Factors that were significant during the early growth of infrastructures for the prepayment of health care were different to those that played a significant role in extending participation and entitlement to larger segments of the population.

a) Socio-economic Development

Socio-economic development, along with its bureaucratic and demographic correlates -- the number of years that social security systems have been in existence and the age structure of the population -- has been considered to be the most significant determinant of the welfare effort in the comparative literature on social policy.¹ Many authors have convincingly demonstrated that there is a high correlation between a country's level of socio-economic development, urbanization and accumulation of national wealth, and its expenditure on social security programmes.² Similar observations have been made about

¹ See the discussion on theoretical framework. Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 384; Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975); Frederick Pryor, *Public Expenditure in Capitalist and Communist Nations* (Homewood, I.L.: Irwin, 1968): 179-80, 205, 219.

² Phillips Cutright, "Political structure, economic development and national social security programs," *American Journal of Sociology* 70(March 1965): 537-50; Phillips Cutright, "Income redistribution: A cross-national

the correlation between GDP as a measure of national wealth, and expenditure on health care, life expectancy and infant mortality rates.³ Vulnerable populations benefit when industrialization and urbanization provide the state with the economic means to pay for social security benefits or health care.⁴ Yet aggregate data on GDP and expenditure trends in the social sectors clearly does not tell the full story. Scholars have found it much more difficult to unravel the complex interplay between historical, political and bureaucratic factors, and socio-economic development, industrialization and urbanization.

The links between socio-economic development and the growth of infrastructures for prepayment of health care are clearest during the late nineteenth and early twentieth century. The displaced populations, unemployment, unsanitary dwellings and unsafe working conditions that often mark the early years of industrialization heightened the risks of poverty, illness and neglect of the needy. Urbanization broke down the traditional network of care provided by families and rural communities, leaving urban populations unprotected during times of unemployment, poor health and old age. The countries that were first to industrialize were also the first to introduce collective provisions for financing social benefits through charitable organisations, guilds, friendly societies, sickness funds and so on. They were established not only to protect individuals from the uncertainties of urban life, but also to relieve local authorities, rate-payers and doctors of the welfare burden of caring for the sick and the poor. Great Britain and northern continental Europe were the first to industrialize and urbanize. The rural Nordic countries, southern Europe and the English-speaking New World were much later to industrialize and to introduce similar structures for health care financing. The sickness funds and friendly societies never took hold in countries such as Finland and Sweden, or Australia, Canada, New Zealand and the US.

Beyond these early developments, evidence in favour of a correlation between socio-economic development and extensions in coverage through prepayment of health care

analysis," *Social Forces* 46(1967): 180-90; Henry J. Aaron, "Social security: International comparisons," in *Studies in the Economics of Income Maintenance*, by Otto Eckstein ed. (Washington, D.C.: The Brookings Institution 1967); and Joseph A. Pechman, Henry J. Aaron and Michael K. Taussing, *Social Security: Perspectives for Reform* (Washington, D.C.: The Brookings Institution 1968).

³ J.P. Newhouse, "Development and allocation of medical care resources: Medico-economic approach," in *Development and Allocation of Medical Care Resources*, Proceedings of the 29th World Medical Assembly, Tokyo, Japan Medical Association, 1975; J.P. Newhouse, "Medical care expenditure: A cross-national survey," *Journal of Human Resources* 12(1)(Winter 1977): 115-125; Robert J. Maxwell, *Health and Wealth: An International Study of Health-Care Spending* (Lexington, Massachusetts: Lexington Books, 1981); OECD, *Measuring Health Care 1960-1983: Expenditure, Costs and Performance*, OECD Social Policy Studies (Paris: OECD, 1985); OECD, *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*, OECD Social Policy Studies No. 2 (Paris: OECD, 1987); George J. Schieber and Jean-Pierre Poullier, "International health spending and utilization trends," *Health Affairs* 7(4)(1988): 105-112.

⁴ Jerald Hage and Robert Hanneman, *The Growth of the Welfare State in Four Western European Societies: A Comparison of Three Paradigms* (Madison, W.I.: Institute for Research on Poverty, 1977).

becomes progressively weaker. By the twentieth century, cash benefits were slowly supplemented by rudimentary entitlement to medical treatment as a benefits in kind in many of the countries that had such programmes. Voluntary participation was replaced by compulsory membership for a means-tested portion of the population to ensure participation by low-income groups. Incremental growth in participation and entitlement was interspersed with the occasional rapid extension in coverage. Increased health benefits often occurred at the same time as other significant reforms in social security, but there are no convincing correlation between these events and socio-economic development. New Zealand and the United States were both pioneers and leaders in social security reforms during the 1930s. The US did not include health care as a benefit under the Social Security Act of 1935.⁵ New Zealand not only included health care in 1938, but it took a quantum leap by introducing compulsory participation and universal entitlement as a separate benefit. The US has become one of the richest countries in the world, but remains a welfare laggard, while New Zealand has maintained its extensive provisions despite a much lower national income.

Based on timing that OECD countries introduced compulsory participation and universal entitlement to health care, the empirical evidence against the significance of socio-economic development as a significant determinant becomes overwhelming. New Zealand was a poor rural country, recovering from the Great Depression and entering World War II when it implemented its National Health Service in 1938. Great Britain, Sweden and Norway introduced their reforms during the post-war reconstruction, while Canada, Denmark and Australia introduced theirs during the economic expansion of the late 1960s and early 1970s. Although this may suggest that social transformations and economic growth were significant factors, this was not the case in Finland during the early 1960s, nor in Spain and Greece during the economic slowdown of the early 1980s. Furthermore, the governments of Group II countries did not introduce coverage for health care financing during their periods of economic expansion or when they had reached a similar level of socio-economic development. Among the seven richest western countries, Canada, Italy and the UK have introduced compulsory participation and universal entitlement, while France, Germany, Japan and the US do not offer such provisions. Regression analysis of all OECD countries shows no significant correlation between national wealth as measured by GDP per capita and compulsory participation with universal entitlement in health care financing.⁶

⁵ The U.S. Social Security Act of 1935 was one of the attempts to introduce a comprehensive old age, death, disability and unemployment programme.

⁶ The same observation holds true for the 10 countries with the highest GDP per capita, where the rank order is different from the 7 richest countries. See the discussion on outcome in the section below ($R^2 = 0.00$).

The comparative literature on social policy indicates that some socio-economic development, industrialization and urbanization may be a necessary pre-condition to the welfare effort, which in turn provide the means for growth in physical, human and financial resources in the health sector. No western country introduced comprehensive coverage for health care financing without prior or parallel growth in social security provisions. In settings where these prerequisites are met, an interplay of other factors, such as political processes, bureaucratic structures and the pressures of market failure, may enhance the emergence of more refined provisions such as compulsory participation and universal entitlement. Socio-economic development may be necessary for these factors to play a role in defining health policy, but it was not sufficient as the only causal factor.

b) Political Processes

The legislative reforms that introduced compulsory participation and universal entitlement occurred during the mid-twentieth century, but the debates that accompanied them portray a complex mosaic of unresolved concerns about natural rights, freedom, justice, social contracts and state absolutism that arose out of 17th to 19th century political philosophy.⁷ The tension that existed between individualist and collectivist points of view during previous centuries were repeated, and often distorted, in the arguments about various aspects of health care financing. These observations lend support to a second school of thought that claims that the welfare effort is due, not only to socio-economic factors, but also to a complex interplay between different political processes: ideology, democratization and political party formation.⁸ The eight case studies demonstrated that, although these political processes may not be as significant to expenditure on social security and health care as socio-economic development, they were the key element in shaping the more refined characteristics the associated benefits. Ideology provided the direction for politically motivated reforms to take place, democratization the means, and political parties the continuity and timing.

⁷ See the introduction on the historical role of the state for a more detailed overview of these concepts.

⁸ Jens Alber, Gösta Esping-Andersen and Lee Rainwater, "Studying the welfare state: issues and queries," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 458-468; Peter Flora and Jens Alber, "Modernization, democratization and the development of welfare states in Western Europe," in *The Development of Welfare States in Europe and America*, by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 37-80; and Peter Flora, "The Growth of Mass Democracies and the Welfare States" In *State, Economy and Society in Western Europe 1815-1975: A Data Handbook*, Volume I (Frankfurt: Campus, 1983); G. Esping-Andersen and W. Korpi, "From poor relief to institutional welfare states," in *The Scandinavian Model*, by R. Eriksson et al., eds. (New York: M.E. Sharpe, 1985).

i) Ideology

The eight case histories on the evolution of health care financing revealed two intertwined ideological processes that were difficult to separate. First, the choice between voluntary versus compulsory participation and between restricted versus universal entitlement reflected differences between individualistic and collectivist beliefs. The decisions that governments made in terms of taxation policies and public expenditure policies when faced with these options in health care financing represented complex ideological trade-offs between opposing political platforms that were not apparent from aggregate expenditure data of either the welfare effort or health care itself.⁹ Second, the choice between fees-for-service versus salaries, private practice versus public clinics, specialists versus generalists, hospitals versus primary care, private versus public ownership, health insurance versus tax-funding and so on included underlying meritocratic and egalitarian arguments that went beyond the political arena of the societies in question. Studies that lump these factors under a single heading, or try to measure them by one indicator, confuse the subtle differences between *individualist* and *elite* ideology.¹⁰ In an attempt to avoid falling into this trap, these two processes will be treated separately.

It was left wing oriented governments (socialist, labour, social democratic and liberal in the case of Canada) that passed the legislative reforms for compulsory participation and universal entitlement in all thirteen OECD countries.¹¹ This supports similar observations made in the comparative literature on social policy that when left wing ideologies dominate, governments are more likely to introduce compulsory programmes (Norway and Sweden), and when liberal ideologies dominate (Denmark), they are more likely to introduce subsidised voluntary schemes.¹² In countries where left wing political groups enjoyed many consecutive years in power, public policy reflected a conscious effort to redistribute income and to restrain bourgeois privileges that went beyond simple social security provisions.¹³ Social democratic parties in the Nordic

⁹ Richard M. Coughlin, *Ideology, Public Opinion, and Welfare Policy: Attitudes Towards Taxing and Spending in Industrialized Societies*, Monograph Series No. 42 (Berkeley: Institute of International Studies, University of California, 1980).

¹⁰ Moshe M. Czudnowski, *Political Elites and Social Change* (DeKalb: NIU Press, 1983); G. Field, Lowell and John Higley, *Elitism* (London: Routledge and Kegan Paul, 1980); Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975).

¹¹ In the case of Denmark and Canada, the proposal for these reforms was made under conservative governments, while the legislation was subsequently introduced by liberal governments.

¹² Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

¹³ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf

countries focussed on income redistribution and social reforms through taxation in mixed-market economies, while the more left wing labour parties in New Zealand and the UK emphasised the elimination of the reward system of capitalism through government ownership, publicly run clinics and salaried doctors. Liberal and more right wing parties impeded progressive social security legislation which was felt to interference with competitive markets.¹⁴ Policies on participation and entitlement to health services reflected the choices governments had made based on these ideologies.¹⁵

Figure 11.8 Party Dominance of Governments that Introduced Reforms

Country	Party Dominance
Australia	Labour
Canada	Liberal
Denmark	Social Democratic
Finland	Social Democratic
Greece	Social Democratic
Iceland	Social Democratic
Italy	Socialist
New Zealand	Labour
Norway	Labour
Portugal	Socialist
Spain	Socialist
Sweden	Social Democratic
United Kingdom	Labour

Reform: Compulsory Participation and Universal Entitlement

Both of the ideological camps used arguments about efficiency and equity to support their stance. Left wing oriented groups claimed that compulsory prepayment and universal access to health care was the most efficient way to ensure maximum participation in revenue collection and equitable entitlement to benefits. They feared that high income groups would not voluntarily contribute their share to public programmes and considered means-testing a distasteful way to stigmatise the social groups targeted by this practice. General revenues were favoured over contributory social insurance and direct charges because the latter two were believed to put an unfair share of the financial burden of health care on the shoulders of workers. In direct contrast, liberal and more right wing groups argued that compulsory participation was unnecessary except to ensure that those below an income determined by a means-test carried their own weight. Those

Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., *WZB-Publications* (Hants: Gower, 1987): 404; and Erik Einhorn and John Logue, *Welfare States in Hard Times: Denmark and Sweden in the 1970s* (Kent O.H.: Kent Popular Press, 1979).

¹⁴ Seven B. Wolinetz, ed., *Parties and Party Systems in Liberal Democracies* *The Canadian Liberal Party* (London: Routledge, 1988); and Stanley Henig, *Political Parties in the European Community* (London: George Allen & Unwin, 1979). The Canadian Liberal Party, which until recently was centre-left on the Canadian political spectrum, introduced many progressive social security reforms and should not be equated with other European liberal parties whose political orientation would fall to the right of the Canadian counterpart.

¹⁵ It fails to explain why left wing oriented governments of other countries did not introduce similar policies. Left wing orientation may have been a necessary but not sufficient criterion.

earning above this level of income should be allowed to join voluntary programmes that would also provide them with above standard services. Financing through social insurance was favoured over general revenues because it allowed those who contributed to voluntary schemes to opt out of public programmes and made participation more visible to those who contributed to the financing of health care. These groups felt that universal entitlement was unnecessary and even wasteful because it did not target the populations that needed publicly funded services.

The final mix in financing between prepayment through general revenues, social insurance and direct charges reflected the many compromises that occurred along the way. Debates on the relative merit of tax-funding versus health insurance occurred in all of these countries. Left wing labour groups in New Zealand and Norway argued for universal access to health services provided by the state and financed through general revenues as early as the late nineteenth century.¹⁶ Similar proposals were made in the UK during the early twentieth century. Likewise, proposals for national health insurance were presented in New Zealand in 1924, Australia in 1927, South Africa in 1928, the UK in 1930 and Canada in 1932.¹⁷ New Zealand and the UK introduced a tax-funded National Health Service in 1938 and 1946, although it was labelled as health insurance in New Zealand. Sweden, Norway and Finland consolidated compulsory membership with their sickness insurance funds in 1953, 1956 and 1963, while Denmark continued to rely on subsidised voluntary membership until 1971. Canada and Australia introduced health insurance levies to supplement tax-funding in 1966 and 1974. During the negotiations leading up to the final compromises, the English-speaking countries were more successful in introducing radical reforms than were the Nordic countries.¹⁸

Conflicts about fees-for-service, salaries, private practice, public clinics, specialists, generalists, institutional care, primary care, ownership and so on occurred concurrent to the debates on revenue collection, and continue today in most of the countries examined. Clashes over these issues between the medical profession and other health professionals, unionized health professionals, and between generalists and specialists, are usually presented in the literature as part of an underlying class struggle.¹⁹ The medical

¹⁶ Left wing political groups argued a similar case during the early 20th century in Britain.

¹⁷ British Medical Journal, "British Medical Association's proposals for a general medical service for the nation," Supplement, *British Medical Journal* (26 April 1930). The *British Medical Journal* published a similar proposal in 1938.

¹⁸ Possible reasons for these differences will be described in greater detail in the section on bureaucratic structures.

¹⁹ H. Eckstein, *Pressure Group Politics: The Case of the British Medical Association* (London: Allen & Unwin, 1960); R.F. Badgley, "Health worker strikes: Social and economic bases of conflict," *International Journal of Health Services* 5(1)(1975): 9-17; B. Ehrenreich and J.H. Ehrenreich, "Hospital workers: Class conflicts in the making," *International Journal of Health Services* 5(1)(1975): 43-51; T.R. Marmor and D. Thomas, "Doctors, politics and pay disputes: 'Pressure group politics' revisited," *British Journal of Political Science* 2(4)(1972): 421-442; Vicente Navarro, *Class Struggle, The State and Medicine: An Historical and Contemporary Analysis of the*

profession and other health providers were divided into three competing camps in all the countries examined: specialists working in hospitals, general practitioners and public health officers. All exerted an iron-claw influence over their respective systems and maintained an organisational division which authorities were unsuccessful in breaking, even through the most radical reforms. These struggles were most apparent during the reform period in the UK before 1946, in Canada between 1966 and 1972, and in Sweden before 1969 when there was an overt split between specialists and generalists.

The eight case studies, however, provided clear evidence that these conflicts reflected not just class struggles, but also elite ideology which cut across classes.²⁰ The scientific approach to medicine valorised health care and the medical profession during the past century in a way that was previously unknown. Public health programmes led to the first significant relief from the scourges of communicable diseases that had plagued populations prior to the latter part of the nineteenth century. Technical advances led to cures for conditions that had been left to prayer and quarantine. As medical science became more complex, the gap in information between providers and patients also grew. Knowledge about the course of illness, options for treatment and likely outcome remains largely a mystery even when consumers have access to information. Elite ideology contributed to making this gap in knowledge even larger. Calls for clinical freedom, confidentiality and preservation of the doctor-patient relationship prevented public authorities from gaining the control over financing and provision of health services that they had hoped for through some of the reforms. Despite fears by doctors that compulsory participation and universal entitlement would lead to socialised medicine, the profession retained control of health care in most of the countries examined.

The resulting elite ideology was used in pressure politics to influence the reform process.²¹ In the English-speaking countries, doctors, voluntary hospitals, friendly societies and other vested-interest groups influenced the opinion of commissions of enquiry and departments of health through open confrontation.²² They fought against the introduction of compulsory prepayment and universal entitlement with obstructive publicity campaigns and threats of civil disobedience. In New Zealand, Canada and

Medical Sector in Great Britain (London: Martin Roverson, 1978; Vicente Navarro, "Social class, political power and the state and their implications in medicine," *Social Science and Medicine* 10(9/10)(1976); Rudolf Klein, *Ideology, Class and the National Health Service*, Project Paper No. RC4 (London: Kings Fund, 1980).

²⁰ Specialists are accorded greater esteem than generalists, and there is a distinct pecking order even among the specialities, starting with geriatrics and psychiatry at the bottom ranging through general surgery and internal medicine and peaking with specialties such as cardiology and neurosurgery.

²¹ Alan R. Ball and Frances Millard, *Pressure Politics in Industrial Societies: A Comparative Introduction* (London: Macmillan, 1986). Sidney Sax, *A Strife of Interests: Politics and Policies in Australian Health Services* (Sydney: George Allen & Unwin, 1984).

²² Doctors who played a significant role in advancing the cause for universal access to medical care were punished by excommunication from the medical community.

Australia, doctors, private hospitals and insurance organisations succeeded in frustrating the legislative process on several occasions by having doctors refuse to work in salaried clinics, by billing patients directly and by supporting private insurance plans. In the Nordic countries, the vested-interest groups were much more subtle, but equally, if not more, successful in influencing the reforms. Instead of public confrontations, they exerted their authority strategically by infiltrating the policy-making machinery of the government.²³ Unpopular proposals, such as the Norwegian Civil Defence Health Plan and the Swedish H \ddot{o} jer Plan, were blocked long before going to Parliament.²⁴ Differences in financing mechanisms, remuneration of doctors and ownership were due as much to these ideological undercurrents as to overt political platforms of the governments that introduced the final reforms.

ii) Democratization

If democracy is taken to mean government by the people, this factor had an indirect rather than direct impact of the reform process. In modern states, the acts of government are performed by representatives of the people, elected on a free and equal basis, not the population itself. In an ideal democracy, the actions of government are always in perfect accordance with public preference. This rarely happens. Direct democracy, such as by referendums, only takes place on rare occasions.²⁵ Instead, governments try to respond in relative *degrees*, for a relative period of *time* and in relative *correspondence* with preferences of the elected representatives of citizens.²⁶ The infrastructures needed to collect the funds to pay for health care are complex, and require, time to develop and the participation of the public. A strengthening of the democratic process was critical in enhancing this development because it allowed populations to influence governments through the electoral process without having to resort to bloody uprisings²⁷, but there was little evidence in this study to suggest that democratization played a role beyond that of a facilitator in the introduction of prepaid health care.

²³ In Denmark, the Medical Association deliberately refused to participate in the consultation process since it did not want to support the dying sickness funds.

²⁴ Later, during the Swedish Seven Crown Reform and Finnish Public Health Reform, Nordic doctors raised the same protest that their English-speaking counterparts had raised during earlier battles.

²⁵ Switzerland, which has developed the theory and practice of referendum to perfection, is an exception. David Butler and Austin Ranney, eds. *Referendums: A Comparative Study of Practice and Theory* (Washington: American Enterprise Institute, 1978).

²⁶ Arend Lijphart, *Democracies: Patterns of Majoritarian and Consensus Government in Twenty-One Countries* (New Haven: Yale University Press, 1984): 2.

²⁷ Social insurance legislation increased after a 'suffrage threshold' of 50 per cent of the male population had been reached. Peter Flora and Jens Alber, "Modernization, democratization and the development of welfare states in Western Europe," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 37-80.

Modern democracy is a recent phenomenon. There were no true democratic governments during the nineteenth century.²⁸ Older parliamentary systems, such as in the UK and Belgium, were slower to extend franchise than were Denmark, Norway and Finland where, by contrast, democratization was late to develop. By the twentieth century, statism and the divine right monarchies gave way to democracy, but it was not until the end of World War II that most western countries enjoyed a continuous period of democratic regime. New Zealand and Australia were among the first countries to have fully democratic regimes with firm popular control of government institutions and universal adult suffrage.²⁹ New Zealand was the first to introduce compulsory participation and universal entailment; Australia was among the last. Greece, Portugal and Spain have recently introduced similar legislation, but have not enjoyed continuous democratic regimes since World War II. All other OECD countries have had continuous democratic governments since World War II, but the countries classified in Group II in this study did not introduce compulsory participation and universal entitlement in health care financing.

