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The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy*

Government-sponsored health insurance is a central pillar of the modern welfare state. In advanced industrial democracies, public spending on medical care accounts for an average of 6 percent of gross domestic product (GDP), making it the largest category of social spending after public pensions.¹ Despite the popularity and resilience of established health programs, however, the introduction of government-sponsored health coverage has been highly controversial everywhere. Few social programs involve the state so directly in the workings of the economy and the practice of a powerful profession. Few entangle the interests of so many diverse and resourceful groups. And few cast in such stark relief the ideological principles at stake. Although the participants in conflicts over health policy have differed from nation to nation, no country has acquired national health insurance without a fierce and bitter political fight.

Yet, as similar as these conflicts have been, they have not resulted in the same outcome in all nations. Although Canada and the nations of western

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1. Computed from Organization for Economic Cooperation and Development, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries* (Paris: Organization for Economic Cooperation and Development, 1994), 38. The comparison with pensions is made by Karl Hinrichs, "The Impact of German Health Insurance Reforms on Redistribution and the Culture of Solidarity," *Journal of Health Politics, Policy and Law* 20 (1996): 653–87.

Europe all guarantee universal health care, the scope, content, and time of passage of their programs vary considerably. Under the pioneering leadership of Chancellor Bismarck, Germany established the first system of compulsory sickness insurance in the late nineteenth century.² In 1911, Britain followed Germany's lead and created a national contributory program for manual workers. By 1948, however, it had abandoned the German model to become the first western government to adopt a program of free and universal entitlement to publicly provided medical care.³ Canada, by contrast, did not establish a nationwide insurance program until 1957, and then, in keeping with provincial developments, only for hospital care. When Canada finally consolidated its comprehensive insurance program in the early 1970s, it followed neither German nor British precedent but instead allowed the provinces to be the sole insurers for most medical services. The United States, of course, does not have national health insurance despite recurring political debates over the subject. In 1965, President Lyndon Johnson and his allies capped off a long, ideologically charged battle for government health insurance with the passage of Medicare for the elderly and disabled and Medicaid for segments of the poor.⁴ But all subsequent efforts to extend coverage to the remaining uninsured, including the campaign launched by President Bill Clinton in 1993, ended in failure.

What explains the contrasting fate of national health insurance in different nations? Why does Britain have a national health service based on public provision of medical care and Canada a provincially administered system of government health insurance based primarily on private provision? And perhaps most puzzling, why has national health insurance never been enacted in the United States? These are among the great questions of comparative politics and social policy, and many possible answers to them vie for consideration. National health insurance programs might develop as a result of economic change or the advancement of medical science. They might be a reflection of distinctive national cultures or of the demands of powerful societal groups. None of these frequently cited factors, however, convincingly explains the divergent health policies enacted by industrialized democracies in the twentieth century. Although these factors have shaped health policies in some nations and at some moments, their importance and effect have differed across countries and over time. To make sense of these differences requires an explanatory perspective that is sensitive to the sometimes complex historical interplay of forces that leads countries to adopt particular national health policies.

This article presents such a perspective and demonstrates its utility through a focused comparison of the development of health policy in three broadly similar nations: Britain, Canada, and the United States. Rather

2. Deltov Zöllner, "Germany," in *The Evolution of Social Insurance, 1881–1981*, ed. Peter A. Köhler, F. Zacher, and Martin Partington (New York: St. Martin's, 1982), 25–26.

3. Rudolf Klein, *The Politics of the National Health Service*, 2d ed. (London: Longman, 1989), 1.

4. Theodore R. Marmor, *The Politics of Medicare* (New York: Aldine, 1973).

than view national health policies as the result of one or a few key variables, I argue for a historically grounded approach that emphasizes the political institutions within which policy decisions are made and the diverse feedback effects that those decisions have on subsequent political struggles. My central thesis is that the emergence of national health insurance conforms to a developmental logic that is as much historical as it is political and institutional. Because policies enacted at one point in time restructure economic markets and reshape subsequent political dynamics, and because the subject and context of debates over medical care in industrial democracies have changed over time, the evolution of national health policies cannot be explained without an understanding of the sequence and timing of major government interventions in the medical sector. When rare opportunities for fundamental policy change arise, the *form* that national health policies take depends on the market structures, policy ideas, interest group strategies, and public views that have formed in response to previous government policies, as well as on the prevailing ideological and economic climate faced by modern welfare states across the industrialized world. The *prospects* for policy change, however, depend critically on the opportunities and constraints created by government institutions. The political decisions made (or not made) during these critical junctures in turn feed back into future political struggles, progressively limiting the range of possible outcomes. In this perspective, therefore, the focus shifts from the distinctive destinations countries have reached to the similar political and historical processes by which they have reached them.

This article contributes to an expanding body of comparative scholarship on the effects of institutions on political behavior and public policy outcomes. In keeping with this scholarship, I argue that the structure of a nation's political institutions systematically influences both the types of interests and ideas that enter into political debates and the kinds of policies that countries adopt. Yet, in an attempt to increase the scope and explanatory power of new institutionalist explanations, I place special emphasis on the role of historical sequence and timing. I also contend that institutionalist analyses must examine the evolution and effects of private as well as government institutions. One of the most welcome effects of the renewed attention to institutions in the social sciences has been a rebirth of interest in political history and development. This article suggests, however, that institutionalists need to become even more self-consciously historical in their analyses of politics, and to broaden their inquiries to consider the constraints that the development of private market institutions creates for public policy making.

I begin by reviewing and criticizing the three most common families of explanations advanced to explain health policy divergence among nations: economic explanations, cultural explanations, and interest group explanations. As commonly presented, these explanations all suffer from notable weaknesses – although some of these defects can be remedied by recasting their main causal claims. The historical institutionalist perspective offers a useful framework for synthesizing and reordering these claims. It draws

attention to the ways in which political institutions influence the articulation of and response to political demands for policy reform. It also correctly emphasizes long-term processes of historical development. Many historical institutionalists do not go far enough in this regard, however, as they fail to separate at least two distinct conceptions of the role of history in political analysis and to identify concretely the causal mechanisms by which past policies shape present political possibilities.

My discussion of historical institutionalism leads first into my specific claims about health policy and then into a country-by-country comparison of health policy development in Britain, Canada, and the United States. As “most similar systems,” these three nations share a common cultural heritage, have relatively similar economies, and have experienced comparable battles over national health insurance.⁵ But they also have quite different political institutions, have followed distinctive health policy paths, and have ended up with markedly different medical systems. I show how these different outcomes reflect both institutional differences and the alternative paths that these nations took at critical junctures, and I suggest that this finding has larger implications for the study of the comparative politics of social policy.

MARKETS, VALUES, AND GROUPS

Like research on the welfare state more generally, the comparative study of health policy displays three main theoretical traditions. The first – generally based on large-scale statistical studies – focuses on economic forces and argues that nations at comparable levels of economic development and medical sophistication adopt similar health programs. The second – an offshoot of the enduring debate over “American exceptionalism” – focuses on national political cultures and argues that health policy convergence is limited by the distinctive beliefs held by a country’s citizens and political elites. The third tradition – indebted to pluralism and sociological studies of the medical profession – focuses on the major interest groups with a stake in national health programs and argues that health policies reflect the outcome of struggles among competing groups. Although not monocausal, these explanations all place particular emphasis on one crucial variable. For this reason, they are not readily capable of explaining how political institutions and the long-term effects of critical policy choices foster policy divergence among nations that otherwise share similar economic, cultural, and political characteristics.

Economic Development and Medical Complexity

Perhaps the simplest form of explanation links the emergence of national health insurance and other social policies to the timing and tempo of industrialization. Arguments of this sort are “functionalist” in that they view the welfare state as a mechanism for meeting new or enhanced needs

5. Adam Przeworski and Henry Tuene, *The Logic of Comparative Social Inquiry* (Malabar, FL: Robert E. Krieger Publishing, 1970), 32–34.

created by socioeconomic development. In these accounts, health and social programs develop roughly in tandem with industrialization and its related transformations.⁶

These sorts of functionalist explanations have a certain inherent plausibility, inasmuch as most social programs associated with the welfare state aim to ameliorate problems that did not exist before the advent of the modern economy. Moreover, the relative timing of national health proposals conforms broadly with functionalist expectations, with Britain, the first to industrialize, considering compulsory health insurance first and Canada, the last to industrialize, taking it up last. Yet economic development is actually an extremely poor guide to the timing of major health policy breakthroughs, much less to their scope or content. How does one explain, for example, the failure of the United States to enact compulsory health insurance, not just in the 1910s, when many (but not all) American states lagged behind British levels of industrialization but also in later years, when the United States was more industrialized than either Britain or other countries with similar programs? Why did it take Canada so long to establish national health insurance, and why, despite having very similar economies, do Canada's and America's health policies remain so markedly different? Industrialization might help promote the emergence of health insurance as a political issue. But the actual pattern of programmatic achievements appears to bear only a weak relation to either the timing or level of economic development.

Perhaps, however, it is not economic development *per se* that matters but factors that more directly affect the demand for and supply of medical care. A crude indicator of both demand and supply is the early diffusion of voluntary sickness and health insurance. On this measure, Britain again leads the way, followed by the United States and Canada. In Britain, non-commercial insurance funds run by local friendly societies provided coverage to nearly one-seventh of the population even before the 1911 legislation – a ratio that the United States would not reach until the 1940s and Canada, until the 1950s.⁷ J. Rogers Hollingsworth and his colleagues have assembled a more comprehensive picture of the relationship between medical development and government intervention in the medical sector. Ex-

6. Variants of the argument include the "logic of industrialism" perspective, in which the welfare state emerges to fill the gap left by the decline of traditional social institutions and the rise of new forms of social dislocation, and the structural Marxist perspective, in which the welfare state is a response to the systemic imperatives of capital accumulation in capitalist economies. For discussions of these perspectives, and their difficulties, see Harold L. Wilensky, Gregory M. Luebbert, and Susan Reed Hahn, *Comparative Social Policy: Theories, Methods, Findings* (Berkeley, CA: Institute of International Studies, 1985), 5–12; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Harvard University Press, 1992), 12–14; and Gosta Esping-Anderson, *The Three Worlds of Welfare Capitalism* (Princeton, NJ: Princeton University Press, 1990), 13–14.

7. The figures for Britain, the United States, and Canada are from, respectively, Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 240; Health Insurance Association of America (HIAA), *Source Book of Health Insurance Data* (Washington, DC: Health Insurance Association of America, 1991), 24; and C. Howard Shillington, *The Road to Medicare in Canada* (Toronto: Del Graphics Publishing, 1972), 202.

amining Britain, France, Sweden, and the United States, they find a modest positive correlation between government intervention and demand for medical care and between government intervention and the complexity of medical technology.⁸

Like the economic development thesis, however, explanations that focus on the evolution of the medical sector account for only the broadest of differences among nations – and even then, they do not account for them well. There is simply no invariant relationship between medical progress and government finance or regulation of medical care. Expansion of the medical sector may create pressures for state involvement, but it may also strengthen the opponents of government intervention. The rising costs of medical care can be financed by government, or private insurers can assume the burden. Furthermore, developments in medicine are not autonomous from public policy. They are influenced, and even decisively shaped, by the policy choices that government officials make or do not make.⁹

Despite their obvious weaknesses, however, functionalist explanations do convey important insights. National health policies are indeed constrained by economic conditions and by the underlying features of the medical sector. Because health care finance and delivery are characterized by imperfect and extremely asymmetric information, as well as high levels of uncertainty about diagnosis and treatment, market failure is endemic in the medical sector. The incentives are therefore strong for third parties – whether public or private – to step in as intermediaries between patients and providers, performing such functions as insuring patients against risk and policing doctors and hospitals. These functional exigencies do not, however, dictate a unique response. The particular institutions that have come to play these intermediary roles vary widely from nation to nation, ranging from public finance and provision (Great Britain) to a mix of public and private tools (Canada) to a predominantly private system (the United States). In short, although the economic features of medical care have created similar political dilemmas in all industrialized nations, they have not determined whether or how governments have responded to these dilemmas, or whether the institution designed to remedy market failures have been private, public, or some mix of the two.