Furthermore, responsive democracy requires that eight institutional guarantees be fulfilled: freedom to form and join organisations; freedom of expression; right to vote; eligibility for public office; right of political leaders to compete for support and votes; alternative sources of information; free and fair elections; and institutions for making government policies that depend on voter preference.³⁰ These principles embody the classic, but often conflicting democratic principles of liberty and equality. The governments that introduced policies to enforce compulsory participation and universal entitlement often had to defend themselves against accusations of anti-democratic behaviour. This has led some authors to conclude that the parliamentary monarchies lacking some of these ideological restraints felt a more pressing need to control the bureaucratic machinery and appease militant labour movements at the turn of the century. These same countries later supported more paternalistic policies through the introduction of extensive social security programmes than their liberal continental counterparts.³¹ The strong growth of sickness funds in Denmark and Norway at the turn of the century would support this theory, but the late development of sickness funds in

²⁸ Arend Lijphart, *Democracies: Patterns of Majoritarian and Consensus Government in Twenty-One Countries* (New Haven: Yale University Press, 1984): 37; David Arter, *The Nordic Parliaments: A Comparative Analysis* (London: Hurst, 1984).

²⁹ Göran Therborn, "The rule of capital and the rise of democracy," *New Left Review* 103(May-June 1977): 11-17.

³⁰ Robert A. Dahl, *Polyarchy: Participation and Opposition* (New Haven: Yale University Press, 1971); and John D. May, "Defining democracy: A bid for coherence and consensus," *Political Studies* 26(1)(March 1978): 1-14.

³¹ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

Sweden and Finland and the later introduction of extensive provisions in Denmark and Finland, contradict it.

Majoritarian³² or consensual³³ regime type did not seem to influence the outcome either; countries in both Group I and Group II have these regimes. Among the countries with majoritarian democratic regimes, New Zealand, the UK, Canada and Australia have introduced the reforms in question, while the US has notably resisted similar legislation. Among the countries with consensual regimes, the Nordic countries have introduced these reforms, while most continental northern European countries have not taken this step.

Several other factors were also examined for their possible impact on the reform process leading to compulsory participation and universal entitlement. The extent of pluralism and religious-linguistic homogeneity worked against such reforms: Denmark, Iceland, Ireland, Japan, New Zealand, Norway, Sweden, the UK and Australia have been classified as non-plural societies; Finland, France, Italy, Canada, Germany and the US have been classified as semi-plural societies; and Austria, Israel, Luxembourg, Belgium, the Netherlands and Switzerland have been classified as plural societies.³⁴ Group I countries belong primarily to the non- and semi-plural societies, while Group II countries tend to belong to the semi-plural and plural societies. Plural societies may be more likely to offer greater choice to their populations, including choice in health care financing. Most of the countries in Group I are classified as having weak executive power (Finland being an exception), but some Group II countries also belong in this category.³⁵ The following other key characteristics of democratic regimes did not correlate with the classification of countries into Group I and Group II according this study: majority rule versus power sharing, unicameral versus bicameral parliaments, two party versus multiple party systems, majority versus proportional representation, unitary versus federal states and majority versus minority constitutional rights.

Public choice, as expressed through the electoral process, is an imperfect substitute for consumer choice.³⁶ Some authors have tried to construct theoretical models to approximate the classical consumer-demand relationship based on median-voter

³² Government by the majority in accordance with the wishes of the majority is the essence of the majoritarian model.

³³ Government by and responsive to a minority or as many people as possible is the essence of the consensual model.

³⁴ Val R. Lorwin, "Segmented pluralism: Ideological cleavages and political cohesion in the smaller European Democracies," *Comparative Politics* 3(2)(January 1971): 148.

³⁵ Arend Lijphart, *Democracies: Patterns of Majoritarian and Consensus Government in Twenty-One Countries* (New Haven: Yale University Press, 1984): 88.

³⁶ D. Muller, *Public Choice* (Cambridge, Cambridge University Press, 1979).

preferences.³⁷ Rules that offer incentives for voters to reveal their economic preferences could be developed,³⁸ but are often not politically desirable. Representative democracy is therefore not a reliable way to reflect the balance between a politician's objective to maximise votes to stay in power and the voters' objective to maximise their net benefit from public policies.³⁹ The delegation of choice to elected representatives, sub-maximal voter turnout, lack of accurate information, silent majorities, government monopolies and so on are all unavoidable imperfections of even the most idealised democratic process. For citizens to have a significant effect on health policy, the electorate must be offered distinct platforms, voters must make identified, well-informed choices, and governments must have a concrete mandate to implement these choices. During most of the reform period leading up to the introduction of compulsory participation and universal entitlement, parties offered generalities, voters responded to distorted images of platforms and the media created its own political agenda.⁴⁰ Health care financing was only a stirring campaign issue during elections in New Zealand in 1935 and Australia in 1969.

Evidence for the significance of democratization as a determinant of health policy is therefore weak and marked by contradictions. It probably played its most significant role in the introduction of compulsory participation and universal entitlement as a precursor to other political processes such as political party formation and in allowing social transformations to take place peacefully. This in itself was a significant achievement.

iii) Political Party Formation and Vested Interests

Most political parties have evolved since World War I and II.⁴¹ The key groups are liberals, conservatives, socialists, Christian democrats and communists.⁴² Because older equivalents have changed their names and ideological orientation, it is difficult to classify them under one ideological family, and their functional equivalents are more significant than their names.⁴³ In modern societies, interest groups *articulate*, while parties *aggregate*

³⁷ Rovert P. Inman, "The fiscal performance of local governments: An interpretative review," in P. Mieszkowski and M. Straszheim, eds., *Current Issues in Urban Economics* (Baltimore: Johns Hopkins, 1978).

³⁸ G. Tullock and N. Tiedeman, "A new and superior principle of public choice," *Journal of Political Economy* (December 1976).

³⁹ Joseph A. Schumpeter, *Capitalism, Socialism and Democracy* (New York: Harper, 1950): 282; Anthony Downs, *An Economic Theory of Democracy* (New York: Harper & Row, 1956).

⁴⁰ Nelson W. Polsby, "Party realignment in the 1980 election," *Yale Review*, 72(Autumn 1982): 42-54.

⁴¹ The US Democratic Party (1828) and British Conservative Party (1832) were two early exceptions. The Anglo-American and Scandinavian are two of the most extensively studied systems.

⁴² Klaus von Beyme, *Political Parties in Western Democracies* (Aldershot: Gower, 1985); K. Lawson, *The Comparative Study of Political Parties* (New York: St. Martin's Press, 1976): 4.

⁴³ Theories on the determinants of modern political parties include the following: they derive from developments in parliamentary systems; they derive from new states and the collapse of constitutional systems; and they are part of political modernisation. J. La Palombara and M. Weiner, eds., *Political Parties and Political Development* (Princeton: Princeton University Press, 1966): 7.

public interest and choice, but the boundaries between these distinctions are not clear. In earlier societies, these functions were performed by different classes, estates or the bureaucracy. The ideological unity of parties is frequently undermined by interest groups that existed before policies and political platforms were formulated. In party typology, the ideology of multi-party systems (Nordic and other European)⁴⁴ are more likely to coexist with interest groups than in two-party systems (Anglo-American).⁴⁵ Parties work through competition, while interest groups avoid competition by penetrating and infiltrating the committees and ministries that are significant to them.⁴⁶ The eight case studies gave clear evidence that doctors, insurance organisations and, to a lesser extent, private hospitals formed three powerful lobbies that influenced party platforms throughout the many health care financing reforms that have taken place during the past century.

Hypotheses that the formation of modern political parties provided continuity in regime and timing for the introduction of significant peaceful reforms in social policy⁴⁷ need to be seen in this context and were supported by observations in the case study countries. At the turn of the twentieth century, during the early growth of the trade guilds, sickness funds, friendly societies and so on, the process of political party formation was still in its infancy in most western countries.⁴⁸ The forerunners to both left wing and right wing political parties supported these organisations for different reasons. Parties with right wing platforms hoped that contributory programmes would lead to greater self-reliance, less money spent on various forms of social assistance and decreased taxes. Parties with left wing platforms hoped that public subsidies would act as a vehicle for income transfers from the rich to the poor. Countries that were early to democratize, such as the UK, Canada, Australia and New Zealand, had time for nineteenth century liberal free-market and *laissez-faire* ideologies to take hold. They resisted government subsidised social security programmes. Countries that were late to democratize, such as the Nordic countries, had small and splintered right wing political parties that were

⁴⁴ L.D. Elpstein, *Political Parties in Western Democracies* (London: Pall Mall, 1967).

⁴⁵ Harold D. Clark and Moshe M. Czudnowski, *Political Elites in Anglo-American Democracies: Changes in Stabel Regimes* (DeKalb, Illinois: Northern Illinois University Press, 1987).

⁴⁶ G. Alderman, *Pressure Groups and Government in Great Britain* (London: Longman, 1984); H. Eckstein, *Pressure Group Politics* (London: Allen & Unwin, 1960); D. Marsh, ed., *Interest Groups in Britain* (London: Junction Books, 1983); B. Pym, *Pressure Groups and the Permissive Society* (London: David & Charles, 1974); J. La Palombara and M. Weiner, eds., *Political Parties and Political Development* (Princeton: Princeton University Press, 1966): 7.

⁴⁷ Francis Castles, *The Social Democratic Image of Society* (London: Routledge and Kegan Paul, 1978): 76; Christopher Hewitt, "The effects of political democracy and social democracy on equality in industrial societies: A cross-national comparison," *American Sociological Review* 42(1977): 450-64.

⁴⁸ Jean Blondel, *Political Parties: A Genuine Case for Discontent?* (London: Wildwood House, 1978); Kenneth Janda, *A Conceptual Framework for the Comparative Analysis of Political Parties* (Sage: Beverly Hills, 1980); G. Sartori, *Parties and Party Systems* (Cambridge: Cambridge University Press, 1976).

divided among conservative, agrarian, Christian Democratic and liberal parties. The united left provided strong support for working class welfare-oriented ideologies.⁴⁹

In the Nordic countries, proportional representation led to many small and diversified political parties. This resulted in multi-party consensual political systems with fragile coalition governments whose survival depended on political compromises.⁵⁰ At the turn of the century, the monarch, supported by an appointed government, a conservative bureaucracy and a conservative bourgeois minority, was pitted against an emerging liberal-peasant majority in the Lower House of Parliament.⁵¹ As industrialization and urbanization spread, socialist and communist parties gained strength and demanded social reforms. An increase in sickness funds and social security provisions occurred parallel to these events. As urbanization progressed, rural political factions lost popular support, and cleavages occurred between conservative and socialist coalitions. Right wing conservative governments backed contributory social insurance, while left wing opposition parties called for tax-based financing as early as the 1890s. Compromises between these two opposing political groups led to extensive expansion in the financial infrastructures needed to pay for health care through government subsidised sickness insurance.⁵² According to this political scenario, Denmark led the way, followed by Norway, Sweden and Finland. Finland's evolution was delayed by slower industrialization, Finnish-Swedish language conflicts and violent battles of secession with Sweden and Russia.

In the Anglo-American countries, majoritarian rule led to two-party adversarial systems that were radically different from the Nordic multi-party consensual systems.⁵³ Coalition governments were an exception and compromise discouraged. At the turn of the century, liberal *laissez-faire* ideologies dominated with much weaker left wing oppositions. Socialist and communist parties existed, but were never able to secure a strong foothold. In Australia, Canada and New Zealand these political tendencies were accentuated by a strong reaction against any government intervention brought on by memories of their colonial past. During the development of the early infrastructures for health care financing, the UK therefore led the way in terms of the evolution of friendly societies and the former English-speaking colonies lagged far behind, although some public services were initially financed by the British Treasury and later, the state budget

⁴⁹ Among the eight case studies, the English-speaking countries that were early to democratize also had majoritarian rule, while the Nordic countries had consensual rule. In other European countries, these cleavages do not so closely.

⁵⁰ Neil Elder, Alastair H. Thomas and David Arter, *The Consensual Democracies? The Government and Politics of the Scandinavian States* (Oxford: Martin Robertson, 1982).

⁵¹ Det Danske Selskab, *Nordic Democracy* (Copenhagen: Det Danske Selskab, 1981).

⁵² It was easier for the Nordic countries to expand coverage through the sickness insurance funds than for the English-speaking countries to extend their tax-bases.

⁵³ The majority rules with no concern for unanimity or minority concerns.

when the colonies gained their independence. Direct out-of-pocket payments and private insurance played a much more significant role. The dominant liberal political mood kept state-run programmes and subsidies for the friendly societies to a minimum in an attempt to encourage self-reliance and thrift.

At the time of the introduction of compulsory participation and universal entitlement, the relative advantages and disadvantages of these political models had changed. The consensual model had enhanced public subsidies for the sickness funds and the majoritarian model had discouraged such left wing compromises during the right wing or liberal party dominance of the early twentieth century. Policies calling for compulsory membership and universality were more radical reforms that had all the potential elements needed to evoke strong protest from opponents -- political parties and vested interests. Policies calling for salaries, public clinics, major organisational reforms, public ownership and funding through taxes required not only ideological commitment, but also party strength. Parties also had to have sufficiently clear political platforms that their policies were not diluted by the time the legislative phase was reached, and they had to stay in power long enough to prepare, pass and implement these policies. Labour parties in New Zealand, Australia, the UK and Norway were committed to such radical social reforms as were the Social Democratic parties in Sweden, Denmark and Finland as well as the Liberal Party in Canada. As is often the case in representative democracies,⁵⁴ the electorate was not presented with a clear choice. Many of these policies, therefore, became hidden agendas that were often lost along the way during the battle with opposition parties and vested interest groups.

Labour governments in New Zealand and Britain relied on their majority to introduce tax-funded and salaried National Health Services in 1938 and 1946. The Liberal government in Canada and Labour government in Australia introduced their reforms despite strong protest from the opposition in 1966 and 1973, but their weaker position as federal states and strong opposition from vested interest groups diluted the more radical elements such as tax-funding, salaries and state ownership. The multi-party consensual political systems of the Nordic countries had a distinct disadvantage during the introduction of radical reforms. The universal sickness insurance programmes introduced by Sweden and Norway in 1953 and 1955 were filled with the remnants of compromises

⁵⁴ Martin Harrop and William L. Miller, *Elections and Voters: A Comparative Introduction* (London: Macmillan, 1987); Andrew McLaren Carstairs, *A Short History of Electoral Systems in Western Europe* (London: George Allen & Unwin, 1980); Roy C. Macridis and Bernard E. Brown, *Comparative Politics: Notes and Readings* (Homewood, Illinois: Dorsey Press, 1977); Gordon Smith, *Politics in Western Europe: A Comparative Analysis*, 5th Edition (London: Gower, 1989).

that grew out of the consensual model.⁵⁵ The late arrival of political parties in Finland delayed expansion of its sickness insurance programme until 1963. Some of the more radical elements, such as salaried doctors and public clinics, were not introduced until later.⁵⁶ Denmark was much more complex. Although political parties were early to develop, liberal ideologies played a dominant role for a much longer period of time. When the Social Democratic Party did come to power, it was plagued by a series of weak coalitions. Furthermore, generous subsidies for voluntary membership in the sickness insurance funds had achieved virtual universal adhesion by 1960, making further extension a weak political platform.

Regime stability can be viewed as constitutional continuity and peaceful transfer of power through electoral decisions; political stability can be looked at as the length of time that a particular party is in power. The social policy literature suggests that party continuity is a significant determinant of early progressive reforms because it increases the likelihood of successful enactment of legislation and of fiscal commitment.⁵⁷ Evidence for this hypothesis comes mainly from Norway and Sweden where Labour and Social Democratic governments enjoyed long periods in power and were successful in introducing progressive reforms in health care financing during the 1950s. Denmark and Finland may have been retarded by frequent changes in weak coalition governments. Evidence from the English-speaking countries is less conclusive. In New Zealand, the UK and Australia, it was newly elected Labour governments that introduced compulsory prepayment and universal entitlement. In Canada, it was when the Liberal party regained power after a period of Conservative rule.⁵⁸ In the UK and Australia, the reform governments lost to the opposition in subsequent general elections, while in the other six countries there was no change in power. Lack of political durability compromised health care reforms that had been carefully planned during the late 1920s and 1940s in Canada and Australia.⁵⁹ This would indicate that political stability does not guarantee reforms, but instability might compromise it.

⁵⁵ In Sweden, the Höjer Report of 1948 presented a radical alternative to the Sickness Insurance Law of 1953, and in Norway, the health care component of the Civil Defence Law of 1953 presented a radical alternative to the Compulsory Universal Sickness Insurance Law of 1956.

⁵⁶ Seven Crowns Reform of 1969 in Sweden and the Public Health Act of 1972 in Finland.

⁵⁷ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

⁵⁸ Denmark and Finland also introduced their reforms shortly after changes in government.

⁵⁹ Legislation was prepared for extensive expansion in health insurance in the 1920s and for the introduction of British-styled National Health Service in the late 1940s. New governments either ignored or reversed policies introduced by previous governments.

It is necessary to balance the significance of political parties in the introduction of compulsory participation and universal entitlement to health care with that of leadership and personalities. The latter have been described by a number of scholars as key factors in public policy.⁶⁰ It is surprising that the comparative literature on social policy has given so little attention to this potentially significant determinant of the welfare effort.⁶¹ The case studies gave clear evidence that it was the leadership and personalities of government ministers and other senior officials that, more often than not, played a key role in formulating policies, making political parties stick to their election platforms and implementing reforms. Advocacy and tenacious opposition from the medical profession and other vested interest groups was equally a determinant. The machinations that occurred behind the scene in shaping the final policy during the consensus-making process in the Nordic countries, is in direct contradiction to the usual stereotyped view of their lifeless party platforms, inanimate bureaucracies and faceless political characters. The bureaucratic process itself was headed by individuals who, in many cases, had a decided impact on the policy making process. Some authors maintain that bureaucrats engage in empire building to increase their budgets, raise their salaries and extend their power. This study provides no evidence, however, to substantiate this hypothesis.

c) Bureaucratic Structures

Proponents of a third second school of thought claim that it is the ageing of bureaucratic infrastructures or the length of time that a programme has been in existence and the consensus-making machine of corporatism -- the interplay of highly organised interest groups and governments -- that was principally responsible for a flourishing of social security provisions such as pensions, unemployment benefits, sick pay, accident insurance and family allowances.⁶⁵ These observations are not strictly transferable to some aspects of health policy. For example, Group I and Group II countries are interspersed over the spectrum of corporatism: Norway, Sweden, Finland and Austria

⁶⁰ Jean Blondel, *Government Ministers in the Contemporary World* (London: Sage, 1985); Jean Blondel, *Political Leadership: Towards a General Analysis* (London: Sage, 1987); R.M. Stogdill, *Handbook of Leadership: A Survey of Theory and Research* (New York: Free Press, 1974); J. McGregor Burns, *Leadership* (New York: Harper and Row, 1978).

⁶¹ G.D. Paige, *The Scientific Study of Political Leadership* (New York: Free Press, 1977); B. Kellerman, *Leadership: A Multidisciplinary Perspective* (Englewood Cliffs, N.J.: Prentice-Hall, 1984).

⁶² Hugh Helco, *A Government of Strangers* (Washington: Brookings Institution, 1977); P. Kellner and Lord Crowther-Hunt, *The Civil Servants* (London: Macdonald, 1980).

⁶³ The civil service was crucial to the health care reforms examined in this study. H.H. Gerth and C. Wright Mills, *From Max Weber* (New York: Oxford University Press, 1972): 196-245; Gerhard Colm, *Essays in Public Finance and Fiscal Policy* (New York: Oxford University Press, 1955).

⁶⁴ W.A. Niskanen, *Bureaucracy and Representative Government* (Chicago: Aldine, 1974), chapter 5.

⁶⁵ Gerhard Lembruch and Philippe C. Schmitter, eds., *Patterns of Corporatist Policy-making* (Beverly Hills: Sage, 1982); Philippe C. Schmitter "Interest intermediation and regime governability in contemporary Western Europe and North America," in *Organising Interests in Western Europe: Pluralism, Corporatism and the Transformation of Politics*, by Suzanne Berger, ed. (Cambridge: Cambridge University Press, 1981).

ranked among the most corporatist countries by the late 1970s, followed by the Netherlands, Denmark, Belgium and West Germany, and trailed by Britain, the US, Canada, Australia, New Zealand, Japan, France and Italy. Although the Nordic countries are more corporatist than the English-speaking ones, this factor fails to correlate with degree of participation and entitlement in health care financing, or timing of the introduction of significant reforms.

Links between the ageing of bureaucratic infrastructures and the growth of prepaid health care were clearest during the late nineteenth and early twentieth centuries.⁶⁶ From the Middle Ages to the nineteenth century, care for the sick and the poor was largely the business of the church and charitable organisations. Venerable institutions were financed by the church and quarantine hospitals by the state. Later, private and voluntary hospitals were financed by a hodgepodge of bazaars, lotteries, tea parties, private patrons, charitable organisations, provident funds and user-fees. Like the workhouse infirmaries, hospitals served primarily to isolate the undesirable and dangerous from society. Loss of income was a greater threat during illness than the cost of medical care which, during the nineteenth century, was still regarded as ineffective, if not dangerous. Accident, disability and sick pay were among the earliest cash benefits provided by mutual cooperatives, trade guilds, sickness funds, friendly societies and so on; treatment by doctors and hospitals as a benefit in kind was introduced much later. Uncoordinated benefits were introduced in an sporadic manner, interspersed with the occasional significant reform. These were later unified at local levels, then at regional/provincial/state levels and finally at the national level. The financial infrastructures needed to collect funds were complex and required time to develop. No country introduced health care benefits in total isolation from other social benefits.