Political Culture and Public Opinion

A second broad category of explanations for national health and social policies explains policy outcomes not as the result of the forces of modern-

8. J. Rogers Hollingsworth, Jerald Hage, and Robert A. Hanneman, *State Intervention in Medical Care* (Ithaca, NY: Cornell University Press, 1990), 30–62.

9. For this reason, the statistical technique used by Hollingsworth and his colleagues—hierarchical causal path analysis—is suspect. As Hollingsworth and colleagues recognize (*ibid.*, 216–28), this technique assumes that the causal link between medical system characteristics and state intervention is unidirectional (that is, complexity causes intervention). If, as I argue, the relationship is one of mutual causation, the results will be biased.

ization, but as a reflection of distinctive national cultures.¹⁰ Culturalist explanations differ significantly in how they conceive of culture and in whom they see as the crucial cultural agents (the public or political elites). But they share a common concern with the web of shared understandings that motivates political action and shapes policy design.

To many scholars, the stubborn individualism of American political culture has offered an obvious explanation for the failure of the United States to follow the European lead and enact compulsory health insurance in the early 1900s. Daniel Hirshfield argues, for instance, that early efforts to pass compulsory health insurance in the United States met defeat because Americans were not yet ready to accept the wider conception of freedom social insurance entailed.¹¹ In a similar vein, Roy Lubove attributes the demise of the first campaign for compulsory health insurance to a powerful cultural consensus in favor of voluntarism.¹² And Daniel Levine takes the culturalist explanation for the failure of compulsory health insurance and other social programs to its logical conclusion in arguing that “Americans did not have social insurance before 1935 because Americans did not want social insurance.”¹³

We can see here the Panglossian burnish of culturalist explanations of American exceptionalism: The proof that Americans did not want national health insurance is the fact that they did not get it. Lacking contemporary opinion data for much of the early twentieth century, this claim is difficult to assess.¹⁴ But the experience of other countries raises doubts. For one, few of the scholars who have addressed this period have attempted to show that the passage of compulsory health insurance in other countries was a response to widespread popular pressure. In fact, this would be difficult to do, since the overwhelming evidence is that these early programs were promulgated by government elites well in advance of public demands.¹⁵ For another, the link between culture and policy appears much less straightforward in comparative perspective. Britain, after all, gave birth to the antistatist liberalism of Locke and Smith. Yet its leaders were able to justify compulsory insurance by recasting liberal values and drawing on alternative collectivist currents in British political culture. Similarly, Cana-

10. See Clifford Geertz, *The Interpretation of Cultures* (New York: Basic Books, 1973); Gabriel Almond and Sidney Verba, *The Civic Culture* (Boston: Little, Brown, 1963); and Gaston Rimlinger, *Welfare Policy and Industrialization in Europe, America, and Russia* (New York: Wiley, 1971). For a comparative application to health policy, see Lawrence R. Jacobs, “Institutions and Culture: Health Policy and Public Opinion in U.S. and Britain,” *World Politics* 44 (1992): 179–209.

11. Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932–1943* (Cambridge, MA: Harvard University Press, 1970).

12. Roy Lubove, *The Struggle for Social Security, 1900–1935* (1968; Pittsburgh: University of Pittsburgh Press, 1986).

13. Daniel Levine, *Poverty and Society: The Growth of the American Welfare State in International Comparison* (New Brunswick, NJ: Rutgers University Press, 1988), 179.

14. See, however, Starr, *The Social Transformation of American Medicine*, 278–79.

15. Hugh Heclo, *Modern Social Politics in Britain and Sweden* (New Haven, CT: Yale University Press, 1974), 288–304.

da and the United States share many important cultural traits. Canadians and Americans “are probably as alike as any other two peoples on the earth,” “national differences reported by crossborder opinion polls are frequently small,” and more than 61 percent of Americans chose the Canadian medical system over the American system when asked to pick between descriptions of the two.¹⁶ Yet Canada has national health insurance and the United States does not. Indeed, the vastly different health policies of Canada, Britain, and the United States present a strong challenge to at least the simplest of culturalist arguments, since all three countries are closely tied by history and have common cultural roots.

Furthermore, the extent to which a given constellation of cultural understandings enters into legislative debates is deeply influenced by the organization of a nation’s political institutions. At the heart of constitutional design lie fundamental questions of democratic representation. How and to what extent should citizens’ preferences shape government action? What kinds of claims are the legitimate subject of political deliberation? The Founders offered one enduring answer to these questions, creating a constitutional structure that limited and channeled popular demands and hindered rapid policy change.¹⁷ In contrast, the unification of powers in parliamentary systems facilitates swift legislative action and offers a more centralized form of accountability at the ballot box. The configuration of electoral rules also mediates between citizens’ preferences and the specific political outcomes that those preferences create. Electoral rules help determine the number of parties, the nature of candidate and party strategies, and the range of positions that gain adherents in political office.¹⁸ The weakness of the organized left in the United States, for instance, is a product not just of the dominance of liberalism but also of the separation of powers and the winner-take-all character of U.S. elections, which have limited the ability of fringe parties to challenge the hegemony of the two dominant parties.

Finally, culturalists tend to overlook – or at least downplay – the historical interaction between political culture and policy change. A decade or so of research on comparative public policy suggests that government policy does not simply respond to the values and demands of the mass public but also crucially shapes them. Policies may have what Paul Pierson calls “lock-in effects,” encouraging rational individuals to orient their actions around the new expectations and institutions that policies create.¹⁹ Or they may shape individual values by defining the rights and obligations of citizenship

16. Seymour Martin Lipset, *Continental Divide: The Values and Institutions of the United States and Canada* (New York: Routledge, 1990), 2, xvi, 138.

17. See in particular *The Federalist*, Nos. 10, 51 (James Madison).

18. Maurice Duverger, *Political Parties* (New York: Wiley, 1954); Douglas R. Rae, *The Political Consequences of Electoral Laws* (New Haven, CT: Yale University Press, 1971); Gary W. Cox, “Centripetal and Centrifugal Incentives in Electoral Systems,” *American Journal of Political Science* 34 (1990): 903–35.

19. Paul Pierson, “When Effect Becomes Cause: Policy Feedback and Political Change,” *World Politics* 45 (1993): 606. See also, Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (New York: Cambridge University Press, 1994); and Esping-Anderson, *Three Worlds*.

or setting out the criteria by which individuals are eligible for special benefits or required to bear special burdens.²⁰ Canada's Medicare program, for example, has given rise to an extensive set of public expectations about the proper way to finance medical care, and it has become a powerful symbol of national values. Similarly, the British National Insurance Act of 1911 conditioned the public to accept government involvement in medical care and helped free state medicine from the stigma of the British poor laws.

The essential contribution of the culturalist tradition is to remind political analysts that policymaking is not the matching of objective problems with solutions, but rather a process of value-laden debate in which both problems and solutions are, in part, socially constructed. As John Searle convincingly argues, even political institutions are largely social constructs, although they are no less real or significant for being so.²¹ Yet culturalists often move from these critical observations to the more suspect claim that culture or public opinion is the prime moving force in politics. In the health policy domain, this claim simply does not stand up to the evidence. Similar health policies have been justified in very different cultural terms, and very different political cultures have produced remarkably similar health policies. Indeed, a surprising degree of cross-national learning is evident in health policy, with many countries considering the same set of ideas at roughly the same time. If cultural understandings have set boundaries on health policy debates, these limits have been relatively permissive and malleable.

Societal Interests and Political Power

A third class of explanations for national health and social policies – perhaps the dominant form of explanation in health policy analysis – treats public policies as the result of political struggle among competing groups. These explanations have been widely used in analyses of the politics of national health insurance, owing mainly to the highly visible role of organized medicine in the development of such programs. But they are also prominent in explanations of the development of the welfare state more generally, especially in what might be called the “social democratic model” of welfare state growth, which places primary emphasis on the struggle between labor and capital over universal social policies.²²

Of all the groups mentioned in health policy analysis, the medical profession looms largest. Unlike most social programs, government health insurance involves the purchase of services from a clearly defined and often extremely powerful profession. As Ellen Immergut argues, struggles between doctors and the state over healthy policy reflect a very real conflict of interest between the sellers and buyers of medical services.²³ As the sole

20. Bo Rothstein, “Just Institutions Matter: The Moral Logic of the Universal Welfare State,” Uppsala University, photocopy, 1994.

21. John R. Searle, *The Construction of Social Reality* (New York: Free Press, 1995).

22. Michael Shalev, “The Social Democratic Model and Beyond: Two Generations of Comparative Research on the Welfare State,” *Comparative Social Research* 6 (1983): 315–51.

23. Ellen M. Immergut, “The Rules of the Game: The Logic of Health Policy-Making in

sellers of valuable services, doctors are inevitably threatened by the concentration of purchasing power in the hands of one or few powerful buyers. They therefore have good economic reason to resist universal government health insurance even when its short-run effect may be a rise in their incomes. And, in fact, in no western nation with national health insurance did physicians unreservedly welcome the extension of government control.

Still, it is not true, as Immergut suggests, that doctors in all countries and at all times have been equally hostile to government intervention.²⁴ In no country has the medical profession wholeheartedly embraced national health insurance. Nonetheless, the depth of professional opposition and the alternatives that physicians have supported have both varied significantly over time and across nations. Moreover, these differences appear to reflect not only strategic political considerations but also real differences in doctors' preferences rooted in contrasting market structures. In Britain, for example, the profession's response to the prospect of the National Health Service (NHS) was decidedly mixed and ambivalent. Although Harry Eckstein may be exaggerating when he claims that "by 1942 . . . the profession was beginning to agree with the concrete programs no less than the ideal principles of the more ambitious reformers," the British Medical Association (BMA) was nonetheless far more receptive to the idea of reform than the American Medical Association (AMA) had ever been or ever would be.²⁵

Canada presents in some ways an even more revealing contrast with the United States. The Canadian Medical Association (CMA) saw government health insurance as "necessary . . . and probably inevitable" during the 1930s and endorsed government health programs at the provincial level in 1943.²⁶ Less than a decade later, however, the CMA had "abandoned com-

France, Switzerland, and Sweden," in *Structuring Politics: Historical Institutionalism in Comparative Analysis*, ed. Sven Steinmo, Kathleen Thelen, and Frank Longstreth (New York: Cambridge University Press, 1992), 57–58. See also Ellen M. Immergut, *Health Politics: Interests and Institutions in Western Europe* (New York: Cambridge University Press, 1992).

24. If, as I argue, doctors' preferences vary over time and across countries, that would seem to call into question Immergut's claim that her research method allows her to hold the interests of the medical profession "constant and . . . observe the effects of the institutions on the policy process" (Immergut, *Health Politics*, 252 n. 38). Although doctors in the countries she studied certainly had similar interests, clear intertemporal and cross-national differences emerge in her case studies even when one takes into account the different strategic contexts that the profession faced. Moreover, Immergut does not explore the reciprocal influence of policy decisions on the preferences of doctors—a historical feedback effect that will be a major subject of my analysis.

25. Harry Eckstein, *The English Health Service: Its Origins, Structure, and Achievements* (Cambridge, MA: Harvard University Press, 1958), 118. An internal poll of the BMA membership at the time showed a majority of doctors in agreement with the government on every important substantive issue and nearly 40 percent of doctors in agreement with the entire scheme (ibid., 147). BMA opposition increased after the Labour Party came to power in 1945, but the organization never reacted with the kind of vehemence that characterized the AMA's response to the far more modest American reform proposals of the 1940s.

26. Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System and Their Outcomes* (Toronto: McGill-Queen's University Press, 1987), 23.

pletely its 1943 policy . . . by announcing a new policy statement favoring the extension of voluntary plans to cover all Canadians with governments paying the premiums for those unable to provide for themselves.”²⁷ Although the CMA never matched the AMA in the bitterness of its opposition, by the 1950s it was leading the charge against government health insurance with heated rhetoric and high-profile strikes.²⁸

Why do physician attitudes toward national health insurance differ over time and across countries? No doubt many factors are at work, but two seem to have been critical in all cases: the profession’s assessment of its prospects in the political arena and the availability of acceptable private alternatives to government insurance. A large part of the reason for the stridency of the U.S. medical profession is the reality that American doctors never had to confront, as Canadian and British doctors did, the inevitability of some form of government provision. From the 1940s on, the American medical profession also enjoyed the security of rapidly expanding physician-dominated private insurance plans – something British doctors, who feared the miserly friendly societies as much as the state, abjectly lacked. It is no coincidence that the Canadian medical profession’s about-face in 1949 came on the heels of a concerted and largely successful effort by the CMA to establish profession-sponsored voluntary medical plans in the Canadian provinces. In all three countries – Britain, Canada, and the United States – physicians made preemptive concessions when the political deck was stacked against them and fortified their opposition when physician-dominated private insurance plans emerged as a viable option. Situated at the intersection of a threatening political arena and a sometimes hostile economic market, the medical profession responded differently to proposals for national health insurance according to the threats and opportunities that it faced from each quarter.

Explanations focusing on the power of physicians thus fall short in several key respects. If doctors everywhere have resisted the expansion of government control, why then are proposals for national health insurance ever successful? The counterintuitive argument that national health insurance is really in the interest of doctors confuses the effect of national health programs (generally favorable for the medical profession, at least in the short term) with the position of the profession on such programs (invariably negative). At the same time, despite common patterns of professionalization and similar underlying interests, the medical profession has not responded to national health proposals with the same intensity or stance in all countries or at all times, nor has it enjoyed the same success in blocking such proposals. Explaining this variation requires expanding the scope of analysis to explore the market and government institutions shaping professional preferences and orientations. It also requires bringing into the picture other interests with a stake in national health policies.

27. Ibid., 108.

28. Robin F. Badgley and Samuel Wolfe, *Doctors’ Strike: Medical Care and Conflict in Saskatchewan* (New York: Atherton, 1967).

Perhaps the most important of such interests is labor. An influential line of analysis associated with Marxist theorists conceives of the welfare state as the product of labor victories over capital in the electoral arena.²⁹ The paradigmatic case for such theorists is Sweden, where centralized labor unions, in alliance with a successful social democratic party, helped put in place the major components of Sweden's full-employment welfare state. Where labor gained power and allied with strong social democratic parties, this argument goes, extensive and universal social insurance programs were the inevitable result. And chief among these programs – in Sweden and elsewhere – was national health insurance.

At first glance, strong support for the social democratic model appears in the British, Canadian, and U.S. cases. The NHS was, after all, enacted under the Labour Party and is widely seen as “the greatest socialist achievement of the Labour government.”³⁰ The first important step toward Canadian Medicare – the Saskatchewan Hospital Services Plan – was passed in 1946 after the social democratic Cooperative Commonwealth Federation (CCF) captured a majority of seats in the Saskatchewan legislature. And, of course, the United States has never had a major social democratic party: The Socialist Party received 6 percent of the vote and no congressional seats in its best electoral showing, in 1912.

Probing somewhat deeper, however, the social democratic model is actually quite insufficient, not only as an account of what happened in Britain and Canada, but also as an explanation for the contrasts among Britain, Canada, and the United States. In Britain, for example, the 1946 legislation creating the NHS was certainly consistent with Labour principles. Yet, in fact, the final features largely followed the 1944 White Paper prepared by Britain's wartime Coalition government.³¹ In any case, the NHS must be viewed as a direct outgrowth of the 1911 National Insurance Act, which, although passed against the backdrop of widespread labor unrest and increasing Labour Party strength, was crafted by the Liberal Party rather than by Labour.

In Canada, too, the full story is at odds with the social democratic script. Although Saskatchewan enacted hospital insurance under a socialist government, other provinces – such as Ontario – did so under parties committed to free enterprise. The final move to create the national Medicare program was carried out not by a social democratic government but by a coalition of parties of which the generally moderate Liberal Party was the leading partner. To be sure, the Liberal-led coalition depended heavily on the New Democratic Party (NDP), a social democratic party that grew out

29. See, for example, Walter Korpi, *The Democratic Class Struggle* (London: Routledge, 1983); and John Stephens, *The Transition from Capitalism to Socialism* (London: Macmillan, 1979).

30. Michael Foot, quoted in Klein, *The Politics of the National Health Service*, 1.

31. Indeed, a remarkable degree of consensus existed among Conservative and Labour politicians about the necessary features of a national plan, so much so that Klein's authoritative account characterizes the development of the NHS as a process of “social learning” rather than one of partisan struggle (*ibid.*, 26).

of the CCF. But social democrats were by no means the only organized political force that supported compulsory insurance in Canada or elsewhere, and their political ascendance appears to be neither a necessary nor a sufficient condition for the initiation or passage of such programs.

Nor does the prominence of organized labor correspond reliably with the success of national health insurance proposals in Britain, Canada, and the United States. Britain has undoubtedly had the strongest trade union movement of the three countries. Yet, in the early twentieth century, levels of labor unrest and union density in the industrial American states where compulsory health insurance was debated were actually quite comparable to those in Britain.³² The U.S. and Canadian labor movements, on the other hand, followed almost identical trajectories until the 1960s, when Canadian union membership skyrocketed and American membership stagnated. For thirty of the last sixty years, in fact, the unionized proportion of the workforce has been slightly higher in the United States than in Canada.³³

All this should not be taken to mean that the demands of organized labor are not important to the passage of universal health insurance or that labor has been as strong in the United States as it has been in Britain or Canada. It should indicate, however, that labor strength cannot be the sole or final explanation for the passage of national health programs. It cannot be the sole explanation because such programs have been supported by, and implemented under the governments of, parties that are not social democratic. It cannot be the final explanation because the political success of organized labor depends on outside features of its environment over which it has only marginal control. Just as the power of the medical profession varies with the economic and political context within which it must pursue its goals, so the power of organized labor depends critically on the opportunities and constraints it faces in the private sector and the political arena. Understanding those opportunities and constraints is the challenge ahead.

INSTITUTIONS AND POLICY

Faced with the complex and seemingly idiosyncratic causal narratives that lie behind each country's health policies, the natural response is to lament that comparative generalizations are impossible or, when possible, trivial. Yet the weakness of traditional accounts does not imply that suitably gener-

32. Strikes, for example, were actually more frequent in the United States than in the United Kingdom. Victoria Hattam, *Labor Visions and State Power* (Princeton, NJ: Princeton University Press, 1993), Table 1. On comparative unionization, see Skocpol, *Protecting Soldiers and Mothers*, 219. Indeed, the critical difference between British and U.S. unions during this period was not their organizational strength, but their orientation and strategies. In the United States, the national American Federation of Labor led by Samuel Gompers actually opposed compulsory health insurance as a threat to private union contracts.

33. Noah M. Meltz, "Labor Movements in Canada and the United States," in *Challenges and Choices Facing American Labor*, ed. Thomas A. Kochan (Cambridge, MA: The MIT Press, 1985), 315–16.

al explanations cannot be constructed, only that such explanations will need to be attentive to the complex interplay of variables that leads to the failure or enactment of specific national policies. In recent years, scholars have begun to advance a research program that attempts to do just that. Often called “historical institutionalism,” this perspective aims to integrate holistic or evolutionary accounts of politics with an appreciation for the role of political institutions and the importance of historical sequence, timing, and contingency.³⁴ Although the body of scholarship growing out of this perspective remains scattered and sometimes belies its stated eschewal of grand explanations, it nonetheless provides a very useful framework for organizing and synthesizing competing claims about the development of public policy.

Administrative Capacity

Among the major institutional features that have shaped the prospects for government-sponsored health insurance, three have received considerable attention in research on the development of the welfare state: state administrative capacity, federalism, and overall government structure (particularly the contrast between parliamentary and presidential systems). The importance of administrative capacity is a major theme in the writings of such state-centered theorists as Theda Skocpol and her collaborators. Skocpol defines “state capacity” as the ability of “states to implement official goals, especially over the actual or potential opposition of powerful social groups.”³⁵ Although state-centered theorists are not always clear about what contributes to state capacity, most agree that highly capable states are characterized by centralized, well-financed administrative bureaucracies staffed with trained and prestigious civil servants. In addition, state-centered accounts emphasize the distinctive administrative mechanisms that state officials have at their disposal to implement public policies.³⁶

Administrative capacity certainly explains some of the health policy differences among Britain, Canada, and the United States. But its explanatory power appears to wane after the 1930s, and it ultimately seems less important than either federalism or overall government structure. Of the three countries, Britain has clearly had the strongest and most centralized bureaucracy. Although major civil service reforms instituting merit exams and the like were passed at roughly the same time in all three nations, Britain’s administrative apparatus is more unified than Canada’s and more powerful

34. See, for example, Peter B. Evans, Dietrich Rueschemeyer, and Theda Skocpol, eds., *Bringing the State Back In* (New York: Cambridge University Press, 1985); Peter A. Hall, *Governing the Economy: The Politics of State Intervention in Britain and France* (Cambridge: Polity Press, 1986); and Sven Steinmo, Kathleen Thelen, and Frank Longstreth, eds., *Structuring Politics: Historical Institutionalism in Comparative Analysis* (New York: Cambridge University Press, 1992).

35. Theda Skocpol, “Bringing the State Back In: Strategies of Analysis in Current Research,” in *Bringing the State Back In*, 9.

36. Margaret Weir and Theda Skocpol, “State Structures and the Possibilities for ‘Keynesian’ Responses to the Great Depression in Sweden, Britain, and the United States,” in *Bringing the State Back In*, 118.

than the United States'. The Canadian civil service and cabinet system is modeled after the British. But in Canada the tasks of administration are spread across the provinces as well as the national government, and since the 1960s administration has become more decentralized. The U.S. administrative state is something of an anti-model in comparative perspective – late to develop, fragmented, dominated by short-term political appointees, providing little status and meager income to civil servants, and hemmed in by Congress. Yet despite all these sources of weakness, key administrators in the Social Security Administration (SSA) and other pockets of administrative power fought for national health insurance from the New Deal onward, apparently never doubting the ability of their agencies to implement universal health insurance.³⁷ In none of these three countries, in fact, did administrators shy away from developing and implementing quite ambitious national health programs, and in several notable instances – not only in Britain and Canada, but also in the United States – they pushed actively for reform over a considerable length of time.³⁸

Federalism

Federalism has received far less attention from analysts of the welfare state than administrative capacity, but it looms much larger in the political histories of Canada and the United States. Although early theories of bureaucratic revenue-maximization suggested that fragmentation of authority creates inherent tendencies toward fiscal expansion, most current theories of federalism contend that federalism dampens public spending and the expansion of the welfare state.³⁹ According to these theories, federalism raises at least three barriers to the creation and expansion of social programs: first, by dispersing authority, it hinders administrative coordination and political agreement; second, by multiplying arenas of political representation, it increases the number of “veto points” at which political actors can block policy proposals; and, third, by creating distinct regional political jurisdictions, it creates opportunities for mobile individuals or organizations to “exit” from jurisdictions where their interests are threatened. This last feature of federal systems – the possibility of exit – has been a major theme of political-economic theories of federalism, which emphasize the

37. Martha Derthick, *Policymaking for Social Security* (Washington, DC: Brookings, 1979), 316–38. The Social Security Administration (SSA) actually began as the Social Security Board—a three-member board that administered old-age insurance and other Social Security Act programs until 1946, when the SSA inherited its duties. To avoid confusion, however, I use SSA throughout this article.

38. As Immergut notes in the European context, bureaucracies in very different countries “have prepared quite similar proposals for national health insurance, and the differences in what was ultimately enacted cannot be traced to differences in the implementing bureaucracies.” Immergut, *Health Politics*, 24.

39. On early theories, see David R. Cameron, “The Expansion of the Public Economy: A Comparative Analysis,” *American Political Science Review* 72 (1978): 1248. (Cameron, in fact, found the opposite effect.) For current theories, see Paul E. Peterson, *City Limits* (Chicago: University of Chicago Press, 1981); and Peterson, *The Price of Federalism* (Washington, DC: Brookings, 1995).

political constraints that subnational governments face due to their fiscal dependence on mobile economic factors, particularly private capital.