The first infrastructures for collective financing of health care were established by the private sector. Public authorities, however, soon realised that it was in their interest to support this development because one way or another, they also ended up providing part of the financing through social assistance, or subsidies for public health programmes and hospitalisation. During the latter part of the nineteenth century, at the same time as the early infrastructures for health insurance were developing in northern Europe, medical officers of health provided some treatment in addition to their public health duties in the Nordic countries and the UK. Similar provisions in English-speaking colonies came from a totally different direction. European settlers in Australia, Canada and New Zealand began their colonial history with centrally organised medical services, financed through the Exchequer in London, and delivered through military outposts and by naval surgeons.

⁶⁶ Public bureaucracies have been a relatively neglected area of comparative studies. With a few exceptions, most focus on one or two countries. Guy Peters, *Comparing Public Bureaucracies; Problems and Method* (Tuscaloosa: University of Alabama, 1988).

These public provisions were, however, short lived. When the colonies became independent, Britain cut off its financial support. An ongoing revolt against European-styled bureaucracies, which reminded many settlers of the conditions they had fled from, made further public sector involvement through social insurance objectionable and unwelcomed overseas. In Australia, Canada and New Zealand, out-of-pocket payment and private insurance remained the rule long after most European countries had turned to social insurance to finance health care.

Support for the significance of bureaucratic structures in influencing the timing, scope and content of these events comes primarily from detailed analysis of Denmark, Norway, Sweden and Finland from the 1880s onward.⁶⁷ The Nordic countries and the UK followed the lead in social insurance set by Bismark in Germany during the late nineteenth century. Instead of introducing a means-tested compulsory national insurance, however, Denmark offered generous public subsidies for the officially recognised sickness funds which successfully stimulated extensive growth in membership. In Sweden public subsidies were more modest, failing to stimulate a similar growth beyond the mandatory means-tested compulsory membership. Norway, with its complex historical links to Denmark and Sweden, introduced a mixed voluntary-compulsory model. Held back by Swedish, Russian and German occupations, Finland did not develop a sickness insurance system until after the 1950s. The Lloyd George Plan of 1911 in England extended the coverage and benefits provided by the already existing friendly societies. It is difficult to isolate the significance of this evolution from other socio-economic and political determinants because they all have the same rank order. It is entirely possible that the evolution in collective provisions for prepayment of health care was a direct result of underlying socio-economic growth and political forces rather than bureaucratic infrastructures.

There were both advantages and disadvantages to the depolarised policy-making of corporatism during the period of reform leading up to the introduction of compulsory participation and universal entitlement. In the eight case studies, there was clear evidence of the role of corporatism in reforms relating to health care financing. As has been observed in the comparative literature on social policy, the corporatist Nordic countries forced working groups, committees and commissions into a long consensus-making process.⁶⁸ Interest groups, such as the medical profession and the sickness funds, were

⁶⁷ Jens Alber, "Government responses to the challenge of unemployment: The development of unemployment insurance in Western Europe," and Stein Kuhnle, "The growth of social insurance programs in Scandinavia: Outside influences and internal forces," in *The Development of Welfare States in Europe and America* by Peter Flora and Arnold J. Heidenheimer, eds. (New Brunswick, N.J.: Transaction Books and the HIWED Project, 1981): 125-83.

⁶⁸ Francis Castles, *The Social Democratic Image of Society: A Study of the Achievements and Origins of Scandinavian Social Democracy in Comparative Perspective* (London: Routledge & Kegan Paul, 1978); Francis

consulted early in the policy-making process. This led to extensive contact between adversaries and an opportunity for these groups to infiltrate the policy-making machinery.⁶⁹ Radical options, such as the nationalisation of hospitals, salaried doctors and tax-based financing, were eliminated through bargaining and trade-offs long before legislation was presented to parliament. Governments, political parties and interest groups were forced begrudgingly to seek consensus to stay in power, not just in the planning of policies but also in their implementation: "The politics of compromise was forced by the electoral situation, not by the fact that the Swedes loved compromise."⁷⁰

Although the consensus-making machine of corporatism in the Nordic countries prevented long and drawn-out deadlocks in parliament, there was a price attached to the concessions that were made in the process. In Sweden and Norway, there was hardly any debate in parliament when the government tabled legislation to introduce compulsory and universal sickness insurance. There was surprisingly no mention in the press or medical journals that other committees had already developed much more radical proposals for the introduction of British- and New Zealand-styled National Health Services.⁷¹ The hidden compromises of corporatism failed to present voters with these clear-cut alternatives: "No politician worth his salt ... voluntarily seeks consensus: consensus has to be forced upon him."⁷² In Finland and Denmark, there was some debate, but little protest.⁷³ The broadly defined statutes that resulted from the consensus-making process left considerable room for real policy to be defined by administrators and interest groups after the legislative phase. Both Sweden and Finland subsequently had to introduce additional legislation to cover the inadequacies of compulsory universal sickness insurance and independent private medical doctors.

In contrast, the confrontational and polarised policy-making process of the non-corporatist English-speaking countries exaggerated and sensationalised many of the key issues that were debated during the period of reform leading up to the introduction of compulsory participation and universal entitlement. In the more polarised political arena of these countries, there were no corporatist pressures to prevent executives, legislatures and regulatory agencies from introducing partisan policies. Media presentations and mass

Castles, "Scandinavia: The politics of stability," in *Modern Political Systems: Europe*, by Roy C. Macridis, ed. (Englewood Cliffs, N.J.: Prentice-Hall, 1978).

⁶⁹ Gunnar Heckscher, "Interest groups in Sweden: Their political role," *Interest Groups on Four Continents* (Pittsburgh: University of Pittsburgh Press, 1958).

⁷⁰ F.R. Scott, *Sweden: The Nation's History* (Minneapolis: University of Minneapolis, 1977): 476.

⁷¹ Höjer Plan of 1948 in Sweden and the Civil Defence Law of 1953 in Norway.

⁷² Neil Elder, Alastair H Thomas and David Arter, *The Consensual Democracies: The Government and Politics of the Scandinavian States* (Oxford: Basil Blackwell, 1982): 159.

⁷³ In Denmark, the Medical Association refused to be represented on the Social Reform Commission of 1969, wanting to remain neutral during what it felt would be a fight-to-the-finish between the government and the sickness funds.

political leverage often took priority over the findings of working groups, committees and commissions. As a result, labour governments in New Zealand and the UK successfully introduced compulsory participation and universal entitlement to comprehensive health services in 1938 and 1946, which was earlier than most other countries. The Labour and Liberal governments of Australia and Canada attempted to introduce similar legislation during the late 1940s, but changes in government and objections to interference in the market economy from a conservative-oriented opposition prevented the reforms from proceeding. The administrators working behind the scenes in these countries were more successful in isolating their work from the medical profession, insurance organisations and other interest groups than were their Nordic counterparts.

Socio-economic development and political processes appear to have been prerequisites for subsequent expansion in bureaucratic structures for prepayment of health care. Over time, as these infrastructures grew, the public became conditioned to paying taxes and making social insurance contributions towards plans that offered collective benefits. In this respect, the early experience with the friendly societies, sickness funds and other prepayment schemes may have acted as a social conditioning for popular acceptance of the higher taxes and broader tax-bases that would later be necessary to finance ambitious national programmes. Similar tax burdens would have caused popular revolts in earlier times and in different cultural settings.⁷⁴ The great variability in membership rates in these schemes prior to the reforms is an argument against there being a threshold in contributory insurance before governments can introduce compulsory participation and universal entitlement.⁷⁵

Figure 11.9 Membership with Prepayment Schemes Prior to Reforms

Country	Date	Membership as % of Population
New Zealand	1938	20
England	1946	50
Sweden	1953	30
Norway	1956	90
Finland	1963	10
Canada	1966	68 (different in each province)
Denmark	1971	90
Australia	1974	83 (different in each state)

⁷⁴ Vito Tanzi, "Public expenditure and public debt: An international and historical perspective," in *Public Expenditure: The Key Issues* by John Bristow and Declan McDonagh, eds. (Dublin: Institute of Public Administration 1986): 6-37.

⁷⁵ Those without financial protection to pay for health care prior to the introduction of universal entitlement were also those most likely to need these services and those who made the greatest claims on other social security benefits: the sick, disabled, elderly, unemployed, women, children and so on.

d) Market Failure

There are three standard requirements before a market economy can reach equilibrium and function efficiently in the allocation of economic goods in response to the expression of consumer preferences: perfect competition, a full set of markets and perfect information.⁷⁶ If all of these conditions are met, a Pareto-efficient allocation of resources can be expected with state intervention being limited to taxes and lump-sum transfers. Any restrictions in these criteria require additional state intervention to ensure Pareto improvements. Analysis of market failure in health care has come to the forefront in the literature only during recent years and there have been no systematic attempts to identify its existence in a cross-national or historical context.⁷⁷ A review of the history of medicine and the eight case histories presented in this study give clear evidence that market failure existed in health care long before the nineteenth century, that it occurred in all of the countries examined and that it was a significant reason for public sector involvement in health care financing.

Codes governing the conduct of healers date to antiquity when the medical profession consisted of a tightly controlled guild.⁷⁸ A clear distinction can be made between the legal responsibilities that were enforceable by law (intervention of the state), and supra-legal or ethical responsibilities that were left to the profession itself (self-regulation and exclusion from the guild). The guild approach to medicine restricted competition and markets. The doctrine of secrecy restricted information. Fee schedules influenced prices. Early laws pertaining to healers were mainly concerned with the transition from blood revenge to the principle of monetary compensation for injury. One of the earliest evidence of these duties is the Code of Urnammu (2112-2095 BC). Statute 15 reads as follows: "If a man ... cut off the foot of [another man ...] he shall pay ten shekels of silver."⁷⁹ The *Code of Hammurabi* (1792-1750 BC) establishes a system of direct fee-for-service payment based on the nature of services rendered and the ability of the patient to pay. For two millennium, this fundamental balance between healers and patients remained essentially unchanged.

Public revenues provided the financing at an early stage for quarantine hospitals, health-related provisions under poor law relief and the public health movement in all the

⁷⁶ K.J. Arrow and F.H. Hahn, *General Competitive Analysis* (Edinburgh: Oliver and Boyd, 1971); E. Malinvaud, *Lectures on Microeconomic Theory* (Amsterdam: North-Holland, 1972); Antony B. Atkinson and Joseph E. Stiglitz, *Lectures on Public Economics* (London: McGraw-Hill, 1980).

⁷⁷ The literature on market failure in the health sector was reviewed in the introduction on determinants. Parallels will be drawn with the literature on public sector economics in the following section on normative functions of government in health care.

⁷⁸ See the *Hippocratic Oath*. British Medical Association (BMA), *Handbook of Medical Ethics*, (London: BMA, 1984): 6.

⁷⁹ Careleton B. Chapman, *Physicians, Law, and Ethics* (New York: New York University Press, 1984): 3-5.

countries examined. In the Nordic countries, local authorities became responsible *de facto* for financing hospitals long before the end of the last century. In the English-speaking countries private revenues played a more significant role. Australia, Canada and New Zealand, had only a small landed gentry to establish voluntary, charitable and venerable institutions. As in the Nordic countries, this forced public authorities to provide financing and build public hospitals at an early stage. In this respect, Australia and Canada built more of these institutions than New Zealand, which was a much poorer country. In England, they were even more numerous. As antiseptic techniques improved and medical science advanced, hospitalisation became an increasingly standard part of health care. Direct out-of-pocket payments, bazaars, lotteries, tea parties, private patrons and so on became insufficient as the main source of financing for most hospitals. With time, many of the private and non-profit institutions that were chronically underfinanced came to depend on public subsidies to stave off bankruptcy. In all eight countries, governments that provided financing for hospitals also demanded control over the institutions that they were bankrolling, even when the ownership remained in private hands. In this context, competition was far from perfect and markets severely restricted, giving rise to further government regulations, subsidies and direct provision of services.

Parallel to these developments in institutional care and public health, the trade guilds, sickness funds, friendly societies, providence funds and other health insurance organisations provided cash benefits at times of illness for groups of workers and their families. All of these organisations were established to respond to the uncertainties of urban living (unemployment, old age, illness and so on) by pooling risks and resources -- a standard market technique for dealing with risk through insurance. During their early existence, the staple revenue for these organisations was provided by contributions from workers and employers. The state did not interfere with their activities. With time, however, they experienced many of the same problems that are associated with market failure in health insurance today: inconsistent contribution schedules, exclusion criteria, disclaimers, waiting periods, time limits, skim-creaming, unjustified retention rates, reserves, diversion of funds, corrupt administration, bankruptcies, low adhesion, free-riders, moral hazards and so on. When treatment by medical doctors became a benefit in kind, the various prepayment organisations of all of these countries experienced additional problems due to conflicts with doctors who accused them of interfering with the practice of medicine. Collusion among doctors against the funds, and among funds against doctors, only contributed to market imperfections.

Governments initially became indirectly involved in financing ambulatory care in response to these market failures.⁸⁰ In the Nordic countries, they offered public subsidies on a voluntary basis to the sickness funds that observed standardised criteria for membership and benefits.⁸¹ When the net gains of these subsidies offset the additional benefits that they had to provide to comply with regulations, these funds had a competitive edge over those that did not receive subsidies. This was especially true when the subsidies were generous, as in Denmark and Norway, where they led to a quick rise in membership rates; when they were less generous or non-existent, as in Sweden, Finland and the English-speaking countries, the subsidies were less effective in attracting new memberships. A firm conviction that voluntary participation failed to attract adequate members, especially among low-income earners and their families, led most of the Group I countries to introduce compulsory participation for a means-tested portion of their population.⁸² In Denmark, where entitlement to other social benefits was made conditional on active membership in voluntary funds, this rule had the same effect as compulsory membership for most of the population. With time, as the means-test and regulations changed, a greater percentage of the population was covered by these provisions, but this varied greatly from country to country, as was seen in the figure above.

At the time of the introduction of legislation calling for compulsory participation and universal entitlement, a continued failure of the competitive market to provide adequate health care for at least part of the population through prepayment schemes served as a powerful argument for additional government intervention on the basis of both efficiency and equity. As institutional care -- the most expensive component of health services -- became increasingly financed through public funds, reformers argued that an extension of coverage to ambulatory care would represent only a minor additional financial outlay to the public sector. This argument certainly had merit in the case of the Nordic countries, New Zealand and Canada where universal access to hospital care was already financed largely through public funds before the reforms. In Canada, universal access to hospitals was introduced under the National Hospital and Diagnostic Services Act of 1957, nine years before the Medical Care Act of 1966.⁸³ In Australia, access to treatment on public wards was introduced temporarily under the Hospital Benefits Act of 1946, years before entitlement was extended to ambulatory care in 1973.⁸⁴ In Great Britain, treatment of war casualties during World War I and World War II exposed the population to universal

⁸⁰ In Britain and the Nordic countries, they also became directly involved in financing ambulatory care through the clinical services provide by the state-employed Medical Officers of Health.

⁸¹ Subsidies were also introduced to prevent the bankruptcy of some funds.

⁸² Many Group II countries introduced similar legislation.

⁸³ Individual provinces, such as Saskatchewan and British Columbia, had previously introduced similar coverage.

⁸⁴ Queensland maintained this system after the other states reverted to a means-tested system.

entitlement to hospital care prior to the creation of the National Health Service in 1948, although this entitlement was retracted following the wars.

In the Nordic countries, the free-rider problem was extensively used to argue in favour of extending compulsory sickness insurance to the whole population. Low membership in the sickness funds in Sweden in the early 1950s provided additional ammunition for those who claimed that the potential gains from introducing compulsory participation in revenue collection outweighed the risk of increased expenditure due to universal entitlement. The low membership in the friendly societies in New Zealand prior to 1938 provided a similar argument. The restriction of ambulatory care to members of the sickness funds and those who could afford to pay cash in Norway in the early 1950s was thought to contribute to an inappropriate use of free institutional care by those who had no other coverage.⁸⁵ In Denmark and Canada, the reforms were originally proposed by conservative political groups who believed that centralised control over public expenditure would enhance administrative efficiency, and eliminate the misappropriation of public funds through high retention rates and reserves of some private insurance organisations. In New Zealand and the UK, the reformers feared that disability payments, sickness pay and illness-related unemployment benefits would reach astronomic levels if universal access to state-controlled health services were not created to monitor these potential abuses.

Figure 11.10 Government Responses to Market Failure

Market Failure in Health Care	Financing	Government responses
Risks, uncertainty, asymmetric information		Prepayment
Cost of health care, need		Prepayment
Moral hazards, free riders		Co-payments
Supplier induced demand, congestion		Co-payments
Monopolies, monopsonies,		Regulations
Endowments, insolvency		Subsidies
Rivalness, excludability, externalities		Public services
Free riders		Compulsory participation
Adverse selection		Universal entitlement

A caveat is necessary when discussing market failure in health care in the context of this study. Given that all the governments that introduced compulsory participation and universal entitlement had left wing ideologies, there is a risk that market failure was specifically highlighted in these countries in defence of these reforms. There is also a possibility that extensive government regulations, subsidies and direct provision of

⁸⁵ Advocates of reforms in the other Nordic countries made a similar claim prior to introducing universal sickness insurance, but it is impossible to validate this claim because of the many other factors that may have influence ambulatory/institutional utilisation ratios.

services distort imperfect markets more in these countries than in those where there is less government intervention, leading to a vicious circle of escalating imbalances. The international literature on market failure in health care comes almost exclusively from the UK, Canada, New Zealand, Australia and the Nordic countries, especially Sweden. There is much less literature on this subject from the US, Germany and France, where one would assume that market failure in health care is even more pronounced due to the less direct involvement of governments in correcting these imperfections. There is plenty of evidence that the phenomena described in the English and Scandinavian literature on market failure also exists in other countries. One possibility is that, in countries where governments have not tried to introduce compulsory and universal policies, state intervention may be viewed as a normal regulatory activity in response to market imperfections rather than as a socialist political agenda. Future work is needed to validate this hypothesis.

2. Normative Functions of Governments (how and what)

Whatever the reasons for the introduction various of degrees of participation in and entitlement to health services, the state needs the financial means to carry out its business, and policies on *how* and on *what* to spend them. Many of the differences that are observed in health care financing in the OECD can be explained by the choices that governments have made when faced with conflicts between their role in resource allocation, income distribution and stabilisation of economic activity.¹ These three activities have come to be viewed as normative functions of government in all western societies, irrespective of their political inclination: all use regulations, subsidies and direct provision of services as a way to allocate social goods; all use various forms of taxation (social insurance) and social security benefits (cash and in kind) as a way to redistribute income; and all use fiscal and monetary policies as a way to influence employment, prices and economic growth. Each plays an important role in addressing various market failures in the health sector. This study gave rich insights into how and what governments did to use health care financing as an instrument for performing these functions.² The introduction of legislation for compulsory participation and universal entitlement was part of this process.

Figure 11.11 Health Care Financing as Instruments of Public Policy

Functions	Allocation	Distribution	Stabilisation
Instruments	Regulations Subsidies Services	Revenue collection Reimbursements Benefits in Kind	Employment Cost Controls Production

a) Allocation Function

A distinction needs to be made in how several categories of goods and services are allocated in mixed-market economies.³ Some goods can be classified as **private goods**. These are marketable in that they can be sold at a price that is based on their market

¹ Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York: McGraw-Hill, 1984): 6-19.

² There is a danger of a tautological circle in the analysis of normative functions of governments. It is easy to postulate the functions that institutions fulfill and then rediscover these through empirical validation. The following analysis therefore has an unfortunate, but unavoidable fatalistic flavour. It is necessary to a fuller understanding of how, and not just why, governments became involved in the financing of health care.

³ Richard Rose, "Public employment and public expenditure," in *Public Expenditure: The Key Issues*, by John Bristow and Declan McDonagh, eds. (Dublin: Institute of Public Administration, 1986), 81-82.

value and are allocated efficiently through a competitive market mechanism. Both private firms and public enterprises may produce marketable goods. Private goods produced by public enterprises include transportation, postal services, energy and so on. Other goods can be classified as **public goods**. They are non-marketable because they lack rivalness and excludability, and often have externalities that make it difficult to limit their consumption to any individual user.⁴ Examples of these goods include military services, courts, police, fire departments. Everyone in society can share their collective benefit. **Merit goods** are marketable but given away free-of-charge because governments judge it desirable that they be available without exclusion due to non-payment. Examples of these goods include food, housing and education.⁵ Finally, governments can choose to tax **demerit goods** such as tobacco and alcohol because of their undesirable effects.⁶ Through their allocation function, governments use regulations, subsidies and direct provision of goods and services as instruments to correct failures that occurs in the allocation of social goods in a competitive market, as well as to achieve a desired balance between them.⁷

Health care is not a homogeneous activity, and cannot be fitted into any one of these categories in either Group I or Group II countries. Most health care goods and services are mixed goods because they have some rivalness and some excludability.⁸ For example, the benefits of immunisation are not only externalised like public goods by preventing the spread of disease in the community, but are also internalised like private goods by preventing personal illness which leads to rivalness and excludability if the supply of vaccine is limited. Yet, public health services, such as disease control, prevention and health promotion are usually provided as public goods. Hospital care and physician services, although marketable, are increasingly provided as merit goods, free-of-charge or with modest co-payments. Long-term residential care for those who are dependent on the rest of society at either extreme of the life cycle is often still regarded a private good.

⁴ P.A. Samuelson, "The pure theory of public expenditures," *Review of Economics and Statistics* (November 1954): 386-89; P.A. Samuelson, "Diagrammatic exposition of a theory of public expenditures," *Review of Economics and Statistics* (1955): 350-56; H. Aaron and M.C. McGuire: "Efficiency, equity and optimal supply of a public good," *Review of Economics and Statistics* (February 1969); J.M. Buchanan, *The Demand and Supply of Public Goods* (Chicago: Rand McNally, 1968); M. Peston, *Public Goods and the Public Sector* (London: Macmillan, 1972); J.M. Buchanan, *The Demand and Supply of Public Goods* (New York: Rand McNally, 1968); J.G. Head, *Public Goods and Public Welfare* (N. Carolina: Duke University Press, 1974).

⁵ A. Sandmo, "Ex post welfare economics and the theory of merit goods," *Economica* 50(1983): 19-33; K.J. Arrow and F.H. Hahn, *General Competitive Analysis* (Edinburgh: Oliver and Boyd, 1971); E. Malinvaud, *Lectures on Microeconomic Theory* (Amsterdam: North-Holland, 1972); H.R. Varian, *Microeconomic Analysis* (New York: Norton, 1978).

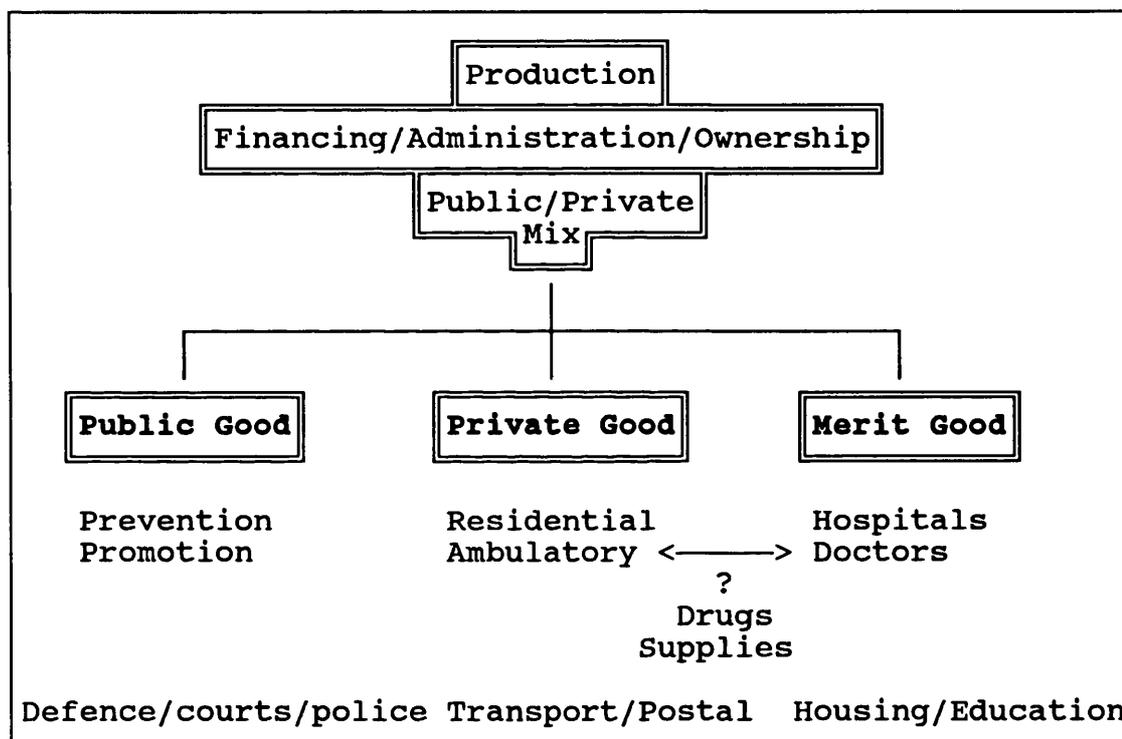
⁶ W. Baumol, "On taxation and the control of externalities," *American Economic Review* (June 1972).

⁷ The term social goods will be used generically to refer to public goods, mixed goods and merit goods.

⁸ John G. Cullis and Peter A. West, *The Economics of Health: An Introduction* (Oxford: Martin Robertson, 1979): 36-38; Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York: McGraw-Hill, 1984): 71-73; Carl S. Shoup and John Head, "Public goods, private goods and ambiguous goods," *Economic Journal* (September 1969); J.M. Buchanan, "An economic theory of clubs," *Economica* (February 1965).

Institutions for this kind of care usually require payments by residents or their families. Their ownership and management is shared between the private and public sectors. Most countries also make a limited number of these institutions available as merit goods through public subsidies for patients who could not afford to pay. Ambulatory care not provided by doctors, pharmaceuticals, medical appliances and so on is more difficult to place. Sometimes it is sold as private goods; at other times they are provided as merit goods.

Figure 11.12 Public, Private and Merit Goods



The principal difference between health care financing in Group I and Group II countries is the place that the boundaries are drawn to account for some of these differences in the allocation of health care as an economic good. When they introduced compulsory prepayment and universal entitlement, countries in Group I choose to treat most health services as merit goods, irrespective of whether or not sub-components behave more as public, mixed or private economic goods. The intention was to eliminate the elements of excludability and rivalness based on ability to pay. Previous restrictions to access based on market forces and ability to pay were replaced by professional control and limits in the supply of public resources.⁹ Direct charges were maintained on some excluded goods and services, and as symbolic co-payments on others. In Canada, only

⁹ Doctors and other health care providers act as gate-keepers to access in even the most highly planned systems.

hospital care and services provided by doctors were initially treated as merit goods. All other ambulatory care continued to be treated as private goods. In New Zealand, Norway, Sweden and Finland general practitioners continued to charge a fee, while patients received a partial reimbursement from the state or insurance fund. In the UK, above-standard care continued to be provided through a small private sector. Direct charges and co-payments were continued on pharmaceuticals and medical supplies in almost all countries.

Although the classification of most health care as a merit good helped Group I countries overcome some of the problems created by market failure, it created others. The nature of the economic good determines its efficient and equitable allocation, not its production function or arbitrary classification as a merit good by governments. Components that behaved as private goods continued to be allocated more efficiently and equitably through a decentralised market mechanism based on consumer preference, and some out-of-pocket payment. Components that behaved as public goods were better allocated through centralised planning. When these classifications were wrong, social goods became congested and began to behave increasingly like private goods. By offering doctors and other health care providers gratuities or "black money" to jump the queue, an underground market environment was sometimes created that undermined the official policy on how to treat the involved goods and services.¹⁰ This phenomena was observed to some extent in each of the eight case studies and many introduced subsequent reforms to deal with the resulting barriers to universal entitlement. More research is required to identify the threshold at which congestion takes place and the type of health care goods that are most vulnerable to this phenomenon.

Apart from the problems that were created by underground markets, no western country can claim to have found the ideal solution to the planned allocation of social goods.¹¹ In practice, national resource allocation is usually carried out in a haphazard manner, based on a combination of historical trends, influenced by public choice (voters),

¹⁰ In recent years this has become especially apparent in the former Eastern European communist countries. Patients make significant co-payments due to gratuities despite universal entitlement to all health care as a merit good.

¹¹ R. Klein, "Priorities and the problems of planning," *British Medical Journal* 22(1977): 1076-7; B.-A. Kaminsky, "Rational planning models for resource allocation in health care," *Health Management Forum* (Summer 1984): 43-57; A.B. Atkinson, *The Economics of Inequality*, 2nd Edition (Oxford: Clarendon Press, 1983); Julian Le Grand, *The Strategy of Equality Redistribution and the Social Services* (London: George Allen and Unwin, 1982); N. Mays and G. Bevan, *Resource Allocation in the Health Service: A Review of the Methods of Resource Allocation Working Party (RAWP)* (London: Bedford Square Press/NCVO, 1987); A. McGuire, "Ethics and resource allocation: An economist's view," *Social Science and Medicine* 22(1986): 1167-74; G.H. Mooney and A. McGuire, eds., *Medical Ethics and Economics in Health Care* (Oxford: Oxford University Press, 1988).

pressure groups, political parties and the power of various ministries.¹² As a result of these forces, the regional budgets (B_r) of most western countries remain historical and resource-driven. The previous year's regional budget (B_{t-1}) is increased incrementally to accommodate approved requests from individual institutions ($B_{i..n}$).

$$B_r = (B_{t-1} + \Sigma B_{i..n})$$

The UK and Nordic countries were among the first to try to improve the planned allocation process by basing their regional budgets on a baseline adjusted budget that was determined by the population structure of the region (B_b) and adjusted for morbidity (M), socio-economic factors (S), resource levels (R) and cross-boundary flows (F) as well as other factors (K).¹³ Canada and Australia tried similar techniques at the regional level within individual provinces and states. These techniques have reduced but not eliminated inequities because, even the most sophisticated statistical analysis,¹⁴ cannot address the fundamental question of the relationship between need and provision of health care.¹⁵

$$B_r = B_b[M,S,R,F \dots K]$$

A variety of methods have been tried to improve the planned allocation of resources to local institutions (B_i). Retrospective reimbursements may be based on price (P) and services rendered (Q) such as admissions, length-of-stay or individual services ($B_i = \Sigma P_i Q_i$). This leads to a maximisation of output and expenditure without any guarantee of improved efficiency, effectiveness or equity. Diagnosis Related Group (DRG) reimbursements are a variation on retrospective systems.¹⁶ They also lead to maximisation of price (P_{DRG}) and services rendered (Q_{DRG}). Although they encourage internal efficiency because hospitals are paid the same for each episode of illness irregardless of the length-of-stay or the level of resources used. They also potentially lead to increased costs as institutions and health professionals maximise revenues ($B_t = P_{DRG} Q_{DRG}$) by manipulating volumes and diagnostic groups. Global prospective

¹² K. Arrow, *Social Choice and Individual Values*, 2nd ed., (New York: Wiley, 1951); and D. Mueller, *Public Choice* (Cambridge: Cambridge University Press, 1979); Alan R. Ball and Frances Millard, *Pressure Politics in Industrial Societies: A Comparative Introduction* (London: MacMillan, 1986).

¹³ United Kingdom, Department of Health and Social Security, *Sharing Resources for Health Care in England: Report of the Resource Allocation Working Party* (RAWP) (London: HMSO, 1976); Michael Butts, Doreen Irving and Christopher Whitt, *From Principles to Practice* (London: Nuffield Provincial Hospital Trust, 1981); M.J. Buxton and R.E. Klein, *Allocating Health Resources: A Commentary on the Report of the Resources Allocation Working Party* (London: HMSO, 1978).

¹⁴ Coopers and Lybrand, *Integrated Analysis for the Review of RAWP* (London: Coopers and Lybrand, 1988).

¹⁵ Roy Carr-Hill, "RAWP is dead: Long live RAWP," in *Competition in Health Care: Reforming the NHS* by A.J. Culyer, A.K. Maynard and J.W. Posnett, eds. (London: Macmillan, 1990): 192-200; United Kingdom, Department of Health and Social Security (DHSS), *Review of the Resource Allocation Working Party Formula* (London: HMSO, 1988).

¹⁶ Raymond R. Arons, *The New Economics of Health Care: DRGs Case Mix, and Length of Stay* (New York: Praeger, 1984); R.B. Fetter, Y. Shin, J.L. Freeman, R.F. Averill, and J.D. Thompson "Case Mix Definition by Diagnosis Related Groups," *Supplement, Medical Care* 18(20)(1980): 1-53.

reimbursements may be based on planned allocation formulas. Health Management Organisations (HMOs) or Preferred Provider Organisations (PPOs) are local variations on prospective reimbursements.¹⁷ The key variables needed to establish an equitable budget in all of these cases are often missing: population, case-mix, socio-economic factors and so on ($B_t = (B_0[M,S,R,F \dots K])$). All lead to some inequity as better performing institutions grow stronger and laggards fall further behind. Group I countries use the prospective model more than the retrospective model, and visa versa for Group II countries. But this is not a hard fast rule.

The planned allocation of scarce resources requires a trade-off between two conflicting concepts -- Pareto efficiency and social justice or equity. These issues were not resolved through the introduction of compulsory prepayment and universal entitlement. Central strategies often failed to be transmitted to the local level.¹⁸ Because of incremental changes over time, political pressure tactics, practice styles, ideology and class struggles,¹⁹ the resources of local institutions within a given region continued to vary greatly. The definition of catchment populations, cross-boundary flows, centres of excellence, the balance between capital and recurrent expenditure, limited resources, unbalanced demands and so on all created the same problems following the reforms as they do today.²⁰ Local institutions, departments and individual health care providers were able to remain unresponsive to central strategies. What was intended as a rational top-down approach to resource allocation often end up as a bottom-up utilisation drive system because of retrospective reimbursements or manipulation of global budgets at the institutional level.²¹ The resulting imperfections in planning were at times as inefficient and inequitable as the market failures they were intended to replace. These issues, which remain largely unresolved, are at the centre of the health care financing reforms taking place today in both Group I and Group II countries.

b) Distribution Function

A distinction can be made in how income and wealth is distributed and how resources are allocated in market economies.²² Efficient use of resources requires that factors of

¹⁷ Peter Boland, *The New Healthcare Market: A Guide to PPOs for Purchasers, Payors and Providers* (Homewood, Illinois: Dow Jones-Irwin, 1985).

¹⁸ R.E. Klein and J. Lewis, *The Politics of Consumer Representation: A Study of Community Health Councils* (London: Center for Studies in Social Policy, 1976).

¹⁹ Rudolf Klein, *Ideology, Class and the National Health Service*, Project Paper No. RC4 (London: Kings Fund, 1980).

²⁰ Princeton University and Bristol-Myers Squibb Company, *The Economics of Health Care: Challenges for the Nineties* (London: MEDIQ, 1990).

²¹ Michael Ellman, *Socialist Planning*, 2nd Edition (Cambridge: Cambridge University Press, 1989).

²² Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York: McGraw-Hill, 1984): 82-101.

production equal the value of their marginal product. But distribution of income is rarely equal to the proceeds from the sale of factor products in either capitalist or socialist societies. Instead, distribution of income is based on a number of imperfect factor endowments. Labour endowments depend on the ability and desire to sell personal services. These are influenced by variables such as education, professional skills, salary structure, family connections, social status, personality, race, sex, age and so forth. Capital endowments depend on inheritance, marriage and lifetime savings. These are also influenced by variables similar to those described for labour income. Health status can be seen as both a natural and acquired endowment. In contrast to the allocation of resources, Pareto efficiency and social welfare functions fail to provide a satisfactory or fair mechanisms for the distribution of income. This has led some authors to claim that "just and equitable distribution is not within the purview of economics but should be left to philosophers, poets and politicians."²³ Natural-law philosophers such as Hobbes and Locke would support endowment-based criteria. Bentham and Mills would support utilitarian criteria. Rousseau, Marx and Rawls would support different variations on egalitarian criteria.

Through their distribution function, governments try to correct some of the inefficiencies and injustices that occurs in the natural distribution of income and accumulation of wealth. They use two sets of instruments for this purpose -- revenue collection and income redistribution. A gross overview of the current accounts of most western countries indicates that the main instruments used for revenue collection are taxation, social insurance, grants, interest, loans and other miscellaneous categories.²⁴ The balance between these categories, and between central and local levels of government varies greatly from one country to another.²⁵ On the expenditure side, outlays are made on goods and services, transfer payments, grants-in-aid, interest and other miscellaneous categories. A distinction once again needs to be made between central and local government spending as well as between capital and current expenditure. Because funds are usually pooled rather than earmarked, the revenue collection process is rarely directly linked to the distribution process (pensions and unemployment benefits. The instruments used to achieve efficiency and equity in the two processes are likewise different.

²³ Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York: McGraw-Hill, 1984): 83.

²⁴ For a detailed taxonomy of the different modalities of revenue collection, see Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York McGraw-Hill, 1984) and A.R. Prest and N.A. Barr, *Public Finance: In Theory and Practice* (London: Weidenfeld and Nicolson, 1985). In developing countries, grants in the form of foreign aid may be a significant component revenues. A.R. Prest, *Public Finance in Developing Countries*, 3rd Edition (London: Weidenfeld and Nicholson, 1985).

²⁵ OECD, *Revenue Statistics of the OECD Member Countries, 1965-1985* (Paris: OECD, 1986).

Much of the literature on the welfare state deals with various aspects of efficiency and equity relative to the income distribution function of governments. Revenue collection for health care is clearly part of this process, but with rare exceptions,²⁶ it is usually treated as part of the resource allocation function or a pooling of risk through insurance.²⁷ Health care provided through the public sector is a benefit in kind, and patient reimbursements are a form of transfer payment or cash benefit. The governments of the eight countries examined in this study intended compulsory and universal entitlement to serve as an instrument for income redistribution, and not only to protect the population against the uncertainties of illness.

Two issues and their associated policy options were at the centre of the debates on revenue collection during the reform period -- direct versus prepaid financing mechanisms and voluntary versus compulsory participation. As described earlier, the cornerstone of revenue collection in most western countries is prepayment, which falls into one of three broad categories: general revenues characterised by the British National Health Service, social insurance characterised by Bismarkian sickness funds and private insurance characterised by American consumer sovereignty.²⁸ Each of these was used to some extent by the eight countries at the time of their reforms. When faced with a choice between progressive, proportional or regressive contribution schemes, advocates of Pareto efficiency choose a progressive tax (social insurance) based on income and collected at source.²⁹ They argued that the coercive power of the poor needed to be exercised through the democratic political process to enforce income redistribution.³⁰ The continued use of direct charges and co-payments was defended and accused on the basis of both efficiency and equity criteria, as well as on broader socio-economic, political and bureaucratic grounds. In Sweden they were seen as an economic incentive to encourage the efficient use of scarce resources. In Canada they were seen as an ineffective way to influence efficiency and a regressive way to distribute the welfare burden illness. These issues remained unresolved in Group I countries.

Government redistribution strategies invariably require that significant efficiency/equity tradeoffs be made. First, as tax rates rise, a point is reached beyond

²⁶ R. Klein, J. Barnes, M. Buxton and E. Caven, *Social Policy and Public Expenditure* (London: Centre for Studies in Social Policy, 1974); J. Le Grand, "The distribution of public expenditure: The case of health care," *Economica* 45(1978): 125-42; Gottschalk, B. Wolfe and R. Haveman, "Health care financing in the US, UK and the Netherlands: Distributional consequences," 42nd Congress of the International Institute of Public Finance, Athens, 1986.

²⁷ K.J. Arrow, "Uncertainty and the welfare economics of medical care," *American Economic Review* 53(1963): 941-73. See the discussion on health insurance under the section on market failure in health care.

²⁸ J. Hurst, *Financing Health Care in the US, Canada and Britain* (London: King's Fund, 1985).

²⁹ H.M. Hochman and J.D. Rodgers, "Pareto optimal redistribution," *American Economic Review* 59(1957); J.M. Buchanan and G. Tullock, *The Calculus of Consent* (Ann Arbor: University of Michigan press, 1965); W.J. Blum and H. Kalven, *The Uneasy Case for Progressive Taxation* (Chicago: University Press, 1953).

³⁰ A. Downs, *An Economic Theory of Democracy* (New York: Harper, 1957).

which revenues and funds available for redistribution actually decline because individuals work less.³¹ Second, it lowers disposable income which might be spent on food, housing and so on, which have a significant indirect impact on health. The limits to acceptable loss in efficiency in exchange for equity gains are not clear in health care and the cutoff-point at which this occurs is open to considerable debate.³²

Detailed analysis of equity in health care financing is complex because the source of revenues is diverse and pooled.³³ Although Gini coefficients and Lorenz curves have been used as indicators of income inequality,³⁴ they are less useful in the analysis of health care financing.³⁵ Analysis of equity in revenue collection for the health care can nevertheless be separated into vertical and horizontal components.³⁶ Vertical equity requires that contributions be related to ability to pay, and that unequals be treated in an appropriately dissimilar way. Several models have been developed for measuring vertical equity,³⁷ which is determined by the progressivity of the contribution scheme.³⁸ Horizontal equity requires that contributions be similar among those with comparable income or wealth, and that equals be treated equally. Methodologies for measuring this in terms of family size, pre-tax versus post-tax income, capital assets and inherited wealth are much more complex.³⁹ Couple the collection and benefit processes through risk-rated contributions and membership-dependent access works against both of these components of equity.

³¹ This point can be calculated using the Laffer curve. D. Fullerton, "On the possibility of an inverse relationship between tax rates and government revenues," *Journal of Public Economics* 19(1)(1982).

³² Rudolf Klein, Robert Pinker, Peter Collison and A. J. Culyer, *Acceptable Inequalities? Essays on the Pursuit of Equality in Health Care?* by David G. Green, ed. (London: IEA Health Unit, 1988).

³³ A. Wagstaff, "Progressivity and horizontal equity in the finance of health care: Some tentative cross-country comparisons," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

³⁴ A.B. Atkinson, "On the measurement of inequality," *Journal of Economic Theory* 2(1970): 244-63; A.B. Atkinson, *The Economics of Inequality* (Oxford: Clarendon Press, 1975); F.A. Crowell, *Measuring Inequality* (Oxford: Philip Allan, 1977); A.K. Sen, *On Economic Inequality* (Oxford: Clarendon Press, 1973).