Yet despite the clear logic of these theories, federalism has not had the same effect on the development of health policy in the United States and Canada, nor have the two countries' federal systems evolved in the same direction. In the United States, the effects of federalism have largely comported with the expectations of orthodox theories. Before the New Deal, reformers were forced to campaign for their proposals at the state level, and the difficulties of coordinating state-by-state efforts, mobilizing political support across localities, and assuaging the concerns of state leaders about capital flight presented virtually insurmountable barriers to the passage of major compulsory insurance programs. After the New Deal, reformers shifted their aspirations to the federal level, beginning a long struggle for national health insurance that would result in the passage of Medicare and Medicaid but make little further progress. With the exception of Hawaii – which, by virtue of its geographic isolation, was spared a serious threat of exit when it adopted its near-universal health program in 1974 – health policy innovations at the state level in the United States have been limited and incremental.⁴⁰

In Canada, by contrast, the provinces proved to be a crucial incubator of policy activism, and national health insurance was enacted even as the provinces were becoming more, not less, autonomous. Although federal-provincial relations obstructed national health insurance immediately after World War II (when proposals for government health insurance expired with the collapse of the Dominion-Provincial Conference of 1945), provincial efforts later paved the way for national legislation. Moreover, Canadian Medicare was not instituted through the consolidation of federal authority. To the contrary, although provincial health insurance programs have to meet national standards and are partially funded by the federal government, they are locally administered and differ from province to province.

What explains the divergent role that federalism has played in Canada and the United States? Why has the U.S. experience largely supported orthodox theories of federalism, whereas the Canadian experience has given rise to a competing revisionist literature that sees federalism as conducive to social democratic political victories and the expansion of social programs?⁴¹ Many factors account for the comparative distinctiveness of

40. In contemporary research on state health policies, the constrained range and scope of state-level initiatives are frequently linked to the Employee Retirement Income Security Act (ERISA), a 1974 federal law that prevents states from taxing or regulating insurers who “self-insure” (that is, pay for employee medical claims themselves). But, as Carolyn Tuohy argues, “there was little evidence of state activism in the health care financing arena before the passage of ERISA in 1974” (“Variation in Health Care Policy in the American States: The Dog That Didn’t Bark,” [University of Toronto, photocopy, p. 2]). The obvious exception to this generalization is of course Hawaii, which started its program just as ERISA took effect and now enjoys a special ERISA waiver.

41. For a summary of this revisionist scholarship, see Gwendolyn Gray, *Federalism and Health Policy: The Development of Health Systems in Canada and Australia* (Toronto: University of Toronto Press, 1991), 12–14.

Canadian federalism, including the prominent coincidence of provincial and ethnoreligious demands for autonomy. My focus, however, will be on two important and dynamic features of Canadian and U.S. federal institutions: first, the way in which each country's federal structure has interacted with other factors – particularly partisan competition – to further or hinder movement toward national health insurance; and, second, the way in which political struggles and decisions have reshaped federal relations over time. I argue that federalism does indeed create characteristic risks and opportunities, but that the relationship between federalism and broader aspects of the political and fiscal environment is often a more important determinant of policy outcomes than the fact of federalism itself.

Two features of that environment are crucial in the health policy field: the ability of third or minor parties to gain power in subnational governments and the effort of the federal government to equalize finances across subnational jurisdictions.⁴² On both these dimensions, the United States and Canada depart sharply. Although a few of the American states have experienced serious multiparty electoral competition, “in these and the few other instances of statewide tri-partyism . . . the period of tri-partyism was brief and ended with an adjustment back into two-partyism.”⁴³ The historical dominance in most states of two or fewer major parties has limited the degree to which state policy departs from national patterns and thereby narrowed the range of state policy experimentation. In contrast, most of the Canadian provinces have had vibrant multiparty systems, and the constellation of parties has differed significantly from province to province, thus widening the range of experimentation. This is in part a result of the parliamentary structure of provincial governments, but it also reflects the limited ability of the national government to accommodate regional interests. Strict party discipline in parliament hinders the major parties from absorbing regional factions, and the Canadian federal government lacks a territorially organized legislative body such as the U.S. Senate. Regionally based parties are thus viewed as important defenders of provincial interests in both interprovincial deliberations and national politics.⁴⁴

Canadian federalism is also based on a much stronger commitment to fiscal equalization among subnational governments than exists in the United States.⁴⁵ This has mitigated provincial fears of labor and capital flight and permitted the poorer provinces to play a leadership role in Canadian social policy that their limited fiscal resources might otherwise have precluded. Furthermore, the Canadian federal government has pursued social policy aims largely through conditional grants to the provinces

42. For a parallel argument that expands on these points, see Paul Pierson, “Fragmented Welfare States: Federal Institutions and the Development of Social Policy,” *Governance* 8 (1995): 463–67.

43. Frank J. Sorauf, *Party Politics in America* (Boston: Little, Brown, 1968), 32.

44. Antonia Maioni, “Parting at the Crossroads: The Development of Health Insurance in Canada and the United States,” *Comparative Politics* 29 (1997): 413–14. I am also indebted to Kent Weaver for emphasizing this point.

45. Pierson, “Fragmented Welfare States,” 466.

rather than through the creation of national programs. These grants have encouraged the development of administrative capacity at the provincial level while allowing provincial leaders to claim credit for social programs. And it has given those provinces that have taken the lead in the creation of social programs strong incentives to press for supportive national standards and funding.

Overall Government Structure

The final and most important institutional feature that has shaped health policy in Britain, Canada, and the United States – overall government structure – is also the most difficult to define.⁴⁶ Perhaps the most appropriate definition is R. Kent Weaver and Bert Rockman's concept of "regime type."⁴⁷ In addition to distinguishing between presidential and parliamentary systems, Weaver and Rockman contrast three ideal-type parliamentary systems: multi-party coalition regimes (such as Germany), party government regimes (such as Britain), and single-party dominant regimes (such as Japan). Regime type does not refer to particular partisan distributions but rather to general patterns of political cleavage and interaction facilitated by the organization of political institutions and the framework of electoral rules.

As similarly structured parliamentary systems, both Britain and Canada fall into Weaver and Rockman's party government category. National two-party competition is encouraged by the confluence of parliamentarism, single-member districts, and plurality elections. But though Weaver and Rockman emphasize the British and Canadian tendency toward two-party competition, another distinguishing feature of these parliamentary systems – especially when compared with the United States – is the recurrent influence of small insurgent parties, such as the British Labour Party and the Canadian New Democratic Party. Even without proportional representation, insurgent parties do not face the same barriers in Westminster-style systems as they do in the separation-of-powers system of the United States.

Despite similar structures, the British and Canadian systems operate quite differently because of the intervening influence of federalism. Compared with both Britain and the United States, Canada has had a uniquely rich history of regionally based social movements. Regional parties have formed governments in a number of provinces, but have not aligned with the major national establishment parties.⁴⁸ Because of the different politi-

46. Immergut, for instance, speaks of a country's "institutional configuration," which she defines as "the political system taken as a whole, with all its institutional provisions and a particular distribution of partisan representatives," Immergut, *Health Politics*, 28. The danger here is including aspects of the political environment that are not, properly speaking, institutional. The "distribution of partisan representatives," for example, is obviously shaped by electoral rules and procedures, but it is also influenced by a host of noninstitutional factors—public opinion, foreign crises, economic performance, political scandals, and so on.

47. R. Kent Weaver and Bert A. Rockman, "Assessing the Effect of Institutions," in *Do Institutions Matter? Government Capabilities in the United States and Abroad*, ed. R. Kent Weaver and Bert A. Rockman (Washington, DC: Brookings, 1993), 19–21.

48. Lipset, *Continental Divide*, 205.

cal forces operating at the federal and provincial levels, parliamentary negotiations in Canada are marked by a distinct two-level logic. Indeed, federal-provincial relations have given rise to highly institutionalized extra-parliamentary channels by which national and provincial ministers meet to negotiate agreements.

The U.S. political system is unique among advanced industrial democracies. Power is divided and shared among three branches of government, each with its own independent authority, responsibilities, and bases of support. In contrast with parliamentary practice, executive and legislative authority are distinct. American presidents are independently elected, they have a fixed term of office, their cabinet is not drawn from the legislature, and they have the power of the veto, overriding of which requires a congressional supermajority. Within the legislature, power is further divided between two houses, as well as among a host of committees and subcommittees. In the Senate, the filibuster and a tradition of respect for minority rights allow committed senators to block proposals that lack supermajority support. Partly as a result of this extreme institutional fragmentation, parties have never played the aggressive programmatic role in the United States that they have in Europe.

The conventional wisdom among political scientists is that these features of American government are inimical to the enactment of major social reforms. The separation of powers and supermajority hurdles such as the veto and filibuster multiply the number of veto points, diffuse electoral accountability, fragment legislative authority, and lessen the incentives for party cohesion.⁴⁹ As Sven Steinmo has put it,

In the United States, reformers must design and adapt their policies to cater to the objections and desires of a huge number of interest groups and congressional constituencies. In parliamentary systems compromises must be made . . . but when programs have been decided on by relatively small groups of elites, they can [be] and usually are passed through their respective legislatures with very little substantive change or amendment.⁵⁰

Although generic differences between parliamentary and presidential systems are important, blanket critiques of American government need to be qualified in several ways if we are to understand the distinctive pattern of U.S. health policy. First, we must be careful not to compare the American experience with an idealized or overdrawn conception of other countries' parliamentary democracies, or to ignore the influence of secondary regime characteristics like federalism. Second, it is also important to stress that although the separation of powers hinders the passage of some types of

49. On the status quo bias created by multiple veto points, see Immergut, *Health Politics*; and George Tsebelis, "Decision Making in Political Systems: Veto Players in Presidentialism, Parliamentarism, Multicameralism and Multipartyism," *British Journal of Political Science* 25 (1995): 289–325.

50. Sven Steinmo, "American Exceptionalism Reconsidered: Culture or Institutions?," in *The Dynamics of American Politics*, ed. Lawrence C. Dodd and Calvin Jillson (Boulder, CO: Westview, 1994), 126–27.

policies, it encourages the passage of other types. Redistributive social reforms may be disadvantaged by the fragmented organization of Congress, for instance, but universalistic distributive policies – such as the 1946 Hill-Burton Act funding hospital construction – are facilitated by these very same structural features.⁵¹ Third, and most important, we must be attentive to changes in the configuration of institutions over time. In the United States, policy legacies, political struggles, and efforts at political reform have significantly reshaped political institutions over the last century and a half.

HOW HISTORY “MATTERS”

Our review of the institutional landscape of Britain, Canada, and the United States thus brings us to the other side of the historical institutionalist project – namely, its commitment to historical analysis. Although those who consider themselves historical institutionalists are probably in greater agreement about the need for historical analysis than they are about the exact definition of institutions, the historical side of historical institutionalism is in many ways less distinct and well developed than the institutionalist side. This is not because institutionalists fail to uphold their stated conviction that politics must be studied in historical context, but because they have encountered difficulties in explicating a distinctive understanding of the role and importance of historical analysis, beyond the truism that history matters.

Path Dependence

One conception of history's role that has been catching on among historical institutionalists is contained in the notion of *path dependence* – a term popularized by economists W. Brian Arthur, Paul David, and Douglass North.⁵² As these theorists use the term, path dependence is meant to suggest the importance of “temporally remote events, including happenings dominated by chance elements rather than systematic forces.”⁵³ Even seemingly trivial events at an earlier point in time may have dramatic long-term economic consequences when certain self-reinforcing mechanisms – large set-up or fixed costs, learning effects, coordination effects, and the like – are present.⁵⁴ As a result, gaps may open and persist between the

51. The classic account of how congressional individualism fuels distributive particularism is David R. Mayhew, *Congress: The Electoral Connection* (New Haven, CT: Yale University Press, 1974).