³⁵ M. Sawyer, "Income distribution in OECD countries," in *OECD Economic Outlook Occasional Studies* (Paris: OECD, 1976).

³⁶ M.C. Berliant and R.P. Strauss, "The horizontal and vertical equity characteristics of the federal individual income tax 1966-1977," in *Horizontal Equity, Uncertainty and Economic Well-Being* by M. David and T.M. Smeeding, eds. (Chicago: Chicago University Press, 1985).

³⁷ N.C. Kakwani, "Measurement of tax progressivity: An international comparison," *Economic Journal* 87(1977): 71-80; N.C. Kawani and N Podder, "Efficient estimation of the Lorenz curve and associated inequality measures from grouped observations," *Econometrica* 44(1976): 137-48; D. Suits, "Measurement of tax progressivity," *American Economic Review* 67(1977): 747-52; W.J. Smith, "A comparison of two new measures of tax progressivity," *Economic Journal* 91(1981): 1015-9.

³⁸ P.J. Lambert, "Tax progressivity: A survey of the literature," *Working Paper* (London: Institute of Fiscal Studies, 1985); J.P. Formby, T.G. Seaks and R. Hemming and M.J. Keen, "Single-crossing conditions in comparisons of tax progressivity," *Journal of Public Economics* 20(1983): 373-80.

³⁹ R.D. Plotnik, "A measure of horizontal inequity," *Review of Economics and Statistics* 63(1981): 283-88; R.D. Plotnick, "The concept and measurement of horizontal inequity," *Journal of Public Economics* 17(1982): 283-88; and L. Kaplow, "Horizontal equity: measures in search of a principle," *National Tax Journal* (1989); A.B. Atkinson, "Horizontal equity and the distribution of the tax burden," in *The Economics of Taxation*, by H. Aaron and M. Boskin, eds. (1980).

These techniques were not well developed at the time most countries in Group I introduced their legislative reforms. Instead, their governments believed that compulsory participation by those who were able to pay was the most efficient and equitable way to collect revenues for universal entitlement to health care. No quantitative analysis was conducted to calculate the progressivity of the proposed financing mechanisms. The main concern was to extend and enforce the contribution base as broadly as possible.

Two issues and their associated policy options were also at the centre of the debates on the distribution of health care as a benefit in kind -- restricted versus universal entitlement and basic versus comprehensive services. The efficiency and equity of health care as an instrument of income redistribution need to be distinguished from similar issues in revenue collection and resource allocation. Based on the law of diminishing marginal utility, inequalities are inefficient in that they satisfy less urgent needs of the rich at the expense of the more urgent needs of the poor.⁴⁰ The transfer of income from the rich to the poor can therefore be justified from a utilitarian point of view because it would satisfy more intense wants at the expense of less intense wants.⁴¹ Scholars during the 1940s used egalitarian arguments to justify dividing income equally.⁴² Others since then claim that, because people's tastes differ, the marginal utility of income differs and the maximisation of minimum standards may be preferable over equality.⁴³

Applying these arguments to health care as a benefit in kind, some countries maintain that entitlement should be equal for the whole population while others favour targeting needy populations. Some offer comprehensive services while others limit benefits to a minimal set of basic services. Countries in Group I adhere to the former view, while those in Group II adhere to the latter. The introduction of compulsory prepayment and universal entitlement to comprehensive health services were the policies chosen by the countries of the eight case studies.

Conceptually, the role health care plays as an instrument of redistribution need to be analysed in terms that are different from those for the allocation of public and social goods in response to market failure. Conflicts often exist between the most efficient and equitable redistribution of health care as a benefit in kind and the allocation of health care as goods and services.⁴⁴ Each function can and should be evaluated on its own merit so that the compromises that are made along the way are clear.

⁴⁰ H. Dalton, *Some Aspects of Inequality of Incomes in Modern Communities* (London: Routledge, 1920): 10.

⁴¹ A.C. Pigou, *The Economics of Welfare* (London: Macmillan, 1932): 89.

⁴² A.P. Lerner, *The Economics of Control* (London: Macmillan, 1944).

⁴³ A.K. Sen, *On Economic Inequality* (Oxford: Clarendon Press, 1973).

⁴⁴ Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice*, 4th Edition (New York: McGraw-Hill, 1984): 18.

The transfer of income from the "relatively well to the relatively sick" can be carried out effectively through the various forms of prepayment of health care.⁴⁵ Central planning may be an effective way to respond to market failures in the efficient and equitable allocation of health care goods and services, but insufficient as instruments for redistributing endowments unless policies are designed to achieve this objective. Natural and acquired health, and the resulting requirements for health care, are influenced by both labour and capital, as well as by the many variables that influence these endowments.⁴⁶ The lower down the socio-economic scale, the greater the prevalence of illness and potential benefit from health care. Observed increases in reported illness among lower social groups are rarely matched by the rate of increase in utilisation of health care.⁴⁷ Resource allocation mechanisms therefore do not fulfill the requirements for additional redistribution.⁴⁸ Universal entitlement as a resource allocation mechanism may not achieve this objective. Additional targeting for the needy populations may be necessary.

Figure 11.13 Health Care as a Benefit in Kind

Issues	Policy options
Revenue collection	
<i>Mechanisms</i>	Direct charges versus prepayment
<i>Participation</i>	Voluntary versus compulsory
Benefits in kind	
<i>Entitlement</i>	Restricted versus universal
<i>Services</i>	Basic versus comprehensive
Linkages	
<i>Contributions</i>	Risk-rated versus non-rated
<i>Access</i>	Membership-dependent versus open-ended

c) Stabilisation Function

The stabilisation function of government can be achieved through two mechanisms -- fiscal policy and monetary policy.⁴⁹ At first glance health care does not appear to be directly involved in either of these processes. This is a false impression. When health care financing depends on public funds, as it did in all the countries examined in this study as well as in most other western countries, activities in the health sector have a significant

⁴⁵ A.J. Culyer, *The Political Economy of Social Policy* (Oxford: Martin Robertson, 1980): 124-27.

⁴⁶ E. Collins and R Klein, "Equity and the NHS: Self-reported morbidity, access and primary care," *British Medical Journal* 281(1980): 1111-15; B. Buhmann, L. Rainwater, G. Schmaus and T.M. Smeeding, "Equivalence scales, well-being, inequality and poverty: Sensitivity estimates across ten countries using the Luxembourg Income Study Database," *Review of Income and Wealth* (June 1988): 115-42; M.A. King, "An index of inequality: With applications to horizontal equity and social morbidity," *Econometrica* 51(1983): 99-115.

⁴⁷ J. Le Grand, "The distribution of public expenditure: The case of health care," *Econometrica* 45(1978): 125-42.

⁴⁸ It could be argued that this is a failure of the allocation function, but equitable allocation may still fall short of the need for additional redistribution.

⁴⁹ Richard A. Musgrave and Peggy B. Musgrave, *Public Finance in Theory and Practice, 4th Edition* (New York: McGraw-Hill, 1984): 14-16.

impact on economic stabilisation and vice versa. The usual targets of Keynesian policies are employment, prices and economic growth. Monetarist concerns with the adverse effects of deliberate manipulation of these factors ignore the indirect effects that government involvement in resource allocation and income distribution has on stabilisation. Health care expenditure, which continues to increase in most western countries, influences not only growth, but also employment, aggregate demand and prices. Cost containment policies to counteract this trend have filled the health care literature during the 1980s,⁵⁰ but they are seldom referred to as stabilisation policies.⁵¹ Although public sector deficits are making these strategies seem all the more urgent in recent years,⁵² this study did not find a significant correlation between indicators of socio-economic development (GDP per capita, economic growth and national debt) and the introduction of compulsory participation and universal entitlement.⁵³

The potential economic impact of public involvement in health care financing was a subject considerable debate during the period leading up to the reforms. Two different points of view were expressed in the eight case histories. There were those that warned that universal entitlement to health care would lead to a cost explosion and increased public expenditure on health care to the point where it would damage economic stability and public expenditure on other social benefits. Opponents to this point of view claimed that because the public sector already financed hospitals, the most expensive part of health care, it would be advantageous to also have greater control over these expenditures. It was felt that compulsory participation would not only increase revenues, but that it would also give authorities more control over the services that it already financed.

Longitudinal analysis of health care expenditure trends, opportunity costs and displacement effects indicated that both of these divergent points of view had some merit. In nominal values, public expenditure on health care increased rapidly both before and after the introduction of compulsory participation and universal entitlement in each of the eight countries. (See the example below and the Appendix for the remaining countries). Similar increases have, however, occurred in all OECD countries and the rate

⁵⁰ Klaus-Dirk Henke, "Cost containment in health care: Justification and consequences," to be published in *Health Economics Worldwide* by P. Zweifel and H.E. French (Kluwer, 1991); Alexander S. Preker, "Expenditure control through public financing in the OECD," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990; Antony J. Culyer, "Cost containment in Europe," Annual Supplement, *Health Care Financing Review* (1989): 31; and Brian Abel-Smith, *Cost Containment in Health Care*, Occasional Papers on Social Administration (London: Bedford Square Press, NCVO, 1984).

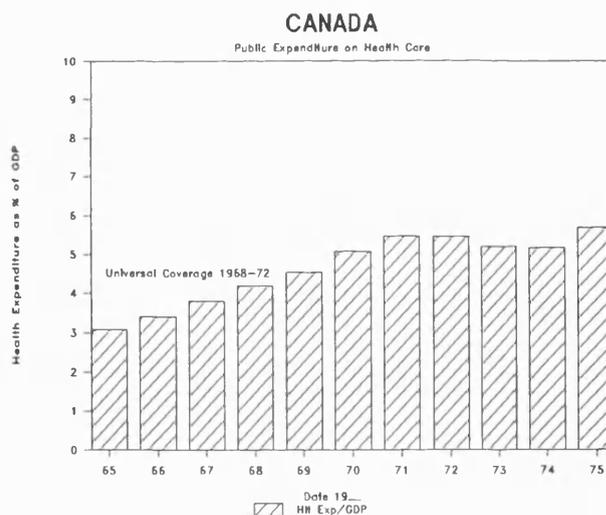
⁵¹ M. Huber and M. Schneider, "Evaluation of the Health Care Reform Act of 1989 on economic growth, employment and prices in the FRG," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁵² Henry Cavanna, ed., *Public Sector Deficits in OECD Countries: Causes, Consequences and Remedies* (London: Macmillan, 1988).

⁵³ See discussion on outcome in the section below.

of growth in Group I has not been significantly greater than those in Group II.⁵⁴ Health care expenditure represented in this way is deceptive because it ignores a number of important hidden features that were difficult to measure in their historical context: demographic growth, health care price increases, changes in utilisation per capita and growth in GDP.⁵⁵ Information on health care price indexes, GDP deflators and utilisation rates was unreliable during the period of the early reforms, making it impossible to represent these trends in real values. Relative to GDP, health care expenditure stabilised during the decade that followed the reforms in most of these countries.⁵⁶ In most cases, GDP elasticity of health care expenditure was less than 1.0 during this period which indicates that relative changes in health care expenditure per GDP did not distort the trends.⁵⁷ The mean elasticity for the OECD group was 1.7 from 1960-75 and 1.3 from 1975-87 in real values.⁵⁸ Both are higher than what was observed following the reforms.

Figure 11.14 Health Care Expenditure Trends During Decade Following Reforms



⁵⁴ François Champagne, André-Pierre Contandriopoulos, Anne Lemay and Alexander S. Preker, "Evaluation of health care performance in the OECD," Second World Congress on Health Economics, University of Zurich, Switzerland, September 10-14, 1990.

⁵⁵ George J. Schieber and Jean-Pierre Poullier, "Overview of international comparisons of health care expenditures," Annual Supplement, *Health Care Financing Review* (1989): 1-9.

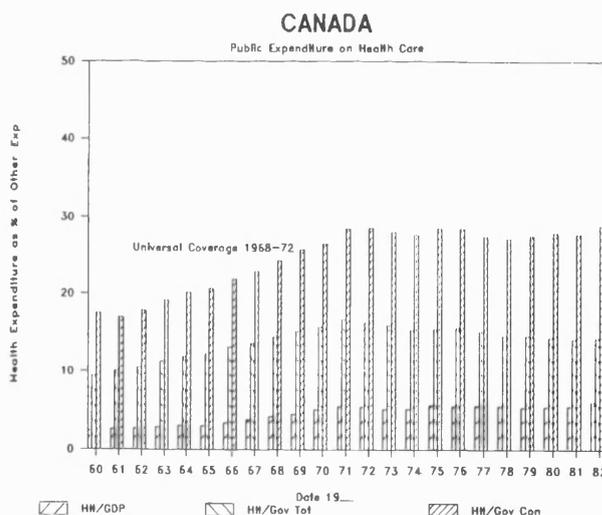
⁵⁶ In each of the countries, the reform was associated with an initial increase in health care expenditure per GDP, which then stabilised during the decade that followed. In Finland, stabilisation of health care expenditure did not occur until after introduction of the Public Health Act of 1972; in New Zealand there was a modest increase throughout the early reform period.

⁵⁷ GDP elasticity of health care expenditure is defined as the percentage change in per capita health care expenditure divided by the percentage change in per capita GDP.

⁵⁸ Antony J. Culyer, "Cost containment in Europe," Annual Supplement, *Health Care Financing Review* (1989): 31.

Health care expenditure relative to total government expenditure and government consumption expenditure also stabilised during the decade that followed the reform. This indicates that the reform was not associated with a significant opportunity cost or displacement effect in terms of money that could have been spent on other economic activities or public works. Government total expenditure and government consumption expenditure increased relative to GDP, which indicated that the public sector continued to consume an increasing part of these economic resources of these countries and that there was both a willingness and capacity to pay. Following this initial decade of stability, public expenditure on health care increased compared with GDP and rose in an erratic manner until the early 1980s, as did expenditure on other social benefits financed through the public sector. It rose more slowly, than total government expenditure. (See the example below and the Appendix for the remaining countries).

Figure 11.15 Historical Health Care Expenditure Trends



There are several compelling arguments in favour of cost containment in health care, but each has its shortcomings. First, since consumer preferences for social goods are concealed, cost containment may be seen as a way to set limits. But arguments that public opinion is expressed through the election process are unconvincing because cost containment is rarely a central issue. Second, it is often presented as a way to force institutions to become more efficient and effective. But in practice, repairs, maintenance and the quality of services deteriorate without eliminating waste. Third, it offers the possibility of stability in health care expenditure relative to the state budget and GDP. But in practice, this only occurs when the budget and GDP also remain stable. Fourth, it

is a way to limit health care expenditure according to the capacity to pay. But there is no evidence that the health sector can contract as rapidly as restrictive fiscal policies are introduced during periods of economic hardship. Instead, it leads to health sector deficits and a destabilisation of service delivery. Finally, advocates of cost containment claim that expenditure on health care encroaches on other social sectors that have a significant impact on health and that it may have a "crowding-out" effect on the private sector. There was no evidence for this in the study. Nor is there any evidence in the literature that more meritorious alternatives are chosen when public sector spending on health care is curtailed or that saving lead to more productive re-investments in other areas of the economy.

This leads to equally compelling counter-arguments against cost containment which also have serious failings. First, if medical care confers benefits in terms of health, the opportunity cost of cost containment may be higher than the savings gained. But cost-benefit and cost-effectiveness studies are not yet advanced enough to establish convincing evidence to support this claim and treatments that lead to increased life-expectancy adds the cost of caring for the more fragile elderly. Furthermore, the human desire to avoid illness and death outstrips the capacity to pay even in the richest countries. Second, health care is a production function in itself that is hurt by aimless cost containment. It employs workers and provides income that is recycled through the economy. Such growth may, however, be undesirable when restrictive fiscal policies are being used to stabilise prices and economic growth. Third, because unemployment is associated with deteriorating health status, cost containment at the time of economic hardship weakens the social infrastructures needed to respond to the potentially increased demand for services. Critics of health care would of course say that the focus is wrong. Food, housing and income support may be more meritorious at such times and have a greater impact on health than health care itself. Finally, in mixed systems, cost containment in the public sector does not stop expenditure in the private sector, but it may hurt equity at a time when this is needed the most.

In addition to the unresolved debate described above, there are also several conceptual problems associated with the generic term cost containment, which is sometimes interchanged inappropriately with the notions of cost recovery and co-payments. The term may refer to either aggregate expenditure trends at the national level or specific institutional responses at the local level. It may refer to public expenditure and leave private expenditure uncontrolled. It may refer to direct costs and ignore indirect costs such as waiting time, lost work and the value of good health. Some authors even question whether cost containment by itself is a valid health care policy option. Because most health care goods and services are not allocated by a market mechanism, the optimal and desired level of spending from the point of view of the consumer is largely

unknown. When spending caps are set too low, congestion occurs and black markets develop which defeats the normative function of governments in the resource allocation process.

The most serious flaw in analyses of expenditure and cost containment policies in the health sector is therefore the lack of positioning of these policies in relation to the three normative functions of government that have been described in this section -- allocation, distribution and stabilisation. The role that health care plays as an instrument of stabilisation can and should be analysed in conceptual terms that are different from those for resource allocation and income redistribution because the objectives are different. When each is evaluated on its own merit, some of the contradictions become apparent. At a time of restrictive fiscal policies, cost containment may be correct from a stabilisation point of view. But it implies significant trade-offs in the redistribution of benefits in kind and the balance in resource allocation between different public and merit goods that should be accounted for in the final analysis. These issues were not properly analysed by the reformers who introduced compulsory participation and universal entitlement as a way to gain greater public control over the allocation of health care goods and services. They remain poorly analysed today.

3. Outcome to Public Financing of Health Care (to what effect)

An attempt was made to look not only at the determinants of policies relating to health care financing but also to establish correlations between these policies and other aspects of modern societies. With rare exceptions, virtually no studies have turned the usual questions about causal factors around and looked at the impact of health policy and expenditure on economic development, political processes, bureaucratic structures and responses to market failure. The few studies that have looked at these issues have left many questions unanswered and hypotheses on the impact of the welfare effort need to be validated before they are transferred to health care as a specific programme feature. Because macro-aggregates never describe reality perfectly, this analysis was supplemented by information from descriptive analysis. Standard indicators were developed to quantify a number of possible long-term effects of the reforms: economic performance, national debt, opportunity costs, displacement effects on social security, political backlash, public sector activity, health care expenditure and equity.⁵⁹

⁵⁹ The rationale for these indicators was described in the section on methodology. I was felt to be premature to include health status as one of these indicators.

Figure 11.16 Outcome Indicators

	Effect	Indicator
<i>Socio-economic Development</i>	Growth	GDP_{cap} and GDP_{gwt}
	Debt	GGD/GDP
	Opportunity cost	GCE/GDP
<i>Political Processes</i>	Displacement	GSE/GDP
	Backlash	HCE_{ela}
<i>Administrative Structures</i>	Expenditure	GTE/GDP and HCE_{ppp}/GDP_{cap}
<i>Market Failure Responses</i>	Equity	Pub/Tot

In the table below, Group I countries were assigned the "dummy" variable $\tau = 1$, while Group II countries were assigned $\tau = 0$. When the landmark legislation in Greece, Italy and Spain occurred too close to the date of the outcome indicators, these countries were assigned $\tau = 0$. Lack of consistent date made it necessary to omit some of the OECD countries, such as Portugal, Iceland, Switzerland and Turkey from this part of the analysis. The variables used were GDP per capita (GDP_{cap}), average real GDP growth rates (GDP_{gwt}), general government debt (GGD), government consumption expenditure (GCE/GDP), government social expenditure (GSE), GDP elasticity of health care expenditure (HCE_{ela}), general government total expenditure (GTE), purchase-power-parity-adjusted health care expenditure (HCE_{ppp}) and the ratio of public to total health care expenditure (Pub/Tot).⁶⁰ This representation allowed some of the abstract ideas described in the discussion on determinants to be translated into concrete concepts that could be measured and validated in a consistent way.

⁶⁰ See the Appendix, Table 11.4 for the references for the data used in the following tables.