52. W. Brian Arthur, “Competing Technologies, Increasing Returns, and Lock-In by Historical Events,” *Economic Journal* 99 (1989): 116–31; Paul David, “Clio and the Economics of QWERTY,” *Economic History* 75 (1985): 332–37; Douglass C. North, *Institutions, Institutional Change, and Economic Performance* (New York: Cambridge University Press, 1990).

53. David, “Clio and the Economics of QWERTY,” 332.

54. Arthur, “Self-Reinforcing Mechanisms in Economics,” in *The Economy as an Evolving Complex System*, ed. Kenneth J. Arrow and David Pines (Reading, MA: Addison-Wesley, 1988), 10.

traditional expectations of neoclassical theory and the actual performance of economies or economic organizations.

In political science, the concept of path dependence has taken on a significantly broader meaning and has found increasingly rich expression in writings on statebuilding and policy feedback. Bringing together much of this research, Paul Pierson has identified a number of distinct channels through which policies passed at one point in time shape subsequent political dynamics.⁵⁵ Policies may alter administrative capacities, create incentives for group formation, teach specific lessons to policy makers, or give rise to widespread public expectations or vast networks of vested interests. Drawing on Arthur, Pierson argues that policies frequently “provide incentives that encourage individuals to act in ways that *lock in a particular path of policy development*,” creating societal commitments that may be quite difficult to reverse.⁵⁶ For this reason, the timing and sequence of policies can be extremely important in determining eventual political outcomes. By pushing policy development down a particular historical path, a policy passed at time T_1 may significantly constrain the range of possible options at time T_2 .

In this respect, path dependence arguments are fundamentally at odds with general equilibrium models. If competitive selection or other negative feedback mechanisms weed out deviations from expected patterns over time, then the path of historical development is irrelevant and a focus on synchronic factors entirely appropriate. In economics, where work on path dependence has had the greatest impact, specifying alternative historical paths is made significantly easier by the widely accepted baseline of efficiency. In political science, the task is more difficult, and requires either comparative analysis or the careful use of counterfactual scenarios. This article relies on both these methods. By comparing the divergent historical trajectories of Britain, Canada, and the United States, I identify and explain the important turning points in the development of each country's national health policies and show how these crucial moments sent each nation down a distinctive historical route. At the same time, I use specific counterfactual scenarios (bolstered by comparative evidence) to suggest how policy developments in each nation might have turned out differently had political conditions or choices been different than they were.⁵⁷

Critical Junctures

An alternative, though by no means incompatible, conception of history's role that is also popular among historical institutionalists is contained in the notion of *critical junctures*. Whereas path dependence implies that seemingly small, even happenstance, changes at one point in time may have large eventual consequences through self-reinforcing processes of societal

55. Pierson, “When Effects Becomes Cause.” 56. Ibid., 606.

57. For more on counterfactual analysis, its rationale, and its proper use, see James D. Fearon, “Counterfactuals and Hypothesis Testing in Political Science,” *World Politics* 43 (1991): 169–95.

response and adaptation, the literature on critical junctures calls attention to periods “of significant change” that typically occur “in distinct ways in different countries (or in other units of analysis)” and that are “hypothesized to produce distinct legacies.”⁵⁸ Examples of critical junctures include the establishment of national constitutions, the process of state formation, the development and realignment of party systems, the commercialization of agriculture during modernization, and the process of labor incorporation into politics.⁵⁹ What all these critical moments have in common is their fundamental impact on subsequent historical dynamics. The ways in which these crucial periods of transition occurred shaped processes of political and economic development for decades to come. Big historical events have big historical consequences.

Advocates of the concept of critical junctures sometimes link their method of study to the notion of path dependence.⁶⁰ Yet the two concepts are not identical. The idea of path dependence is perhaps best suited to explaining the *reproduction* of a critical juncture’s legacy rather than the production of the critical juncture itself. Path dependence suggests why the effects of critical junctures are so profound and enduring. It does not explain why critical junctures occur, nor does it necessarily imply – as the idea of critical junctures does – that political or economic development is characterized by a series of historical “big bangs” or “punctuated equilibria” whose legacies persist for long periods of time.⁶¹

One reason to emphasize the tension between the notions of path dependence and critical junctures is to challenge the relatively static conception of institutions and their effects that has frequently crept into historical institutionalist research. As Kathleen Thelen and Sven Steinmo argue in their comprehensive review of comparative institutional analysis, “[T]he critical inadequacy of institutional analysis to date has been a tendency toward mechanical, static accounts that largely bracket the issue of change and sometimes lapse inadvertently into institutional determinism.”⁶² Part

58. Ruth Berins Collier and David Collier, *Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America* (Princeton, NJ: Princeton University Press, 1991), 29.

59. Classic works dealing with such seminal moments in national development include Seymour Martin Lipset and Stein Rokkam, “Cleavage Structures, Party Systems, and Voter Alignments: An Introduction,” in *Political Parties and Political Development*, ed. Joseph LaPalombara and Myron Weiner (Princeton, NJ: Princeton University Press, 1960); Barrington Moore, Jr., *Social Origins of Dictatorship and Democracy: Lord and Peasant in the Making of the Modern World* (Boston: Beacon, 1966); and Alexander Gerschenkron, *Economic Backwardness in Historical Perspective: A Book of Essays* (Cambridge, MA: Harvard University Press, 1962).

60. See, for example, Collier and Collier, *Shaping the Political Arena*, 27.

61. On punctuated equilibria in institutional development, see Stephen D. Krasner, “Approaches to the State: Alternative Conceptions and Historical Dynamics,” *Comparative Politics* 16 (1984): 223–46.

62. Kathleen Thelen and Sven Steinmo, “Historical Institutionalism in Comparative Politics,” in *Structuring Politics*. This generalization does not, of course, apply to all historical institutionalists, some of whom have been quite sensitive to temporal questions and issues of institutional change. Still, as Paul Pierson notes, “The significance of temporal processes in historical institutionalist analysis is often left implicit or downplayed. Much of this work has been essentially inductive in orientation, and in general practitioners have not been inclined to reflect on

of the explanation for this is that institutionalists, in their eagerness to counter pluralism, Marxism, and other socially deterministic perspectives, have tended to veer toward the opposite extreme, subsuming even societal factors under the institutional rubric and thereby obscuring the interaction between institutions and other factors. Furthermore, institutionalists have shown themselves to be better at describing the constraints on change that institutions pose than at specifying the opportunities for change that institutions create. Like the behavioralists they criticize, institutionalists generally treat stable political patterns (or, in rational-choice parlance, "structure-induced equilibria") as normal or natural, while viewing changes in such patterns as aberrational or rare.⁶³ This helps account for the strong tendency in institutionalist scholarship to attribute political change to forces and events exogenous to existing institutional structures.

Nonetheless, institutionalist explanations are not necessarily about stasis, as the critical junctures metaphor, with its image of stable institutions punctuated by dramatic periods of exogenously determined change, suggests. First, stable institutions do not necessarily produce stable outcomes, because institutions only have effects in conjunction with other, frequently more dynamic factors. Second, the existence of multiple overlapping institutions creates cross-cutting incentives and interorganizational conflict that may lead to change even when institutions are themselves stable. Indeed, political development is perhaps best conceived of in institutional terms as the interplay among different institutional forms with different characteristics, incentives, and logics of evolution.⁶⁴ At the most fundamental level, the history of modern medical systems is the story of an ongoing, often

their methods." Paul Pierson, "Path Dependence, Increasing Returns, and the Study of Politics," Program for the Study of Germany and Europe Working Paper Series 7.7 (Center for European Studies, Harvard University, Sept. 1997), 35. Peter Hall and Rosemary Taylor similarly contend that despite having "something of a comparative advantage with regard to the study of institutional origins and change over rational choice theorists," historical institutionalists "have been slow to capitalize on it," and, as a result, "broader theories about processes of institutional change . . . have yet to emerge." Peter A. Hall and Rosemary C. R. Taylor, "Political Science and the Four New Institutionalisms" (paper prepared for the Annual Meeting of the American Political Science Association, New York, Sept. 1994), 21.

63. For an early and influential article criticizing postwar behavioralism on just these grounds, see Samuel P. Huntington, "The Change to Change: Modernization, Development, and Politics," *Comparative Politics* 3 (1971): 283–322. The concept of structure-induced equilibrium was introduced by Kenneth Shepsle, one of the founders of the rational choice variant of institutionalism. See his "Institutional Arrangements and Equilibrium in Multidimensional Voting Models," *American Journal of Political Science* 2 (1979): 27–59; and William Riker, "Implications from the Disequilibrium of Majority Rule for the Study of Institutions," *American Political Science Review* 74 (1980): 432–47. Although rational choice institutionalism and historical institutionalism overlap substantially, the former is primarily concerned with the way in which political institutions, particularly legislative institutions, stabilize social choice processes and allow rational actors to solve collective action problems. For this reason, rational choice institutionalism has tended to focus narrowly on formal rules and to view institutions as intentional, functional, and often voluntary responses to shared dilemmas of cooperation. This puts the perspective at odds with the broader focus and strongly antifunctionalist thrust of historical institutionalism.

64. Karen Orren and Stephen Skowronek, "Beyond the Iconography of Order: Notes for a 'New Institutionalism,'" in *Dynamics of American Politics*.

conflictual interaction between evolving structures of medical technology, finance, and delivery, on the one hand, and the changing contours of governing institutions and public policies, on the other.

Third, and perhaps most important, large-scale institutions do in fact change, however slowly and episodically. Although some scholars define institutions as “stable, valued, and recurring modes of behavior,” to presuppose institutional stability is to rule out exploring what is perhaps the most important aspect of political life – namely, the evolution of institutions. Although path dependence is generally invoked to explain the endurance of institutions, it is also useful for explaining the breakdown of institutions or the opening up of opportunities for institutional change. Public policies, for example, may help solidify stable political coalitions in support of particular programmatic goals. Or they may fracture previous alliances and thereby undermine their own political base. Or they may help create pressures for the expansion of existing policies or for the extension of existing policies into other areas. All these possibilities and more appear in the history of health policy in Britain, Canada, and the United States.

THE ARGUMENT

My explanation of the development of health policy in these three countries builds upon both the emphasis on institutions that characterizes historical institutionalism and the two conceptions of history’s importance that have been advanced by historically minded social scientists. At heart, my explanation is essentially an argument about historical sequence, timing, and policy legacies. This argument begins with the observation that opportunities for fundamental change in health policy have historically been rare.⁶⁵ Programs guaranteeing medical coverage create widely distributed benefits that electorally sensitive politicians threaten at their peril, and they give rise to resourceful vested interests with a stake in the continuance of current arrangements. Most important, national health policies structure health care markets, and these markets in turn place powerful constraints on government policies. We are used to thinking of private insurance, for example, as a natural alternative to government insurance. But, in fact, where sizable private insurance markets exist, they are invariably supported by government policy, either directly through such measures as tax-subsidization or indirectly through such measures as public coverage of high-cost populations. Once institutionalized, however, private insurance markets place formidable constraints on government efforts to expand public insurance or regulation.

Nonetheless, despite the strong tendency toward “lock-in” in the medical sector, windows of opportunity for policy change have opened up in Brit-

65. Carolyn Tuohy, “Response to the Clinton Proposal: A Comparative Perspective,” *Journal of Health Politics, Policy and Law* 19 (1994): 249–54.

ain, Canada, and the United States at similar historical moments.⁶⁶ The exact constellation of forces that pried open these rare opportunities for change differed from country to country and often reflected internal political events, particularly major changes in party control of government. Yet lying behind these critical junctures were transnational world-historical events – the diffusion of social insurance in the early twentieth century, the Great Depression, the Second World War. What is more, health policymakers in these three nations – and, indeed, in industrial nations more generally – faced relatively similar policy dilemmas rooted in the basic underlying economic characteristics of medical care. Expansion of technology, asymmetries of information between providers and patients, uncertainty about the efficacy of services, rising public expectations – in all industrial countries, these forces drove up medical costs, increased public demand for third-party insurance, and compelled governments to act.

Not only were politicians and policy experts in each country motivated by common circumstances, but they also learned from, and reacted against, the ideas and policy instruments that other countries had employed (or that they believed other countries had employed). Indeed, critical periods of political debate in each country took place against the backdrop of broad transnational trends in the tenor and focus of deliberations about health policy. From the early twentieth century until the 1930s, debates about health policy in Europe and North America were tied up with debates about the propriety of social insurance, and the chief aim of national health policies was to replace the income lost by wage earners during spells of sickness. In the 1930s, the debate shifted from a focus on lost wages and the working class to a focus on the financial barriers to medical care faced by all citizens, rich and poor alike. This universalistic focus would last until the global economic problems of the 1970s, only to be overshadowed by an overriding concern with the cost of medical care and by the emergence of new conservative critics of the welfare state.⁶⁷ These transnational intellectual trends helped shape the climate of policymaking in Canada, Britain, and the United States; and the timing of policy developments relative to them helped set the boundaries of what was possible when opportunities for policy change did arise.⁶⁸

Of overriding importance in each country, however, was the distinctive matrix of incentives and constraints created by political institutions. In Britain, Canada, and the United States, windows of opportunity for policy

66. On windows of opportunity, see John W. Kingdon, *Agendas, Alternatives, and Public Policies* (New York: HarperCollins, 1984), 173–80. Kingdon's model of agenda setting is extremely useful for understanding how problems, solutions, and political opportunities come together at critical junctures. It is less useful for understanding how the evolution of policies and institutions narrows the range of viable alternatives over time.

67. For a similar analysis that focuses on intellectual trends in U.S. health policy debates, see Paul Starr, "Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915–1980," in *Compulsory Health Insurance: The Continuing American Debate*, ed. Ronald L. Numbers (Westport, CT: Greenwood, 1982).

68. This point is also emphasized by Tuohy in her "Response to the Clinton proposal," although she seems to have in mind intellectual trends pertaining to health policy alone.

change opened for a variety of reasons – some endogenous to existing institutional configurations, some exogenous. But in all cases, existing institutions structured the windows of opportunity through which advocates of health care reform attempted to push their desired policy changes. Similar ideas about reform and similar domestic and international influences did not encounter similarly receptive institutional structures. And over time, the public policies that squeezed through these rare windows of opportunity reshaped the politics of health policy in these countries in fundamental and irreversible ways, pushing them down distinctive paths characterized by unique political dynamics.

Three policy decisions (or “nondecisions,” since government *inaction* may be as consequential as government action) were particularly crucial in shaping subsequent political struggles. The first involves the degree to which private health insurance was allowed to develop and the form that private plans took. Where physician-friendly forms of private health insurance were allowed to enroll a substantial portion of the population, encouraged through public policy, or both, the stridency of physician opposition to government-sponsored health insurance increased dramatically, the attachment of the employed middle class to private arrangements grew, the cost of medical care exploded, and the task of passing national health insurance became considerably more difficult.

The second policy choice that appears important is the initial target of government insurance programs. Public insurance programs that focused on the working class (as in Britain) or covered the entire population for a single class of medical services (as in Canada) created an expansionary political dynamic that the U.S. Medicare and Medicaid programs, with their singular focus on the elderly, the disabled, and the very poor, did not. There seem to be at least three reasons why America’s twin government insurance programs have not been effective stepping stones to expanded public coverage. First, the elderly, the disabled, and the very poor are among the most costly and difficult groups in society to insure. Covering them under public auspices has greatly increased the strain on public budgets while freeing the private sector to focus on those populations for which private insurance is most viable. Second, both Medicare and Medicaid are highly categorical programs organized around clienteles that are seen, in an important sense, as outside the mainstream of the economy. In contrast, Britain’s social insurance system for wage-earners, though also categorical, focused on a population that was large, growing, and central to the economy. Third, Medicare and Medicaid piggybacked on existing programs – in Medicare’s case, Social Security; in Medicaid’s, public assistance – and their political fortunes and programmatic rationales have been closely tied to these prior initiatives. This is particularly true of Medicare: House Ways and Means Chair Wilbur Mills vowed to “build a fence around the Medicare program” and forestall future expansions by combining hospital insurance (the original proposal) and physician insurance in a stand-alone program for the aged.⁶⁹

69. Marmor, *The Politics of Medicare*, 69.

The third important policy choice that shaped subsequent policy developments in Britain, Canada, and the United States concerns the relative timing of public efforts to bolster the technological sophistication of medicine, on the one hand, and to increase the access of citizens to health care, on the other. Lawrence Jacobs argues that building up the medical industry prior to expanding access – the American pattern – stymies movement toward universal health insurance by balkanizing citizens, creating an insoluble tension between access and costs, and funneling resources to political opponents of reform.⁷⁰ This overarching characteristic of national health policy helps explain the differing trajectories of Britain and the United States, although the experience of Canada is more complex.

The implication of these arguments about sequence and timing is that policy design matters. Political scientists generally treat public policy as the result of political processes, leaving to policy analysts the task of exploring the content of policies and their long-term effects. The expanding body of research on policy feedback and path dependence suggests, however, that in addition to being an outcome of political processes, policies are also an important influence upon them. Far from starting with a blank slate, policymakers almost always labor in the shadows of an extensive framework of existing policies that critically shapes the types of problems they perceive, the policy lessons they learn, the political conditions they face, and the types of policy instruments they have at their disposal. This is precisely why studies of policy development must take long-term historical processes into account.

Table 1 recapitulates the discussion thus far, listing the important factors that are the subject of the three nation studies and summarizing the major health policy outcomes in each country. Although the factors and outcomes are presented here as if they allow a single point-in-time comparison across nations, it should be emphasized that these are, for the most part, not static contrasts among the three nations, but rather descriptions of historical patterns that unfolded in these countries over time and whose effects can be assessed at a number of sequential historical moments, as well as at the national and subnational levels. The universe of observations is therefore much larger than the number of nations.⁷¹

70. Lawrence R. Jacobs, "Politics of America's Supply State: Health Reform and Technology," *Health Affairs* (summer 1995): 143–57.

71. My methodology thus conforms to the advice of King, Keohane, and Verba, who argue that comparing across time and across geographic subunits is a useful way to avoid indeterminate research designs in small-n studies. Gary King, Robert O. Keohane, and Sidney Verba, *Designing Social Inquiry: Scientific Inference in Qualitative Research* (Princeton, NJ: Princeton University Press, 1994), 217–28. In their otherwise helpful commentary, however, King, Keohane, and Verba portray historical analysis as simply a means to obtain additional observations of dependent and independent variables for multivariate analysis. This is not the methodological approach taken here, nor do I think it describes how most historically minded political scientists view their work. In theoretically guided historical analysis, what is of interest is not the relationship among variables at any particular moment but the way in which multifaceted causal processes take place over time. The focus of such classics of macrohistorical analysis as Alexis de Tocqueville's *Democracy in America* and Max Weber's *The Protestant Ethic and the Spirit of Capitalism* is "less on the causal importance of this or that variable contrasted with others [and] more on

Table 2 better captures the historical dimension of the analysis. Previewing the nation studies, it lists the prominent periods of legislative debate in each nation, briefly describes the major policy outcomes that resulted from them, and situates those policy developments within the context of important world-historical events and the transnational climate of policy discourse.

The three nations I have selected for study provide a revealing test of my argument. Despite being similar in many ways, these three nations have different political institutions as well as very different health policies, and their health systems have evolved in different historical directions. To facilitate my exposition of the distinctive path of each nation, the analysis is organized by country and, within countries, chronologically. Periodically, however, I turn to earlier time periods or to the experience of other countries in order to draw out the critical differences among them. The analysis begins with Britain, then considers Canada, then turns to the crucial negative case of the United States.

BRITAIN

In retrospect, what appears most striking about the events leading up to the establishment of the British National Health Service is their seeming inevitability. Historical accounts of the development of the NHS present an almost seamless web of proposals and policy advances running from the public health acts of the nineteenth century to the 1911 National Insurance Act to the founding of the NHS in 1948. No doubt this seamlessness is overstated. Contingency, unforeseen consequences, and policy reversals all

how variables are joined together in specific historical instances." Ira Katznelson, "Structure and Configuration in Comparative Politics," in *Comparative Politics: Rationality, Culture, and Structure*, ed. Mark Irving Lichbach and Alan S. Zuckerman (New York: Cambridge University Press, 1997), 99. Policy feedback, statebuilding, the timing and sequence of institutional change—these are not "values" of a particular variable but rather complex causal processes that unfold historically and involve large numbers of interlocking, often inseparable causes. For this reason, I am sympathetic with Charles Ragin's argument that qualitative, case-oriented research differs from large-n, statistical analysis in its greater emphasis on "causal conjunctures" and "outcome complexity." Charles C. Ragin, "Introduction to Qualitative Comparative Analysis," *The Comparative Political Economy of the Welfare State*, edited by Thomas Janoski and Alexander M. Hicks (New York: Cambridge University Press, 1994), 299–319. However, Ragin's Boolean algebra approach seems suspect, not only because it conceives of causality in deterministic rather than probabilistic terms, but also because its conception of cases (usually nations) as a holistic set of conditions does not seem well suited to historical comparison. Even when these conditions are stated in historical terms (for example, "at least five years of social democratic rule"), the approach obscures changes within and among cases over time and therefore shares difficulties with simple statistical models based on point-in-time comparisons. A similar critique could be leveled against research based on Mill's famous methods of difference and agreement, which were widely introduced to comparative-historical scholars by Theda Skocpol and Margaret Somer's important essay on "The Uses of Comparative History in Macrosocial Analysis," *Comparative Studies in Society and History* 22 (1980): 174–97. However useful as a guide to case selection and research design, Mill's twin methods of comparison also encourage analysts to treat cases as sets of static conditions that can be disaggregated into distinctive, comparable variables.

Table 1. Major Features of British, Canadian, and U.S. Cases

	Overall Government Structure	State Capacity	Federal System	Initial Public Coverage	Relative Timing of Measures to Expand Access and Capacity	Extent to which Physician- Controlled Private Plans Developed	Final Result
Britain	Party- Government Parliamentary	High	No	Wage- Earners	Access Expansion Before Capacity Expansion	Low	National health service based on universal provision and nationalized hospital system (enacted in 1946); relatively low costs
Canada	Party- Government Parliamentary	Medium	Yes	Universal Hospital Coverage	Access Expansion Alongside Capacity Expansion	Medium	National health insurance based on provincial government insurance and predominantly private provision (1966); relatively high costs
United States	Separation of Powers	Low	Yes	Elderly, Disabled, Destitute	Access Expansion After Capacity Expansion	High	Incomplete mix of private and public coverage; highest costs in world

Table 2. Sequence and Timing of Health Policy Developments in Britain, Canada, and the United States

	World-Historical Context	Tone and Topic of Health Care Debates	Britain	Canada	United States
1910					
1915	World War I		National Insurance Act, Part I (1911) (contributory physician insurance and sickness benefits for wage earners; did not cover dependents or hospital care)		Failed Progressive campaign for compulsory insurance (1915–1920)
1920		Contributory social insurance for wage-earners; focus on lost wages due to sickness			
1925					
1930	Great Depression				FDR rejects including health insurance in Social Security (1934)
1935				Federal efforts ruled out by Judicial Committee of the Privy Council (1930s)	
1940	World War II			Failure of postwar health reform proposals	Failed campaign for national health insurance (1945–1950)
1945			National Health Service Act (1946) (created modern British Health Service; universal provision of physician and hospital services, financed by general taxation; nationalized hospital system)	Saskatchewan Hospital Services Plan (1946) National Hospital Plan (1957) Saskatchewan Medical Insurance Act (1961) National Medical Care Act (1966) (created Canadian Medicare program; universal provincially based government health insurance based mainly on private provision; all provinces have comprehensive health insurance programs by 1971)	Hospital Construction Act (1946) Medicare and Medicaid (1965) Competing plans for universal health insurance all defeated (1970s)
1950		Universal social insurance and provision coupled with Keynesian macro-economic policies; focus on access to mainstream of medical care			
1955					
1960					
1965					
1970					
1975	Oil shocks/Stagflation				
1980		Pressure for cutbacks in existing programs, increasing barriers to passage of new programs; conservative electoral resurgence; focus on medical costs			
1985					
1990					
1995					Failed Clinton health reform effort (1993–1994)

marked the road to the NHS, and the final structure of the program was hardly foreordained by what preceded it. And yet, the view of the NHS as an almost inexorable outgrowth of previous policy interventions does contain a large dose of truth. More so than in either Canada or the United States, health policy conflicts in Britain occurred alongside a remarkably consensual process of policy formation in which policymakers and interest groups attempted to work out the tensions created by existing policies and changing conditions. As Klein argues persuasively, the NHS was in part the product of a long and almost imperceptible process of social learning – a policy outcome “dictated . . . by the logic of circumstances, rather than by the ideology of politicians or the demands of pressure groups.”⁷²

Yet social learning does not occur in a vacuum. If the genesis of the NHS reflected the logic of circumstances, then the question must be how that logic arose and why it was able to play out as it did. Cultural values provide part of the answer. Benthamite utilitarianism, Fabian socialism, and British “new liberalism” all could be – and, at various points, were – harnessed to justify government measures to protect public health and care for the sick and incapacitated. But the creation of the NHS required more than the reworking of established values; it demanded the reconstruction of a vast medical complex and the transformation of deeply rooted public and interest group preferences. These momentous changes unfolded over the course of decades, but they primarily occurred between two critical junctures in the development of British health policy: the passage of the National Insurance Act in 1911 and the creation of the NHS after World War II. Although the enactment of these two landmark measures was greatly facilitated by Britain’s unitary parliamentary structure, their content owed far more to the way in which previous government policies had transformed public opinion, the organization of medicine, the capacities of the state, and the interests of the major groups with a stake in British health policy.