Table 11.1 Outcome Indicators for Effects of Legislative Reforms

Years	τ	GDP	GDP	GGD/	GCE/	GSE/	GTE/	HCE	HCE/	HCE	Pub/
		cap	gwt	GDP	GDP	GDP	GDP	ppp	GDP	ela	Tot
		\$US	%	%	%	%	%	\$US	%	%	%
		87	65-87	85	87	87	87	1987	87	75-87	87
Aus	1	12612	1.8	25.2	18.0	10.8	28.8	939	7.4	0.9	70.5
Aut	0	11664	3.1	48.5	19.0	21.3	40.3	982	8.4	0.8	67.1
Bel	0	11802	2.6	126.6	16.0	36.9	52.9	879	7.4	1.6	76.9
Can	1	17211	2.7	69.2	20.0	4.2	24.2	1483	8.6	0.9	73.9
Den	1	13329	1.9	68.6	25.0	14.8	39.8	792	5.9	0.9	85.5
Fin	1	12838	3.2	20.2	21.0	10.9	31.9	949	7.4	0.9	78.6
Fra	0	12803	2.7	34.0	19.0	26.1	45.1	1105	8.6	3.1	74.8
Ger	0	13323	2.5	42.2	20.0	10.1	30.1	1093	8.2	0.9	78.4
Gre	1	6363	3.1	53.2	20.0	30.9	50.9	337	5.3	2.5	75.3
Ire	0	7541	2.0	128.3	18.0	42.4	60.4	561	7.4	1.5	87.0
Ita	1	12254	2.7	99.4	17.0	35.0	52.0	841	6.9	1.7	79.2
Jap	0	13182	4.2	69.4	10.0	7.4	17.4	915	6.9	1.4	73.0
Net	0	12252	2.1	70.3	16.0	41.7	57.7	1041	8.5	1.1	73.9
New	1	10680	0.9	45.0	15.0	32.1	47.1	733	6.9	0.9	82.5
Nor	1	15405	3.5	31.4	21.0	19.6	40.6	1149	7.5	2.0	97.6
Spa	1	8681	2.3	41.7	14.0	20.8	34.8	521	6.0	1.1	71.5
Swe	1	13771	1.8	71.4	27.0	15.9	42.9	1233	9.0	1.0	90.8
UK	1	12340	1.7	56.5	21.0	17.9	38.9	758	6.1	1.0	86.4
US	0	18338	1.5	48.3	21.0	2.3	23.3	2051	11.2	1.1	41.4

In the table below, the "dummy" variable τ became the independent variable which was used to validate hypotheses about correlations between the introduction of legislation for compulsory participation and universal entitlement to various aspects of socio-economic development, political processes, administrative structures and market failure through regression techniques.⁶¹ Much as positive correlations do not imply causality, when there was no correlation it disproved hypotheses on determinant relationships and popular myths. The negative findings were therefore in many respects more significant than the positive ones. The analysis was performed with and without countries such as Greece, Italy and Spain to rule out the possibility that late entrants might distort the findings.

Table 11.2 Regression Analysis Using τ as the Independent Variable

Independent Variable	R^2 with changes in $\tau = 0$		
	Full List	Spain Greece	Spain Greece Italy
Dependent Variables Below			
GDPcap	0.00	0.10	0.11
GDPgwt	0.03	0.06	0.07
GGD	0.02	0.04	0.12
GCE/GDP	0.11	0.19	0.24
GSE/GDP	0.03	0.06	0.14
HCEela	0.02	0.07	0.14
GTE/GDP	0.01	0.01	0.05
HCEppp/GDPcap	0.26	0.04	0.02
HCEppp	0.07	0.00	0.01
Pub/Tot	0.17	0.23	0.22
No. of Observations		19	
Degrees of Freedom		17	

⁶¹ The statistical significance and reliability of these observations are demonstrated in greater detail in the Appendix, Tables 11.5 and 11.6.

The most striking observation made in this study was the lack of a significant correlation between the introduction of landmark legislative reforms in Group I compared with Group II and most of the outcome indicators. Perhaps most significantly, there was no correlation between these reforms and most of the indicators for socio-economic development. The reform policies introduced by the countries in Group I did not correlate with problems in national wealth, economic growth or national debt. This contradicts claims by some critics who have argued that public expenditure increases the cost of production, lowers demand, displaces the productive labour force and makes industries less competitive.⁶² The indicators in this category are highly standardised and well recognised measures of economic performance and therefore least likely to suffer from distortions due to misinterpretation. Opportunity costs in terms of government consumption expenditure was, however, greater for Group I countries than for Group II when Greece, Italy and Spain were reclassified as $\tau = 0$. There was therefore weak evidence that these policies were associated with governments that had greater consumption expenditure, which might imply less private sector activity. Furthermore, this correlation does not imply causality because public sector activities, such as wages, are spent and recycled through the private sector in western countries.

The introduction of the reforms in Group I countries compared with those in Group II did not show any correlation with a displacement of revenues away from government social expenditure such as social security benefits or slow the expansion of the health sector: correlations with social expenditure and GDP elasticity of health care were both insignificant. The indicators used for political processes and backlash are less standardised than those use for socio-economic development. It is therefore necessary to supplement these findings with observations from the descriptive analysis. There has been a backlash against "free" entitlement to health care in both western and eastern European countries during the late 1980s. Financing through 'painfully visible' general revenues is the frequently cited cause of discontent. Some recent reforms may therefore represent a tax-revolt and anti-government sentiment rather than a backlash again prepayment of health care. But the proposals for reform often include a call for a return to direct charges rather than prepayment which, in the long run, will have a significant negative impact on

⁶² David Cameron, "On the limits of the public economy," *Annals of the American Academy of Political and Social Science* 459(1982): 46-62; Manfred G. Schmidt, "Does corporatism matter? Economic crisis, politics and rates of unemployment in capitalist democracies in the 1970s," in *Patterns of Corporatist Policy-Making* by G. Lehmbruch and Philippe C. Schmitter, eds. (Beverly Hills: Sage, 1982); Richard Rose, ed., *The Dynamics of Public Policy: A Comparative Analysis* (Beverly Hills: Sage, 1976); and Richard Rose and Guy Peters, *Can Governments Go Bankrupt* (New York: Basic Books 1978); Henry Cavanna, ed., *Public Sector Deficits in OECD Countries: Causes, Consequences and Remedies* (London: Macmillan, 1988).

equity and financial protection against the risk of illness. It is too early to know if the countries in Group I are more prone to this trend than those of Group II.

Correlations between the introduction of compulsory participation and universal entitlement with administrative infrastructures was less clear. The reforms were not associated with larger public sectors than in countries that had not introduced these policies, but it did show a weak correlation with higher total health care expenditure per GDP. This observation is surprising because it contradicts most of the current anecdotal evidence in the literature that public sector involvement in health care is an effective way to control costs: "the general conclusion [is] that centralised cash-limited budgets have a significant negative impact on the total and that public finance also reduces total expenditure,"⁶³ because governments are more likely to impose expenditure caps and global budgets than insurance funds. This negative observation is highly significant, because it may indicate that there are some serious problems in existing cost containment theories that need to be re-examined. It merits much more detailed work than was possible during the study. The fact that the observation only holds true when Greece, Italy and Spain were classified as $\tau = 1$ indicates that these countries contribute positively to the correlation. The eight case studies demonstrated that there was always a transient increase before health care expenditure per GDP finally stabilised and decreased during the decade after the reform. This may be the effect observed in the regression analysis.

Finally, the introduction of compulsory participation and universal entitlement was associated with a greater degree of public financing for health care than in countries that do not have these provisions, irrespective of whether the prepayment is made through general taxation, social insurance or health insurance. This observation was most significant when the late entrants, Greece, Spain and Italy, were excluded. Taxes, cash transfer payments, indirect benefits in kind and other publicly financed programmes all lead to income redistribution and greater economic equality for the non-working poor -- the aged, single mothers, older workers and other unemployed.⁶⁴ In this respect the reforms were associated with greater equity than in countries that rely more on privately financed health care. Once again, however, the quantitative indicator used for this variable does not guarantee that other qualitative aspects of equity, such as access and comprehensiveness, will also be met. The impact of increased health care expenditure and

⁶³ Antony J. Culyer, "Cost Containment in Europe," Annual Supplement, *Health Care Financing Review* (1989): 31.

⁶⁴ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley: University of California Press, 1975); Richard Rubinson and Dan Quinlan, "The world economy and the distribution of incomes within states: A cross-national study," *American Sociological Review* 41(1976): 638-39; Richard Robinson and Dan Quinlan, "Democracy and social inequality: A reanalysis," *American Sociological Review* 42(1977): 611-23; and David Cameron, "The expansion of the public economy: A comparative analysis," *American Political Science Review* 72(4)(1978): 1243-361.

increase public financing could be offset by inefficient, ineffective and poor quality treatment. This study did not clarify hypotheses about these issues.

Because HCE_{ppp}/GDP_{cap} appeared to have a significant correlation with the introduction of compulsory participation and universal entitlement, this indicator was checked for cross-correlations against several of the other variables. The strongest cross-correlation was between HCE_{ppp} and GDP_{gwt} (R^2 squared = 0.83). This is similar to the observations that have been made by other authors who have carried out such analysis.⁶⁵ The temptation to conclude that a determinant relationship exist when statistical analysis reveals the presence of strong correlations should be resisted. Without concomitant path analysis, even a strong correlation like this fails to give unequivocal evidence of a causal relationship. The weak correlation between HCE_{ppp}/GDP_{cap} and the other variables, such as GSE/GDP , GTE/GDP and Pub/Tot , is not surprising because they are all cross-linked.

Table 11.3 Regression Analysis Using HCEppp as Dependent Variable

Dependent Variable = HCEppp	
Independent Variables Below	
	R2

GDPcap	0.83
GDPgwt	0.01
GGD	0.03
GCE/GDP	0.09
GSE/GDP	0.32
HCEela	0.03
GTE/GDP	0.24
Pub/Tot	0.25
No. of Observations	19
Degrees of Freedom	17

There are clear limits to relative growth in health care expenditure and the social sectors cannot continue forever to consume an increasing part of GDP.⁶⁶ At one point or another, growth in relative expenditure has to cease. This point has not yet been reached in western societies, although there is some anecdotal evidence from the late 1980s that

⁶⁵ Newhouse (1975 and 1977) found an $R^2 = 0.92$, Kleiman (1974), $R^2 = 0.92$, Culyer (1988), $R^2 = 0.91$, OECD, $R^2 = 0.81$, Parkin, McGuire and Yule (1987), $R^2 = 0.87$. J.P. Newhouse, "Development and allocation of medical care resources: Medico-economic approach," in *Development and Allocation of Medical Care Resources*, Proceedings of the 29th World Medical Assembly, Tokyo, Japan Medical Association, 1975; J.P. Newhouse, "Medical care expenditure: A cross-national survey," *Journal of Human Resources* 12(1)(Winter 1977): 115-125; E. Kleiman, "The determinants of national outlay on health," in *The Economics of Health and Medical Care* by M. Perlman (London: Macmillan, 1974); D. Parkin, A. McGuire and B. Yule, "Aggregate health care expenditures and national income: Is health care a luxury good?" *Journal of Health Economics* 6(2)(June 1987); Antony J. Culyer, *Health Care Expenditure in Canada: Myth and Reality: Past and Future*, Canadian Tax Paper No. 82, (Toronto: Canadian Tax Foundation, 1988).

⁶⁶ Jens Alber "Germany," in *Growth to Limits: The Western European Welfare States Since World War II*, by Peter Flora, ed. (New York: de Gruyter, 1988).

many European countries are experiencing a slow down in the relative growth of their health sectors. There may be two reasons for this trend. On the one hand, it may merely represent a political backlash against public involvement at a time when there has been a resurgence of neo-conservatism on the political scene. On the other hand, it may represent the first signs of a response in health care expenditure to the economic contractions of the late 1980s. Although it was beyond the scope of the study, the 1990s may become determinant in clarifying some of these questions.

CHAPTER 12. THEORIES**A. PROCESSES IN HEALTH CARE FINANCING**

By tracing developments in health care financing over more than a century, the research conducted in this study provided several important clues that convergence, diffusion, interdependence and evolution processes do occur in health policy. Although it may still be too early for a synthesis and the construction of a comprehensive world-wide grand theory on health care financing, the time is ripe for some mid-range theories about OECD countries.

1. Convergence

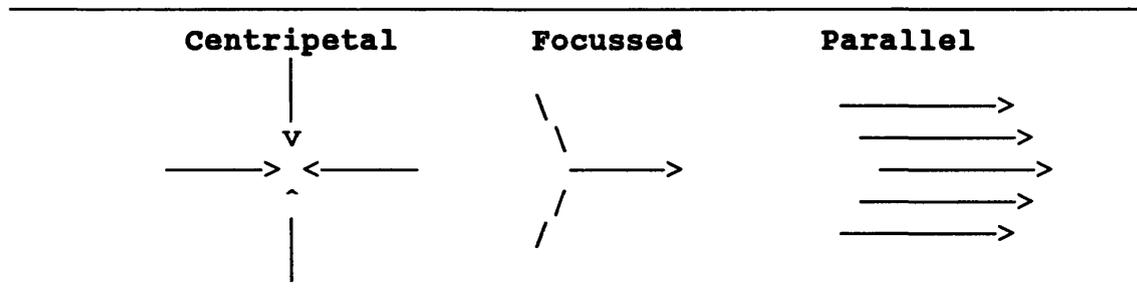
Proponents of convergence theories maintain that countries have common collective responses to similar socio-economic, political, bureaucratic and other forces such as market failure. This study demonstrated that prepayment of health care has increased steadily over the past century in all western countries in response to the uncertainties of illness and their concomitant financial hardships. State intervention in the health sector increased parallel to this process through the normative functions of modern government: resource allocation, income distribution and stabilisation of economic activity. The allocation function was performed through regulations, subsidies and direct provision of services; the distribution function was performed through revenue collection (taxes and social insurance), reimbursements and benefits in kind; and the stabilisation function was performed through employment in the health sector, cost controls and production of services. The introduction of compulsory participation and universal entitlement has been part of a long continuum towards providing more efficient and equitable access to health services. Although there still appears to be a dichotomy in the cluster of policies advocated by Group I and Group II countries, there has been a progressive trend towards greater participation in the financing and extensive entitlement to health care in all OECD countries over the past 50 years, with less and less countries relying on means-testing and access restricted by ability to pay.

Table 12.1 Health Care Legislation in the OECD

	Means-tested	Universal entitlement
Australia	1944/47/48/53	1973/84
Austria	1888/19/60/74/79	
Belgium	1894/63	
Canada		1957/68
Denmark	1892/21/33/60	1971
Finland		1963/72
France	1928/45/67/71/74/78	
Germany	1883/11/27	
Greece	1922/51	1983/86
Iceland	1936	1971
Ireland	1911/81	
Italy	1912/27/43/50/62/70/71	1978
Japan	1922/38/58	
Luxembourg	1901/51/74/80	
Netherlands	1913/64/66/68	
New Zealand		1938/41/70
Norway	1909	1955/70/86
Portugal	1919/35	1977
Spain	1929/42/74	1986
Sweden	1891/1931	1947/53/69/86
Switzerland	1911	
Turkey	1945/50/64	
United Kingdom	1911	1946
United States	1965/72	

Convergence processes can take several forms. This may explain some of the variability and differentiation that occurred within Group I and Group II countries. Similar issues may provoke an identical response each time. Market failure leading to various types of government intervention would be an example of this type of centripetal convergence process. On the other hand, issues may develop into increasingly similar, but still not identical, responses that continue to evolve over time. The standardisation of the criteria for membership and benefits provided by the early sickness funds, friendly societies and health insurance schemes would be an example of this type of focussed convergence process. Finally, issues may develop in the same direction, but into policies that are differentiating and continually evolving. Revenue collection for prepayment of health care through different financing mechanisms (general taxation, social insurance, health insurance and some direct charges) would be an example of this type of parallel convergence process.

Figure 12.1 Convergence Processes



2. Diffusion

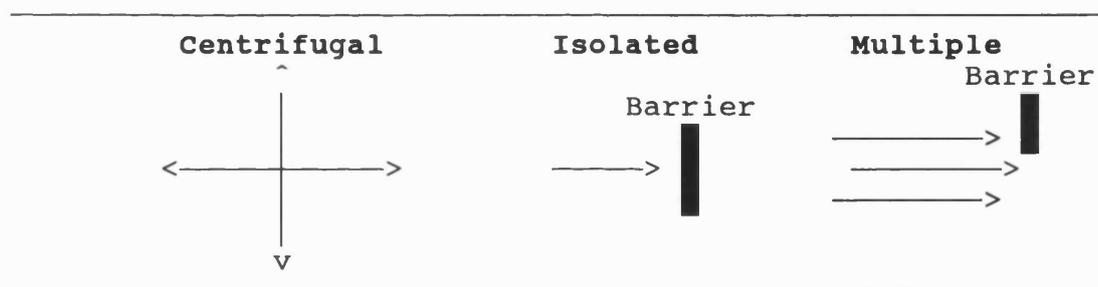
Proponents of diffusion theories maintain that industrial societies and policy-makers imitate the time-proven policies of more advanced countries regardless of their socio-economic, political, bureaucratic or other contexts such as market failure. This study demonstrated that as prepayment of health care increased over time, geographic proximity, hierarchical transmission from leaders to followers, and spread along historical, social, cultural, economic, political, bureaucratic and scientific geographic links influenced the diffusion of ideas and policies. Many of these links, existed between the Nordic countries as one close knit group of countries with geographic proximity, and between the UK and her English-speaking former colonies despite their lack of such geographic closeness. The sickness funds which developed in the Nordic countries and the friendly societies in the English-speaking countries is only one of the many examples of this process. The Nordic consensual policy-making machine and the English-speaking majoritarian confrontational legislative style is another. Continental Europe was divided from these two groups of countries by geographic barriers, culture, language and the absence of many other key links.

Countries that had reached the most advanced stage of socio-economic development were not always the first to introduce innovative reforms. The United Kingdom, although more industrially developed, was later than Germany in introducing social security and health insurance reforms. New Zealand and the US were geographically detached from Europe, but nevertheless leaders in introducing welfare legislation during the 1930s.

Diffusion processes, like convergence, can take several forms. This may once again explain some of the variability and differentiation that occurred within Group I and Group II countries. Policies may scatter in several directions from a central point. Germany provided a bridge between continental Europe, the Nordic countries and the UK during the early development of social insurance, while the English language, as an international means of communication, was determinant in spreading ideas about the

British NHS in a centrifugal-type diffusion process. Isolated events were much more likely to encounter barriers, preventing ideas about these policies from spreading to other countries or other levels of abstraction. Few people heard about the 133-day history of the Hungarian National Health Service of Bela Kun in 1919. By contrast, diffusion from multiple sources was even more likely to have an impact and to overcome different barriers than single experiences and single policies. Few countries were aware of New Zealand's NHS after 1938. But by the end of the 1940s, when the UK had introduced its NHS, and Canada and Australia had gone through the early legislative motions to introduce similar policies, most western countries were aware of these experiences. Awareness was not however sufficient for action, and although both Sweden and Norway were aware of the English-speaking experience during the late 1940s, they introduced compulsory sickness insurance instead of national health services.

Figure 12.2 Diffusion Processes

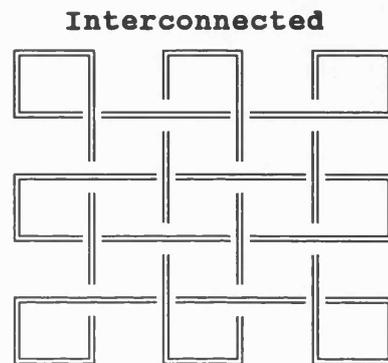


3. Interdependence

The study also demonstrated the distinction between functional interdependence and diffusion. Often socio-economic development provided the physical means for reforms, political processes, their direction, bureaucratic structures, the tools and market failures, the motives for change. These factors were interdependent, with no single one being sufficient. Cross-national links clearly existed during the late 1930s to early 1950s. Officials from New Zealand had visited Russia prior to 1938 and were aware of socialist experiences in health care provision. Norway's wartime shadow cabinet in London during World War II was aware of plans to create a British NHS. The allies fought together during the war and were therefore in close contact with each other. Yet proposals for compulsory participation and universal entitlement progressed as much along the direction of other social security reforms taking place in each country as according to developments taking place in other countries. Australia and Canada had the same motives to correct some of the observed market failure in the provision of health care through the private sector as the UK had during the late 1940s, and they went through

much of the same motion to prepare reforms. They never introduced national health services because of different political and bureaucratic factors. Denmark, Norway and Sweden were in much the same position, but it was easier both politically and administratively to expand their sickness insurance systems to provide universal compulsory coverage than to create national health services.

Figure 12.3 Interdependence Between policies

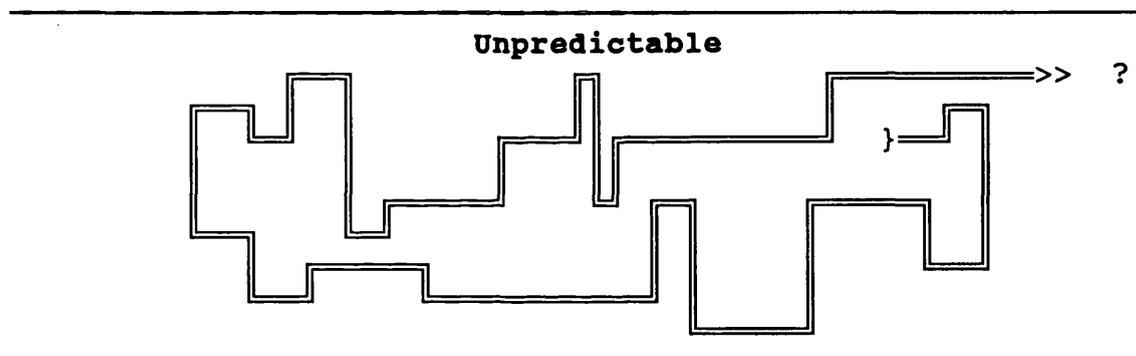


4. Evolution

Socio-economic development, political processes, bureaucratic structures and market failures present themselves in different ways in different societies. Even if convergence, diffusion, interdependence and other factors act as forces to drive health care systems in a similar direction, there is still great scope for differentiation and changes over time. This was observed repeatedly during the case studies. Many of the transformations that occurred over time in the terminology, content, scope, boundaries and units-of-measurement were due to an evolution in concepts, issues and policies. Public expenditure at 10 per cent of the GDP at the turn of the century was considered a threat to the economic stability of the state. Today it ranges from 23 to 60 per cent of GDP. The social order among highly industrialized states was thought to be polarized into two camps -- communism and capitalism -- before the early 1980s. By early 1990, this view is already challenged. During the past century, the threshold for health care expenditure has been pushed upward continually. But today, some of the Nordic countries are experiencing a decrease in the portion of GDP devoted to health care in recent years. Recent health care reforms in western countries are beginning to challenge some of the elements of compulsory prepayment and universal entitlement that have been taken for granted over the past fifty years in many Group I countries.

Public and social Policy appears to evolve over time and not always in the same direction. Health policy may be marked by the same long-term uncertainty as has been observed in social policy,¹ while punctuated by short periods of predictable patterns according to convergence, diffusion and interdependence processes.² The literature on historical, economic and political theory has multiple references to cyclical or repeating patterns appear to evolve in a precarious way over time. Even the long time-span used for this study may have been too short to accurately portray trends in health care financing. Does health policy eventually double up on its historical path or do new options become available just at the moment when a return to the starting point appears inevitable? Does health care face an unavoidable and impending crisis due to a loss of momentum in historical commitments, self-damaging tendencies or political whim?. Although it is too early to decide whether or not recent reversals are due to cyclical variations, "backlash" phenomena or a positive evolution in policies: "systematic investigation [continues to be] needed to establish the extent to which public commitments to the health sector reflect or diverge from commitments to other policy areas and to expansive social policy in general."³

Figure 12.4 Evolution in Policies



¹ Rudolph Klein and Michael O'Higgins, eds., *The Future of the Welfare* (Oxford: Basil Blackwell, 1985).

² Thomas E Getzen and Jean-Pierre Poullier, "International Health Spending Forecasts: Concepts and Evaluation," Second World Congress on Health Economics, University of Zurich, Switzerland, 13 September 1990.

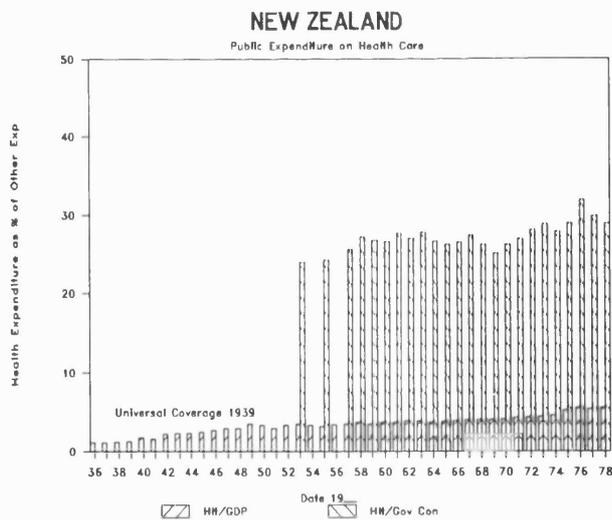
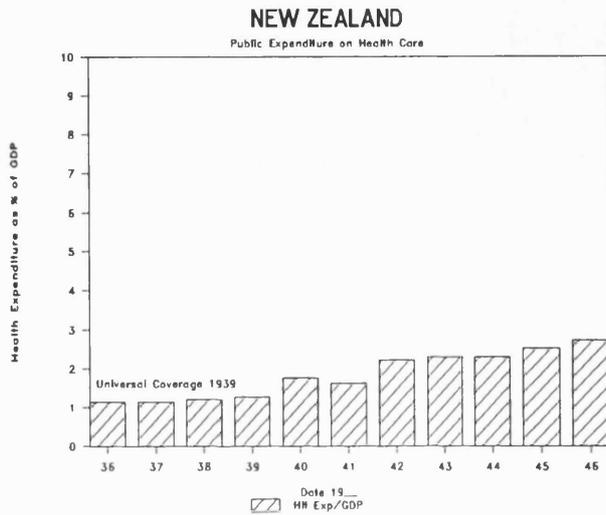
³ Harold L. Wilensky, Gergory M. Luebbert, Susan Reed Hahn and Adrienne M. Jamieson, "Comparative social policy: Theories, methods, findings," in *Comparative Policy Research: Learning from Experience*, by Meinolf Dierkes, Hans N. Weiler and Ariane Berthoin Antal, eds., WZB-Publications (Hants: Gower, 1987): 417.

APPENDIX

FIGURES**Public Expenditure on Health Care**

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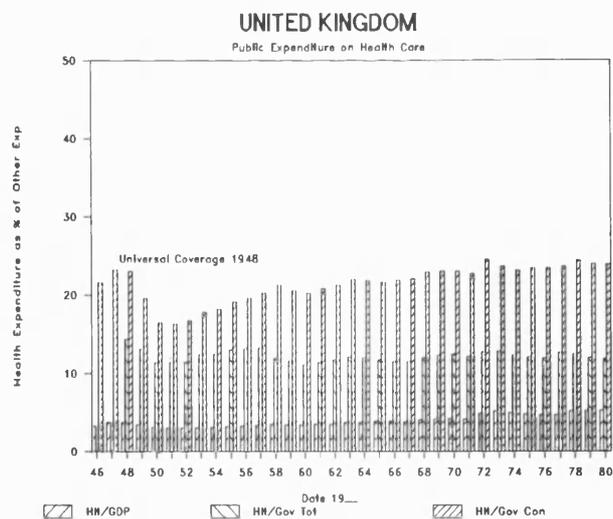
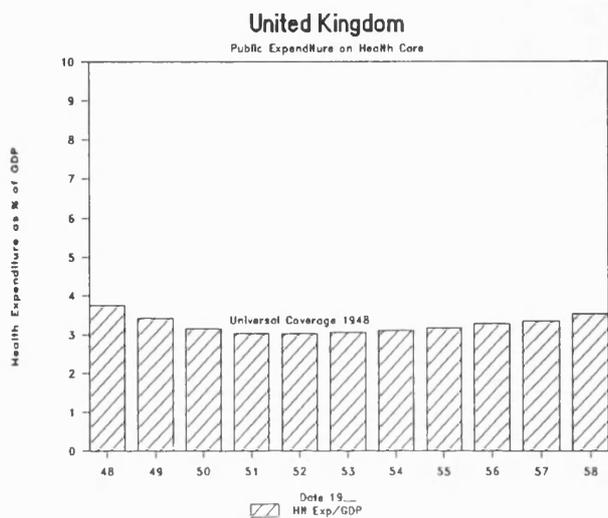
FIGURE 3.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care includes cash reimbursements for medical treatment but not maintenance payment during illness. See table with corresponding number for sources.

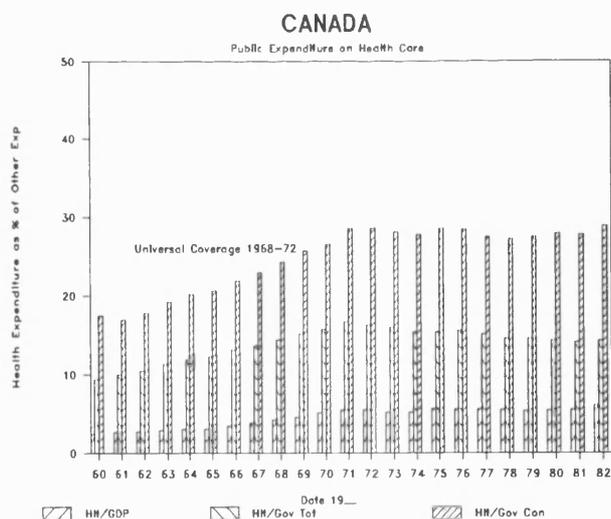
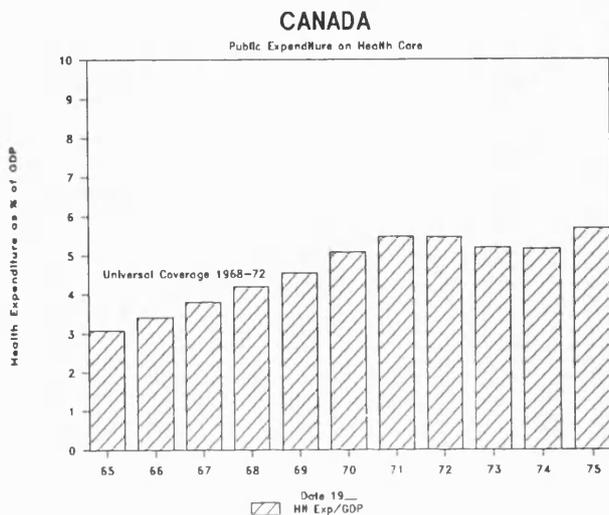
FIGURE 4.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care as recorded by the Department of Health and Social Security is lower than the data reported in the 1985 OECD publication on health care expenditure. See table with corresponding number for sources.

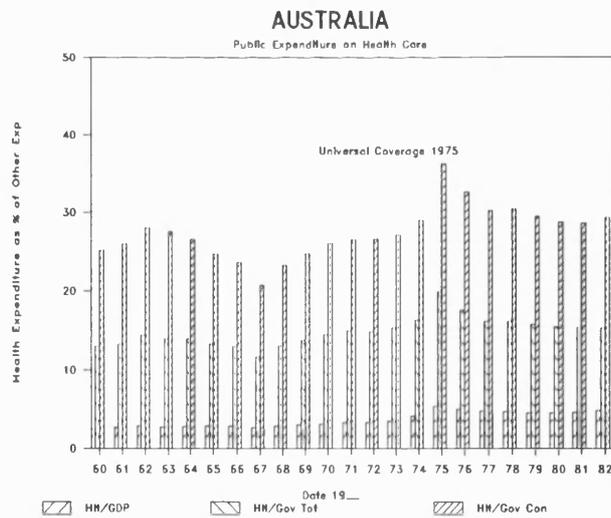
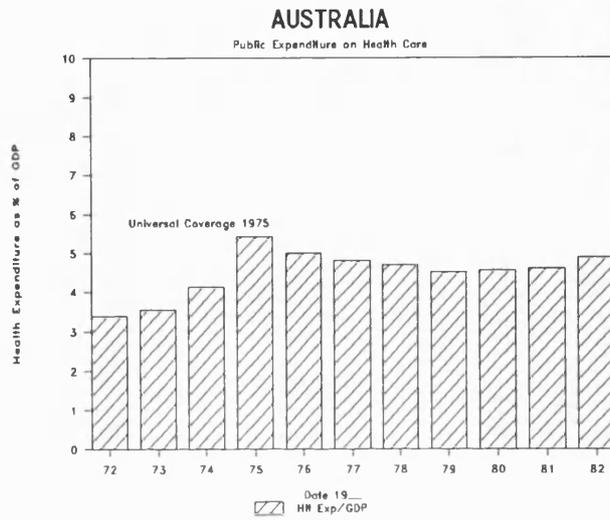
FIGURE 5.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on such 'welfare services' was not included in the aggregates for expenditure on health care. Aggregates for public expenditure on health care includes expenditure on nursing homes and other forms of long-term institutional care. See table with corresponding number for sources.

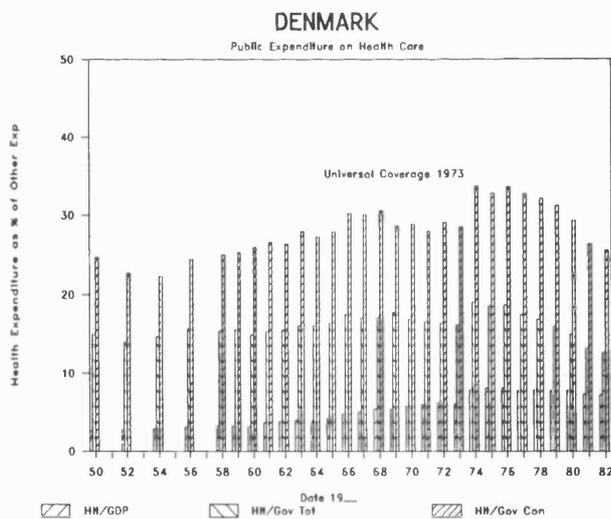
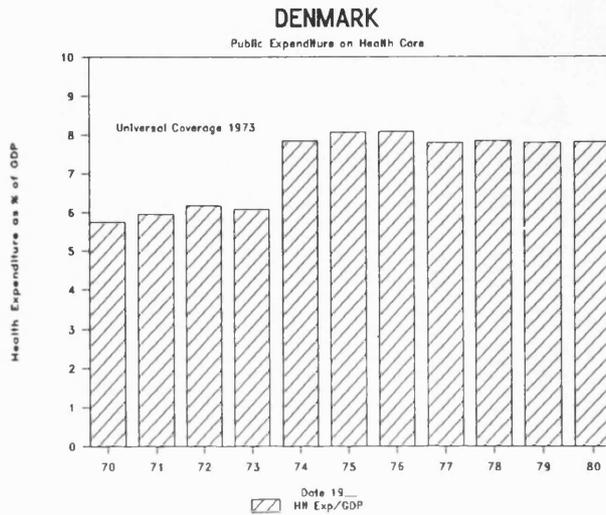
FIGURE 6.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care includes cash reimbursements for medical treatment but not maintenance payment during illness. See table with corresponding number for sources.

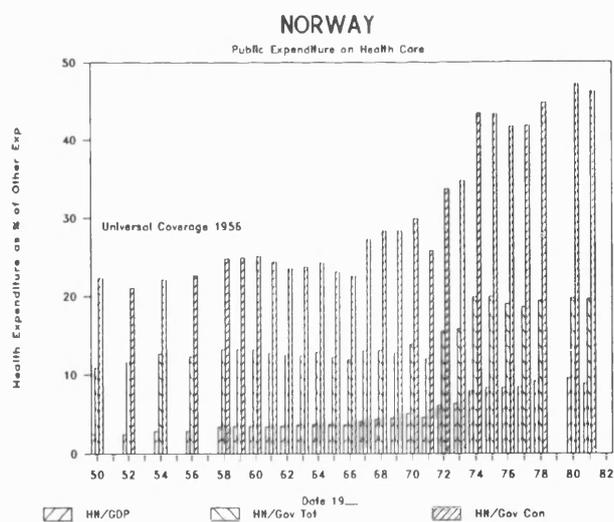
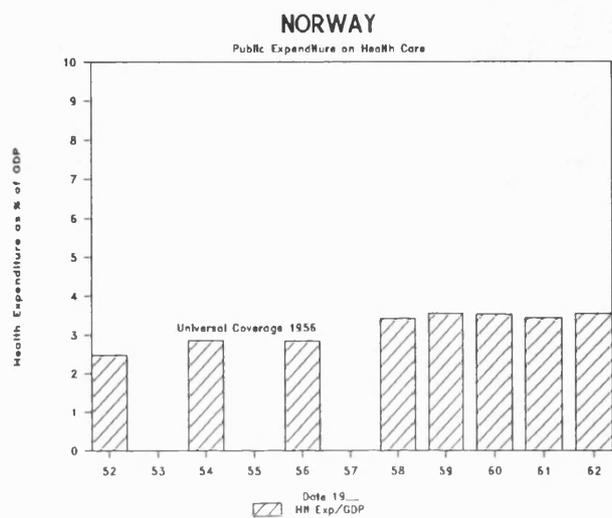
FIGURE 7.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care includes cash reimbursements for medical treatment but not maintenance payment during illness. Total expenditure includes outlays on sickness insurance, hospital care, outpatient care, care of the mentally retarded, care of special groups such as alcoholics and dental care. See table with corresponding number for sources.

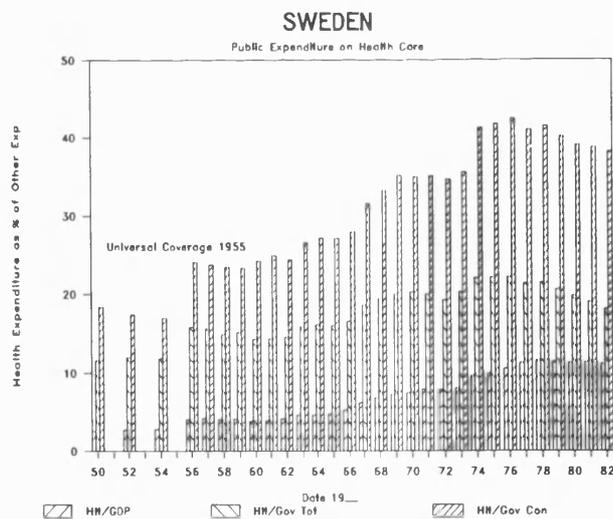
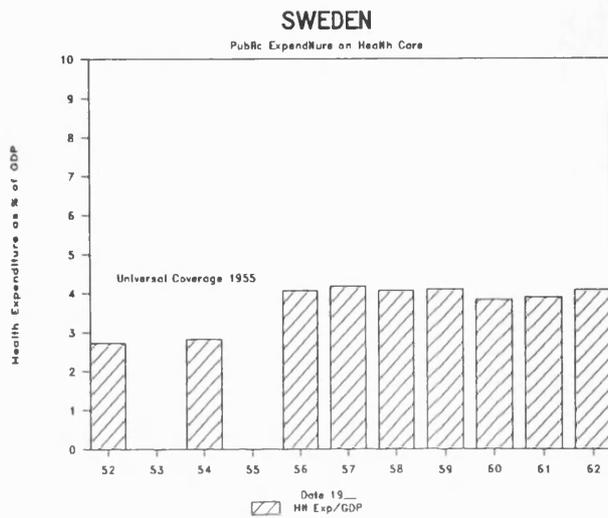
FIGURE 8.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care includes cash reimbursements for medical treatment but not maintenance payment during illness. Total expenditure includes outlays on sickness insurance, hospital care, outpatient care, care of the mentally retarded, care of special groups such as alcoholics and dental care. The values for 1953, 1955 and 1957 were interpolated from the series. See table with corresponding number for sources.

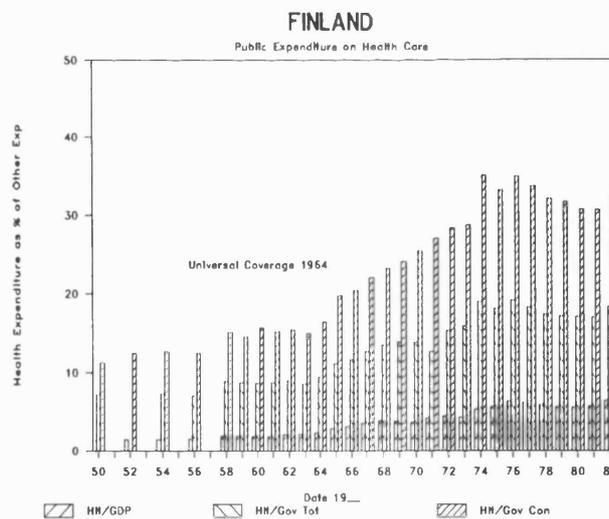
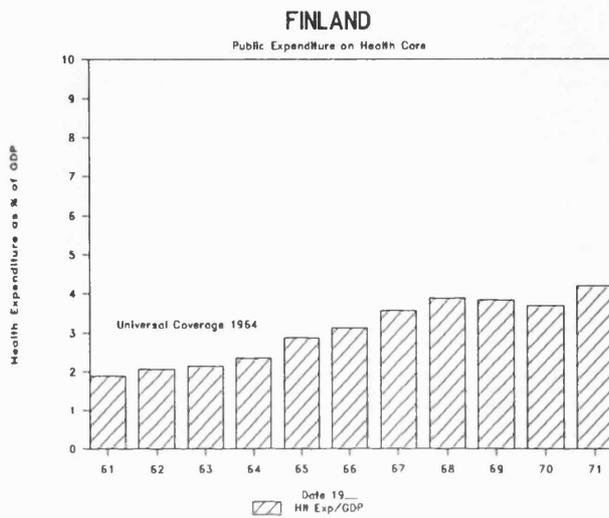
FIGURE 9.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care includes cash reimbursements for medical treatment but not maintenance payment during illness. Total expenditure includes outlays on sickness insurance, hospital care, outpatient care, care of the mentally retarded, care of special groups such as alcoholics and dental care. The values for 1953 and 1955 were interpolated from the series. See table with corresponding number for sources.

FIGURE 10.1



Hlt Exp = Health Expenditure
 Gov Con = Government Consumption Expenditure
 Gov Tot = Government Total Expenditure

Expenditure on health care includes cash reimbursements for medical treatment but not maintenance payment during illness. Total expenditure includes outlays on sickness insurance, hospital care, outpatient care, care of the mentally retarded, care of special groups such as alcoholics and dental care. See table with corresponding number for sources.

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TABLE 1.1 UNIVERSAL COVERAGE: WORLD-WIDE

Countries with Legislative Provisions for Universal Coverage ¹			
OECD Member Countries²			
Australia	Greece	New Zealand	Sweden
Canada	Iceland	Norway	UK
Denmark	Ireland ³	Portugal	
Finland	Italy	Spain	
CMEA Member Countries⁴			
Albania	Cuba	Hungary	USSR
Bulgaria	Czechoslovakia	Romania	
Developing Countries⁵			
Algeria	Malawi	Seychelles	Tanzania
Bermuda	Malaysia	Singapore	Zambia
Costa Rico ⁶	Mauritius	Somalia	Uganda
Cyprus	Nauru	Sri Lanka	
Kuwait	Papua N Guinea	Swaziland	

¹ Adapted from Kaser, *Health Care*, 272; and United States, DHHS, *Social Security Programs*.

² OECD is the acronym for the Organization for Economic Co-Operation and Development. Other countries include Austria, Belgium, Federal Republic of Germany, France, Ireland, Japan, Luxembourg, the Netherlands, Switzerland, Turkey and USA. Yugoslavia participates with special status. Paxton, *Statesman's Year-Book 1986-1987*, 34.

³ Universal coverage of health care, although provided for in the constitution, is not implemented in practice.