The 1911 National Insurance Act

The story of modern British health politics begins with the 1911 National Insurance Act. Part I of the Act created a compulsory and contributory social insurance program providing physician insurance and sickness benefits to British wage-earners. The program was clearly incomplete: It did not cover hospital care or most specialist services, applied only to manual laborers and lower-income nonmanual workers, and excluded workers’ dependents from medical coverage. Yet the 1911 legislation touched the lives of the vast majority of Britons and quickly became the most widely recognized pillar of British social insurance. For all its popular resonance, however, the 1911 Act was scarcely the offspring of political consensus. As champion of the Act, David Lloyd George had to draw on all the institutional resources conferred on him by Britain’s unitary parliamentary structure – resources that political leaders in the United States and Canada at

72. Klein, *Politics of the National Health Service*, 2.

this time sorely lacked. The imperfect agreement that he cobbled together to appease his opponents locked in place a complex and unwieldy scheme that resisted necessary revisions for more than three decades while steadily pushing Britain closer to the postwar NHS.

By the early 1900s, the institutional structure of British government was quite hospitable to the passage of major welfare measures such as contributory health insurance. To begin with, Britain had a national administrative state that, although less centralized and powerful than its counterparts in continental Europe, was fully capable of taking on significant administrative tasks and faced no serious challenge from local governments. Even before the creation of the Ministry of Health in 1919, civil servants within the Board of Trade consistently advocated social insurance programs, including sickness insurance.⁷³ More important, civil service reforms in the 1870s cut off the major source of elite patronage for British parties – a development that, in conjunction with the gradual extension of the suffrage, strongly pressured parties to extend their appeal beyond propertied elites.

Not only did the British government have the authority and means to implement social programs, but the structure of British parliamentary institution also created significant incentives for their passage. And it ensured that once programs were agreed upon among allies of the government and within the Cabinet, they would be summarily enacted. The incentives for enacting social programs were rooted in electoral realities: More workers were voting than ever before, and their votes were giving the Labour Party a substantial foothold in parliament. Mindful of its delicate electoral standing, the Liberal Party entered into alliance with Labour both in 1906, and, tacitly, in 1910.⁷⁴ Although Labour MPs and trade unions were not enthusiastic advocates of social insurance, they were brought along to support it by Liberals who saw it as a means of stabilizing labor unrest while increasing the military and economic strength of the nation.⁷⁵ Once programs were formally proposed after Cabinet debate and consultation, they were guaranteed safe passage through parliament on the steady ship of party discipline.

Administrative elites in Britain could not do whatever they pleased, of course. Despite their powers, they needed political support to formulate, pass, and implement social programs, especially those that relied heavily on intermediate associations like unions, insurance societies, and medical practitioners. After 1910, moreover, the Liberal Party had only the narrowest of parliamentary margins and thus could not afford to antagonize interest groups with influence in local districts. Critically important to the passage of the 1911 National Insurance Act, therefore, was ability of Lloyd George to gain the support, or at least soften the opposition, of the major

73. Skocpol, *Protecting Soldiers and Mothers*, 250–51.

74. Samuel H. Beer, *Modern British Politics: Parties and Pressure Groups in the Collectivist Age* (1965; New York: W. W. Norton, 1982), 146.

75. A. I. Ogus, "Great Britain," in *Evolution of Social Insurance*, 170–71.

interest groups with a stake in the legislation – doctors, friendly societies, and commercial insurers. Lloyd George was able to overcome this phalanx in part by buying off its members, allowing the friendly societies and trade unions to distribute cash benefits while appeasing doctors' fears about lay control by establishing independent public committees to pay for medical services. Yet the feasibility of this generous compromise hinged upon the strategies these groups had adopted in response to past policies and to the political opportunity structure that they faced.

The key to the compromise was the fundamental ambivalence of the major interests toward the expansion of state control. Doctors were perhaps the most ambivalent. Because of the British government's early interventions on behalf of public health, doctors were accustomed to dealing with public authorities. Most hospital care in Britain was delivered through government facilities, and voluntary hospitals were dominated by philanthropic organizations, not physicians. Moreover, most doctors in Britain did not enjoy the stable income of private fee-for-service health plans. To the contrary, many were forced by poverty to turn to associations of workers that provided sickness and burial benefits to their members. In England before 1911, nearly half the adult male population belonged to such friendly societies, which paid doctors a niggardly annual capitation fee for physician services.⁷⁶ The British Medical Association came of age politically battling the societies, and its members wanted nothing more than to escape from their yoke.⁷⁷ Thus the compromise finally presented to the BMA by Lloyd George – independent public insurance committees and an increase in compensation – proved irresistible to the bulk of Britain's impoverished practitioners, who, despite calls for a medical strike from the wealthy BMA leadership, signed up with the new government insurance panels in droves.

The friendly societies and voluntary insurance plans probably represented a more serious barrier to the enactment of compulsory sickness insurance than the doctors. At the time, "the sheer economic size of the industrial insurance industry made it an important center of strength in British politics."⁷⁸ But insurers were also more easily propitiated: Lloyd George simply handed over administration of the new legislation to them. This, of course, provoked a harsh outcry from the BMA, and indeed it was the prospect of lay control rather than government control that prompted the BMA's plans for a strike.⁷⁹ Since the main aim of insurance at the time was to pay for lost wages due to sickness, Lloyd George was able to separate cash benefits from payments for medical services and lodge authority for the latter in independent government panels. But even with this concession to physicians, administration of the Act promised a steady flow of income and customers to friendly societies and commercial insurance carriers.

76. Starr, *The Social Transformation of American Medicine*, 240.

77. Norman R. Eder, *National Health Insurance and the Medical Profession, 1913–1939* (New York: Garland, 1982), 15–22.

78. *Ibid.*, 25. 79. Eckstein, *The English Health Service*, 127.

The concessions made by Lloyd George should not, however, overshadow the basic political realities the 1911 Act reflected. That bargaining helped ensure the passage of the Act says less about what was required to enact the legislation than about what was not required, less about what was in dispute than about what was not in dispute. The authority of the British government to regulate medical care, for one, was not in dispute, having been a fixture of public policy from the poor laws onward. Nor was there any doubt that policy decisions would be made by the national government rather than by local governments or the courts. Bargaining presupposed the existence of national authorities with whom groups could bargain. It presupposed that deals struck with these authorities would survive in the legislature and not to be subverted by local governments or the courts. It presupposed, in short, conditions that were largely absent at this time in both Canada and the United States.

The Aftermath of Victory

The shape of the 1911 legislation reflected two main influences: the pioneering example set by Bismarck's 1883 insurance scheme and the need to forestall effective political opposition. Thus the plan combined the German system's focus on manual workers with a Byzantine administrative structure required to please both insurers and doctors. At the time of its passage, even advocates of the scheme recognized its imperfections. Yet they also believed, as Lloyd George put it, "that once we start no Chancellor of the Exchequer can stop. He has got to go on."⁸⁰ History would prove Lloyd George correct, but not for more than three decades. The 1911 Act would set the agenda of political debate for more than four decades. It would also shape the public demands and interest group strategies that helped bring the NHS into existence. When the next window of opportunity for policy change opened, the landmark program that would come into being would be very much indebted to the legacies of 1911.

The most obvious of these legacies stemmed from the obvious deficiencies of the 1911 Act. Dramatic as its passage was, the Act extended coverage to less than half the population, it failed to cover workers' families, and its medical benefits were largely limited to sickness benefits and general medicine, excluding in most cases both hospital care and other specialized services. The complicated administrative structure created by the legislation thwarted every effort to widen the range of services covered. Although insurers were required to use extra funds to provide additional services, doctors fought bitterly against the provision of benefits by organizations other than government insurance committees, and insurers proved loathe to shift their focus away from low-risk cash benefits. Worse, the logic of competition dictated that insurers with healthy subscribers had sufficient funds to provide a wide range of benefits, whereas insurers whose patients

80. Quoted in Frank Honigsbaum, *Health, Happiness, and Security: The Creation of the National Health Service* (London: Routledge, 1989), 2.

desperately needed specialized care could barely provide the basic services. A significant minority of those eligible for coverage under the Act could not gain admittance to any insurance society. The destructive effects of insurance competition under the 1911 Act were probably more responsible than anything else for the “remarkably general wartime agreement [during World War II] that the insurance method was improper for any future medical system.”⁸¹

Lloyd George had been well aware of the shortcomings of his 1911 triumph. He hoped “in time to merge insurance services with those of local authorities” and to “expand care to the point where it gave nearly everyone all that medical science had to offer.”⁸² In the ranks of the British civil service, he was not alone. Remedying the drawbacks of the 1911 Act and fulfilling its promise became the leading goal of the ministers and civil servants who oversaw British health policy. Throughout the 1920s and 1930s, they zealously pursued a series of changes in the legislation to expand the proportion of the population covered, increase the provision of specialist services, equalize funding across insurance funds, and include maternity benefits in the plan. Virtually all these efforts were defeated by the opposition of the wealthier insurance societies and, in some cases, by the doctors as well. By the end of the 1930s, the pattern had become familiar: Ministers and royal commissions would propose policy reforms; doctors, insurers, and trade unions would squabble and complain; legislation would be delayed and then abandoned. Lloyd George thought he had crafted an opening wedge. Instead, it seemed, he had created a recalcitrant assortment of vested interests unwilling to heed calmer voices of reason and progress.

In fact, however, the 1911 Act did help create the political preconditions for the achievement of Lloyd George’s vision – for far more, indeed, than Lloyd George could have imagined. For while the administrative elite were learning without achieving, the consequences of the Act were slowly reworking the aims and interrelationships of the vested interests it had created. The paradox of the Act was that at the same time that it strengthened the interests with a stake in its continuance, it ineluctably drew them closer to the state. The effect was most prominent in the case of the doctors. Although they had won generous concessions, they were now locked into a system of panel practice whose range of coverage was hopelessly inadequate but whose expansion necessarily meant greater state control of medicine. Going around the panel system was hardly an option, because the Act had also locked into place a hostile network of friendly societies and private carriers. British doctors were therefore firmly caught between the state and their fears of a salaried service and the private insurers and their fears of a return to the indignities of the nineteenth century. They did not, after 1911, have any other options.