⁴ CMEA is the acronym for Council for Mutual Economic Assistance (COMECON). The seven founding members were later joined by Albania (1949-61), German Democratic Republic (1950), Mongolia (1962), Cuba (1972), Vietnam (1978). Yugoslavia, Afghanistan, Angola, Ethiopia, Laos, Mexico, Mozambique, Nicaragua and the People's Democratic Republic of Yemen attend as observers. Paxton, *Statesman's Year-Book 1986-1987*, 48.

⁵ Barriers to access limit true universal coverage.

⁶ Costa Rico is in the process of introducing universal coverage.

TABLE 2.1 HEALTH CARE LEGISLATION: CMEA COUNTRIES

Country ¹	Coverage Through Social Insurance	Coverage As Civic Right
Albania		1947/66
Bulgaria ²	1905/18/51	1973
Cuba	1934	1974/79
Czechoslovakia ³	1888	1966/68/71
Germany GDR ⁴	1883	1968
Hungary ⁵	1891	1919/75
Poland ⁶	1920/33	1971
Romania ⁷	1912/33	1965/68
USSR ⁸	1912/19/36/55	1969

¹ The data in this table is based on Kaser, *Health Care*; and US, DHHS, *Social Security Programs*. Data for Mongolia and Vietnam was not available through this series.

² Compulsory means-tested social insurance was introduced for wage-earners and civil servants in 1905. Universal coverage was provided as civil right under the Constitution of 1971.

³ Compulsory means-tested social insurance was introduced for workers in 1888 under the Austro-Hungarian Empire. Universal coverage was provided as civic right by law on the Health Care of the People on 17 March 1966.

⁴ Compulsory means-tested social insurance was introduced for workers in 1883. Universal coverage was provided as civic right under the Constitution of 1961.

⁵ Compulsory means-tested social insurance was introduced for wage earners in 1888. Universal coverage was granted in theory to all wage and salary earners in 1919 during the 133 days of the Hungarian Soviet Republic of Bela Kun; the medical profession boycotted the programme. Universal coverage was provided as a civic right under the Health Law of 1975. Balog, *Hungary*, 10.

⁶ Compulsory means-tested sickness and maternity insurance was introduced for workers in 1919. Universal coverage was provided as civic right after December 1971.

⁷ Compulsory means-tested social insurance was introduced for employees in 1912 (extended and unified in 1933). Universal coverage was provided as civic right included under Article 79 of the Constitution of 1952.

⁸ Comprehensive means-tested insurance was introduced for workers in 1912. Universal coverage was granted in theory through the revolution of 1919. It was only confirmed in principle as a civil right under the 1936 Constitution and finally implemented through the Health Law of 1969.

TABLE 3.1 NEW ZEALAND: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1939			
Year	1938	1939	1940
Population in Thousands ¹	1,604	1,627	1,636
Current Expenditure in Millions of New Zealand Dollars²			
Gov Consumption ³	-	-	-
Gov Total	-	-	-
GDP	-	-	-
Total Hlt Exp ⁴	5.17	5.94	8.83
GDP ⁵	427	467	503
Relative Expenditure in New Zealand Dollars			
Hlt Exp/Capita	3.20	3.60	5.40
Ratio in Per Cent			
Hlt Exp/GDP	1.2	1.3	1.8
Gov Con/GDP	-	-	-
Gov Tot/GDP	-	-	-
Hlt Exp/GDP	1.2	1.3	1.8
Hlt Exp/Gov Tot	-	-	-
Hlt Exp/Gov Con	-	-	-

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Early values for New Zealand Pounds have been converted into New Zealand Dollars.

³ Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

⁴ New Zealand, DH, *Health Expenditure*, 41, Table I.1.

⁵ New Zealand, DH, *Health Expenditure*, 41, Table I.1.

TABLE 4.1 UK: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1948			
Year	1948	1949	1950
Population in Thousands ¹	50,026	50,324	50,616
Current Expenditure in Millions of Pounds Sterling²			
Gov Consumption ³	1,761	1,977	2,103
Gov Total ⁴			3,382
GDP	11,533	12,261	12,872
Total Hlt Exp ⁵	380	460	484
Relative Expenditure in Pounds Sterling			
Hlt Exp/Capita	7.60	9.10	9.50
Ratio in Per Cent			
Hlt Exp/GDP	3.3	3.8	3.8
Gov Con/GDP	15.3	16.1	16.3
Gov Tot/GDP	-	-	26.3
Hlt Exp/GDP	3.3	3.8	3.8
Hlt Exp/Gov Tot	-	-	14.3
Hlt Exp/Gov Con	21.6	23.3	23.0

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Data for the United Kingdom represents aggregates for England, Wales, Scotland and Northern Ireland.

³ Government Consumption Expenditure, Government Total Expenditure, and GDP based on latest adjusted data in United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

⁴ Data for Government Total Expenditure was not available through the United Nations records prior to 1948-49.

⁵ United Kingdom, CSO, *Annual Abstract of Statistics*, 1955-86. Values for 1948 were extrapolated to a full year from the nine month data available for the incomplete 1948 fiscal year.

TABLE 5.1 CANADA: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1968-72			
Year	1968	1970	1972
Population in Thousands ¹	20,744	21,324	21,822
Current Expenditure in Millions of Canadian Dollars			
Gov Consumption ²	12,652	16,587	20,249
Gov Total	21,327	27,822	35,467
GDP	73,325	86,454	106,005
Total Hlt Exp ³	3,074	4,392	5,786
Relative Expenditure in Canadian Dollars			
Hlt Exp/Capita	148	206	265
Ratio in Per Cent			
Hlt Exp/GDP	4.2	5.1	5.5
Gov Con/GDP	17.3	19.2	19.1
Gov Tot/GDP	29.1	32.2	33.5
Hlt Exp/GDP	4.2	5.1	5.5
Hlt Exp/Gov Tot	14.4	15.8	16.3
Hlt Exp/Gov Con	24.3	26.5	28.6

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

³ OECD, *Measuring Health Care 1960-1983* based on data from Canada, HWC, IFB, *National health expenditures in Canada 1960-1975*; and Canada HWC, *National Health Expenditures in Canada 1970-1982*.

TABLE 6.1 AUSTRALIA: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1975			
Year	1974	1975	1976
Population in Thousands ¹	13,599	13,771	13,916
Current Expenditure in Millions of Australian Dollars			
Gov Consumption ²	9,012	11,193	13,085
Gov Total	16,009	20,291	24,269
GDP	63,191	74,616	85,281
Total Hlt Exp ³	2,612	4,052	4,266
Relative Expenditure			
Hlt Exp/Capita	192	294	307
Hlt Exp/GDP	4.1	5.4	5.0
Gov Con/GDP	14.3	15.0	15.3
Gov Tot/GDP	25.3	27.2	28.5
Hlt Exp/GDP	4.1	5.4	5.0
Hlt Exp/Gov Tot	16.3	20.0	17.6
Hlt Exp/Gov Con	29.0	36.2	32.6

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

³ OECD, *Measuring Health Care 1960-1983* based on data from OECD, National Accounts up to 1967; and Australia, CDH, *Health Expenditure 1975-76 to 1979-80*.

TABLE 7.1 DENMARK: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1973			
Year	1972	1973	1974
Population in Thousands ¹	4,992	5,022	5,045
Current Expenditure in Millions of Danish Crowns			
Gov Consumption ²	32,075	36,808	45,254
Gov Total	56,716	65,312	79,708
GDP	150,728	172,859	193,629
Total Hlt Exp ³	9,305	10,493	15,198
Insurance	3,061	3,133	3,384
Medical	5,059	6,030	10,058
Mental	712	807	961
Dental	473	523	795
Cash	1,105	1,312	1,786
Relative Expenditure in Danish Crowns			
Hlt Exp/Capita	1,864	2,089	3,012
Ratio in Per Cent			
Hlt Exp/GDP	6.2	6.1	7.8
Gov Con/GDP	21.3	21.3	23.4
Gov Tot/GDP	37.6	37.8	41.2
Hlt Exp/GDP	6.2	6.1	7.8
Hlt Exp/Gov Tot	16.4	16.1	19.1
Hlt Exp/Gov Con	29.0	28.5	33.6

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

³ Cash benefits were excluded from the calculations for total expenditure on health care. Nordic Statistical Secretariat, *Social Security*, 1953-87; and *Yearbook of Nordic Statistics*, 1962-84.

TABLE 8.1 NORWAY: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1956			
Year	1954	1956	1958
Population in Thousands ¹	3,394	3,460	3,523
Current Expenditure in Millions of Norwegian Crowns			
Gov Consumption ²	2,915	3,425	3,990
Gov Total	5,072	6,318	7,460
GDP	22,559	27,306	28,924
Total Hlt Exp ³	643	775	988
Insurance	380	461	618
Medical	226	268	307
Mental	14	19	28
Dental	23	27	35
Cash	105	123	179
Relative Expenditure in Norwegian Crowns			
Hlt Exp/Capita	189	224	280
Ratio in Per Cent			
Hlt Exp/GDP	2.9	2.8	3.4
Gov Con/GDP	12.9	12.5	13.8
Gov Tot/GDP	22.5	23.1	25.8
Hlt Exp/GDP	2.9	2.8	3.4
Hlt Exp/Gov Tot	12.7	12.3	13.2
Hlt Exp/Gov Con	22.1	22.6	24.8

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

³ Cash benefits were excluded from the calculations for total expenditure on health care. Nordic Statistical Secretariat, *Social Security*, 1953-87; and *Yearbook of Nordic Statistics*, 1962-84.

TABLE 9.1 SWEDEN: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1955			
Year	1954	1956	1957
Population in Thousands ¹	7,235	7,316	7,367
Current Expenditure in Millions of Swedish Crowns			
Gov Consumption ²	6,989	8,301	9,477
Gov Total	10,080	12,673	14,407
GDP	42,051	49,102	53,793
Total Hlt Exp ³	1,186	1,995	2,246
Insurance	231	811	942
Medical	888	1,091	2,198
Mental	27	41	46
Dental	40	52	60
Cash	105		
Relative Expenditure in Swedish Crowns			
Hlt Exp/Capita	164	273	319
Ratio in Per Cent			
Hlt Exp/GDP	2.8	4.1	4.2
Gov Con/GDP	16.6	16.9	17.6
Gov Tot/GDP	24.0	25.8	26.8
Hlt Exp/GDP	2.8	4.1	4.2
Hlt Exp/Gov Tot	11.8	15.7	15.6
Hlt Exp/Gov Con	17.0	24.0	23.7

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; United Nations, DESA, SO, *Statistical Papers*, 1952-57; and *Yearbook of Nordic Statistics*, 1962-84.

³ Cash benefits were excluded from the calculations for total expenditure on health care. Nordic Statistical Secretariat, *Social Security*, 1953-87; and *Yearbook of Nordic Statistics*, 1962-84.

TABLE 10.1 FINLAND: PUBLIC EXPENDITURE ON HEALTH CARE

Universal Coverage Implemented in 1964			
Year	1963	1964	1965
Population in Thousands ¹	4,523	4,549	4,564
Expenditure in Millions of Finnish Marks			
Gov Consumption ²	2,925	3,349	3,759
Gov Total	5,114	5,865	6,662
GDP	20,541	23,553	25,828
Total Hlt Exp ³	438	552	742
Insurance	19	56	156
Medical	399	471	555
Mental	10	14	16
Dental	10	11	15
Cash	9	17	68
Relative Expenditure in Finnish Marks			
Hlt Exp/Capita	97	121	163
Ratio in Per Cent			
Hlt Exp/GDP	2.1	2.3	2.9
Gov Con/GDP	14.2	14.2	14.6
Gov Tot/GDP	24.9	24.9	25.8
Hlt Exp/GDP	2.1	2.3	2.9
Hlt Exp/Gov Tot	8.6	9.4	11.1
Hlt Exp/Gov Con	15.0	16.5	19.7

¹ United Nations, DESA, SO, *Demographic Yearbook*, 1950-83.

² Government Consumption Expenditure, Government Total Expenditure and GDP are based on the latest adjusted data available through the United Nations records. United Nations, DESA, SO, *National Accounts Statistics*, 1957-83; and United Nations, DESA, SO, *Statistical Papers*, 1952-57.

³ Cash benefits were excluded from the calculations for total expenditure on health care. Nordic Statistical Secretariat, *Social Security*, 1953-87; and *Yearbook of Nordic Statistics*, 1962-84.

TABLE 11.4 ECONOMIC OUTCOME INDICATORS AND THEIR SOURCES

	T	HCE ppp	GDP cap	GDP gwt	GGD/ GDP	GTE/ GDP	GCE/ GDP	GSE/ GDP	HCE/ GDP	Pub/ Tot	HCE ela
Years		\$US 1987	\$US 87	% 65-87	% 85	% 87	% 87	% 87	% 87	% 87	% 75-87
Aus	1	939	12612	1.8	25.2	28.8	18.0	10.8	7.4	70.5	0.9
Aut	0	982	11664	3.1	48.5	40.3	19.0	21.3	8.4	67.1	0.8
Bel	0	879	11802	2.6	126.6	52.9	16.0	36.9	7.4	76.9	1.6
Can	1	1483	17211	2.7	69.2	24.2	20.0	4.2	8.6	73.9	0.9
Den	1	792	13329	1.9	68.6	39.8	25.0	14.8	5.9	85.5	0.9
Fin	1	949	12838	3.2	20.2	31.9	21.0	10.9	7.4	78.6	0.9
Fra	0	1105	12803	2.7	34.0	45.1	19.0	26.1	8.6	74.8	3.1
Ger	0	1093	13323	2.5	42.2	30.1	20.0	10.1	8.2	78.4	0.9
Gre	1	337	6363	3.1	53.2	50.9	20.0	30.9	5.3	75.3	2.5
Ire	0	561	7541	2.0	128.3	60.4	18.0	42.4	7.4	87.0	1.5
Ita	1	841	12254	2.7	99.4	52.0	17.0	35.0	6.9	79.2	1.7
Jap	0	915	13182	4.2	69.4	17.4	10.0	7.4	6.9	73.0	1.4
Net	0	1041	12252	2.1	70.3	57.7	16.0	41.7	8.5	73.9	1.1
New	1	733	10680	0.9	45.0	47.1	15.0	32.1	6.9	82.5	0.9
Nor	1	1149	15405	3.5	31.4	40.6	21.0	19.6	7.5	97.6	2.0
Spa	1	521	8681	2.3	41.7	34.8	14.0	20.8	6.0	71.5	1.1
Swe	1	1233	13771	1.8	71.4	42.9	27.0	15.9	9.0	90.8	1.0
UK	1	758	12340	1.7	56.5	38.9	21.0	17.9	6.1	86.4	1.0
US	0	2051	18338	1.5	48.3	23.3	21.0	2.3	11.2	41.4	1.1

Glossary of Abbreviations Used for Outcome Indicators¹

GDP _{cap}	GDP per capita
GDP _{gwt}	Average real GDP growth rates
GGD	General government debt
GCE/GDP	Government consumption expenditure per GDP
GSE	Government social expenditure
HCE _{ela}	GDP elasticity of health care expenditure
GTE	General government total expenditure
HCE _{ppp}	Purchase-power-parity-adjusted health care expenditure
Pub/Tot	Ratio of public to total health care expenditure

¹ Calculated from World Bank, *World Development Report 1989: Financial Systems and Development*, World Development Indicators (Washington: World Bank 1989); OECD, *Health Care Systems in Transition: The Search for Efficiency* (Paris: OECD, 1990); United Nations, DESA, SO, *National Accounts Statistics*, 1989.

TABLE 11.5 STATISTICAL ANALYSIS USING AS INDEPENDENT VARIABLE

Independent Variable T	Change in $T = 0$		
	No Change	Spain Greece	Spain Greece Italy
Dependent Variables Below			
HCEppp			
Constant	1078.38	948.5	938.73
Std Err of Y Est	370.20	383.19	382.17
R Squared	0.07	0.00	0.01
X Coefficient(s)	-193.38	37.83	65.77
Std Err of Coef.	172.02	176.06	177.58
GDPcap			
Constant	12613.12	11594.9	11654.81
Std Err of Y Est	2964.42	2814.53	2803.67
R Squared	0.00	0.10	0.11
X Coefficient(s)	-296.40	1787.32	1868.43
Std Err of Coef.	1377.45	1293.19	1302.76
GDPgwt			
Constant	2.59	2.61	2.62
Std Err of Y Est	0.80	0.79	0.78
R Squared	0.03	0.06	0.07
X Coefficient(s)	-0.26	-0.37	-0.43
Std Err of Coef.	0.37	0.36	0.36
GGD			
Constant	1.44	66.25	69.26
Std Err of Y Est	0.63	30.61	29.32
R Squared	0.02	0.04	0.12
X Coefficient(s)	-0.18	-12.15	-20.83
Std Err of Coef.	0.29	14.06	13.62
GTE/GDP			
Constant	40.9	41.29	42.26
Std Err of Y Est	12.34	12.28	12.03
R Squared	0.01	0.01	0.05
X Coefficient(s)	-1.64	-2.82	-5.49
Std Err of Coef.	5.73	5.64	5.59
GCE/GDP			
Constant	17.38	17.3	17.27
Std Err of Y Est	3.72	3.55	3.43
R Squared	0.11	0.19	0.24
X Coefficient(s)	2.53	3.26	3.73
Std Err of Coef.	1.73	1.63	1.59
GSE/GDP			
Constant	23.53	23.99	24.99
Std Err of Y Est	12.65	12.43	11.90
R Squared	0.03	0.06	0.14
X Coefficient(s)	-4.17	-6.08	-9.22
Std Err of Coef.	5.88	5.71	5.53
HCE/GDP			
Constant	8.35	7.81	7.72
Std Err of Y Est	1.20	1.37	1.38
R Squared	0.26	0.04	0.02
X Coefficient(s)	-1.35	-0.51	-0.37
Std Err of Coef.	0.56	0.63	0.64
Pub/tot			
Constant	71.56	71.93	72.59
Std Err of Y Est	10.78	10.40	10.49
R Squared	0.17	0.23	0.22
X Coefficient(s)	9.51	10.85	10.63
Std Err of Coef.	5.01	4.78	4.88
HCEela			
Constant	1.44	1.5	1.53
Std Err of Y Est	0.63	0.62	0.59
R Squared	0.02	0.07	0.14
X Coefficient(s)	-0.18	-0.32	-0.46
Std Err of Coef.	0.29	0.28	0.28
No. of Observations	19		
Degrees of Freedom	17		

See previous table for glossary to abbreviations

TABLE 11.6 STATISTICAL ANALYSIS USING HCEPPP AS DEPENDENT VARIABLE

Dependent Variable = HCEppp
Independent Variables Below

GDPcap	Constant	-502.40
	Std Err of Y Est	156.26
	R Squared	0.83
	X Coefficient(s)	0.12
	Std Err of Coef.	0.01
GDPgwt	Constant	1083.03
	Std Err of Y Est	381.75
	R Squared	0.01
	X Coefficient(s)	-47.85
	Std Err of Coef.	114.35
GGD	Constant	1102.93
	Std Err of Y Est	377.16
	R Squared	0.03
	X Coefficient(s)	-2.26
	Std Err of Coef.	2.93
GTE/GDP	Constant	1578.55
	Std Err of Y Est	333.65
	R Squared	0.24
	X Coefficient(s)	-15.32
	Std Err of Coef.	6.54
GCE/GDP	Constant	430.19
	Std Err of Y Est	366.92
	R Squared	0.09
	X Coefficient(s)	28.46
	Std Err of Coef.	22.56
GSE/GDP	Constant	1323.56
	Std Err of Y Est	316.37
	R Squared	0.32
	X Coefficient(s)	-16.92
	Std Err of Coef.	5.98
HCE/GDP	Constant	-911.17
	Std Err of Y Est	166.49
	R Squared	0.81
	X Coefficient(s)	248.19
	Std Err of Coef.	28.99
Pub/Tot	Constant	2203.52
	Std Err of Y Est	333.05
	R Squared	0.25
	X Coefficient(s)	-16.05
	Std Err of Coef.	6.80
HCEela	Constant	1116.56
	Std Err of Y Est	376.86
	R Squared	0.03
	X Coefficient(s)	-112.75
	Std Err of Coef.	142.84
No. of Observations		19
Degrees of Freedom		17

See previous table for glossary to abbreviations

GLOSSARY

Standard Abbreviations

DHSS	Department of Health and Social Services
GDP	Gross Domestic Product
OECD	Organization for Economic Co-Operation and Development
UK	United Kingdom
UN	United Nations
WHO	World Health Organization

Abbreviations Used for OECD Member Countries in Figures

Aus	Australia	Jap	Japan
Aut	Austria	Lux	Luxembourg
Bel	Belgium	Net	Netherlands
Can	Canada	New	New Zealand
Den	Denmark	Nor	Norway
Ger	Germany	Por	Portugal
Fin	Finland	Spa	Spain
Fra	France	Swe	Sweden
Gre	Greece	Swi	Switzerland
Ice	Iceland	Tur	Turkey
Ire	Ireland	UK	UK
Ita	Italy	USA	USA

Abbreviations Used in Figures and Tables

Com	Commonwealth Government of Australia
Con	Consumption Expenditure
Emp	Employers
Exp	Expenditure
Fed	Federal Government of Canada
GDP	Gross Domestic Product
Gov	Government
Hlt	Health
Ind	Individuals
Ins	Insured
Loc	Local Government
Med	Medical
Mun	Municipal Government
Prov	Provincial Government
Tot	Total Expenditure

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