81. Eckstein, *The English Health Service*, 29. This paragraph draws heavily on Eckstein’s analysis.

82. Honigsbaum, *Health, Happiness, and Security*, 4.

Another important effect of the 1911 legislation was the continued growth in the British public's acceptance of, and demand for, state involvement in the delivery and finance of medical care. As Jacobs has carefully shown, by the end of World War II, much of the British public not only was quite accustomed to public medical provision but also believed that the scope of state involvement should be expanded. By an overwhelming margin, the public supported the universalization of public medical coverage and the nationalization of the struggling voluntary hospital system.⁸³ Although some of this support was no doubt a legacy of wartime solidarity and mobilization, a plausible case can be made that these opinions were largely rooted in the public's prior experiences with government health programs, as those perceptions were mediated by long-standing cultural values. The 1911 Act reached an enormous number of Britons: five out of every six families, according to one estimate.⁸⁴ It brought "them into contact with the national government in an unprecedented way," and, in the process, "it began the transformation of relations between British citizens and the State."⁸⁵ Moreover, the reforms favored by the public – the achievement of universal coverage and the guarantee of readily available hospital care – seem to have been closely linked to the specific shortcomings of the 1911 Act.

More was going on in British health politics after 1911 than this brief sketch indicates, particularly in the one important area of medicine that was little touched by the Act – the British hospital sector. The Local Government Act of 1929 transferred control over many public assistance workhouses and infirmaries to local authorities, thus augmenting Britain's extensive public hospital system.⁸⁶ During World War II, the Ministry of Health implemented an emergency medical plan to ensure that hospital facilities would be available for civilian and military casualties. This scheme became in effect a national hospital service and undoubtedly had much to do with the widespread support for the nationalization of voluntary hospitals after the war. Yet "outside the hospital world, the picture of health services in the early part of the war differed little from that of twenty years earlier."⁸⁷ Although the income limit for coverage under the National Insurance Act was raised in 1942, all proposals for wider changes were defeated. For all Lloyd George's belief in the inevitability of progress, the 1911 Act seemed for thirty years to have locked firmly into place an increasingly unwieldy collection of institutions and interests. Yet this very entrenchment was also, ironically, setting the stage for the next great act in the drama of British health politics: the establishment of the NHS at the end of World War II.

83. Jacobs, "Institutions and Culture," 193–96, 201–2.

84. Bentley B. Gilbert, *The Evolution of National Insurance in Britain* (London: Michael Joseph, 1966), 255.

85. *Ibid.*, 255. 86. Eckstein, *The English Health Service*, 34.

87. John E. Pater, *The Making of the National Health Service* (London: King Edward's Hospital Fund for London, 1981), 22.

The Creation of the NHS

World War II was a watershed in the development of the welfare state in many industrialized democracies.⁸⁸ Wartime mobilization strengthened the state and helped promote social solidarity. More important, the war helped end the lingering hardships of the Great Depression – and in an intellectual climate in which Keynesian social spending and corporatist-style industrial policy were widely accepted.⁸⁹ Whereas the first steps toward the welfare state were targeted at male wage earners and based on a paternalistic model of contributory insurance, the expansion of the welfare state after World War II was marked by unreserved enthusiasm about the virtuous cycle of harmony and prosperity that would be unleashed by the universal welfare state.

In Britain, the NHS was the defining achievement of that sunny postwar vision. At a stroke, it nationalized the entire voluntary hospital industry, extended free general medical care to the whole of the British population, and set Britain apart as the first nation to create a comprehensive medical system “based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to everyone.”⁹⁰ Yet, as should be clear by now, the NHS did not spring fully formed from the imagination of the Labour Government’s famous Minister of Health, Aneurin Bevan. Nor did it simply represent the triumph of socialist ideology or the influence of Britain’s wartime experience. Rather, as we have seen, the agenda for reform after World War II can largely be traced to the National Insurance Act of 1911, whose effects rippled out into British health politics through three distinct channels.⁹¹ On the elite level, the Act fostered the growth of a new health bureaucracy whose leaders were committed to rationalizing and expanding the creaky structure erected in 1911. On the interest group level, the Act froze into place a hornet’s nest of vested interests – groups whose ability to thwart improvement of the legislation inadvertently heightened the need for reform and inexorably drew them closer to the state. On the level of public opinion, the Act helped create widespread popular support for free and universal health care. These diverse effects helped shape the boundaries of the possible when a window of opportunity for policy change finally opened after the Labour Party’s rise to power in 1945.

If any moment in modern British politics deserves to be called a critical juncture, it is the landslide Labour victory of 1945. The election gave Labour a parliamentary majority for the first time in the party’s history, it gave the unions a new position of authority in relation to the British state,

88. Peter Flora and Arnold J. Heidenheimer, eds., *The Development of the Welfare State in Europe and America* (New Brunswick, NJ: Transaction, 1984).

89. Andrew Shonfield, *Modern Capitalism: The Changing Balance of Public and Private Power* (New York: Oxford University Press, 1965).

90. Klein, *The Politics of the National Health Service*, 1.

91. Pierson provides a more extensive discussion of these channels in “When Effect Becomes Cause.”

and it brought into parliament a unified and committed band of MPs who had run on a plainly socialist manifesto. Even for a parliamentary system, the extent of party unity and speed of legislative production between 1945 and 1950 were remarkable. In the interlude of 1945–46, for example, Labour Party unity was perfect – there was no cross-voting at all – and the government passed legislation that, among other things, nationalized the Bank of England, the coal industry, and the air transportation system; created a new framework of social insurance and public assistance; and extended wartime powers over the economy.⁹² In the realm of health policy, however, the groundwork for action had already been laid before Labour assumed power, by the 1942 Beveridge report on social insurance and by the 1944 White Paper setting out the wartime Coalition Government's own proposal for a national health service. Although the NHS Act passed in 1946 departed from the White Paper in important respects, it “was as remarkable for the degree of continuity it represented as for its departures from the agreed compromises of the Coalition Government.”⁹³

The main impact of Labour's stunning victory did not, therefore, lie in the final structure of the NHS, but rather in the momentous political opportunity that Labour's triumph created. In those months after 1945, the Labour Government operated with the ruthless efficiency and dispatch for which party government parliamentary systems are both praised and feared. Bevan insisted, much to the chagrin of the medical profession, that he would not negotiate with the BMA before the passage of a bill. The bill itself was hammered out in Cabinet with only feeble dissent, mainly from defenders of local hospitals. From a Cabinet proposal in December 1945 to a White Paper in March to a law in November, the bill moved speedily through the legislative process. The votes in parliament were, of course, overwhelming.

After the passage of the bill, the Ministry of Health did, to be sure, enter into negotiations with the BMA to try to ensure that the plan would be implemented without a doctors' strike. Yet to portray the concessions eventually won by the profession as a sign of doctors' political strength, as Eckstein does, is to miss the larger weaknesses in the profession's political stance that the enactment and implementation of the NHS Act revealed.⁹⁴ First, the profession's official position – in support of extended public coverage but wholly against a salaried service – reflected precisely its unenviable dependence on the state for expanded revenues and patients.⁹⁵ Second, the concessions to doctors were hardly dramatic when viewed within the overall context of the NHS Act. Bevan pointedly com-

92. Beer, *Modern British Politics*, 179–87.

93. Klein, *The Politics of the National Health Service*, 17.

94. Eckstein, *The English Health Service*, 3–4, 161–63.

95. If the 1942 report of the BMA's medical planning commission is any indication, the ideal proposal envisioned by much of the profession was a system of government health insurance covering most of the population and paying for a wide range of services on a nonsalaried basis (Eckstein, *The English Health Service*, 118–22).

plained of medical specialists that he had “stuffed their mouths with gold.”⁹⁶ But in comparison with doctors in other nations, British doctors had been force-fed a distinctly unappetizing meal. Bevan gave the prestigious medical specialists represented by the Royal Colleges assurances that they would be able to practice privately in NHS hospitals. But this concession, it must be remembered, was in a bill that nationalized the entire hospital sector.⁹⁷ In the final days before the NHS was to begin operating, Bevan made what many saw as a dramatic concession to the BMA: an amendment to the legislation declaring that he would not create a full-time salaried service. But whether or not this was a defeat for Bevan, the effect of the NHS even with this concession was to bring virtually all British doctors into contract with the state for the provision of medical services. In short, the salient point is not that the NHS Act embodied concessions to the doctors, but that it passed despite the opposition of the profession, the threat of a doctors’ strike, and the fact that it represented at the time the most collectivist medical program ever passed by a democratic government.

The structure of British political institutions helps us understand why, in the wake of Labour’s stunning victory in 1945, the government was able to pass a landmark social program extending free health care to all Britons. The legacies of the 1911 Act help us understand why that landmark program took the shape that it did. By locking into place a medical complex dominated by friendly societies, general medical practice, and public hospitals, British health policy forestalled the emergence of physician-friendly private insurance and slowed the growth of costly, technologically intensive medical care. By expanding public coverage to roughly half the population, the 1911 legislation acclimated the public to state intervention in medicine while creating predictable public pressures for the expansion of coverage. And by bringing much of British medical care under the purview of the state, the 1911 Act gave rise to a new health bureaucracy whose leaders were committed to improving existing policies and expanding their ambit. The result was an unusually consensual pattern of policy development that was driven as much by the “logic of circumstances” at critical junctures as by ideological and political struggle.

Yet the distinctiveness of the British case can only be appreciated in comparative perspective, and we thus now turn to two countries that followed very different paths from the one just described. In both Canada and United States, political institutions as well as the sequence and timing of policy breakthroughs sharply contrasted with the British experience. But in them we can also see the common processes and constraints that shaped the development of health policy in all three nations.

96. Brian Abel-Smith, *The Hospitals, 1800–1948* (London: Heinemann, 1964), 480.

97. What is more, appeasing the Royal Colleges allowed Bevan to split the medical opposition, leaving the general practitioners of the BMA as the sole professional opponents of the NHS.

CANADA

Canada and the United States have both lagged behind Europe in the passage of major social programs, including national health insurance.⁹⁸ Canada did not consolidate its national health program until the early 1970s, and the United States does not have one to this day. In the case of Canada, however, the “laggard” epithet is misleading because Canada’s provinces have often acted ahead of the federal government in social policy. Thus, although Canada lacked any federal health insurance program until 1958, Saskatchewan implemented public hospital insurance a decade earlier. Indeed, the most distinctive aspect of the Canadian welfare state is not the degree to which it has lagged behind European experience, but the prominent role that federalism has played in its development. Federalism contributed to the defeat of limited national reforms immediately after World War II. Yet it pushed toward national health insurance in later decades, and it played a role in the development of Canadian health policy witnessed neither in unitary Britain nor in the federal system of the United States.

Although the provinces have sole constitutional control over the administration of health programs, the federal government has made widespread use of federal grants and standards to shape provincial policies. This interdependence has fostered an “ongoing dynamic” in which “provincial governments have experimented with policy initiatives,” the “federal government has encouraged the diffusion of those initiatives through the development of a national framework,” and the “provinces in turn have developed their own particular programs within the national framework.”⁹⁹ Provincial policy experimentation occurred first in western Canada, where socialist third parties had the greatest electoral success. These pioneering efforts were facilitated by federal measures to equalize fiscal capacities across provinces and underwrite provincial programs. The initiatives of the provinces subsequently became a crucial impetus for federal action, both by virtue of their status as demonstration projects and because provincial leaders demanded national grants that would subsidize their programs and create a level playing field for competition among the provinces.

Despite the distinctive influence of federalism, however, the development of Canadian health policy has, in other respects, resembled the story in other nations. Opportunities for policy change opened rarely and under circumstances shaped by transnational events and the international climate of ideas. The prospects for reform depended heavily on the opportunities and constraints created by political institutions. And the timing and sequence of policy developments shaped what was possible through a historical process of policy feedback and institutional change. In part because of

98. Robert T. Kudrle and Theodore R. Marmor, “The Development of the Welfare State in North America,” in *Development of the Welfare State in Europe and America*.

99. Carolyn J. Tuohy, *Policy and Politics in Canada: Institutionalized Ambivalence* (Philadelphia: Temple University Press, 1992), 109.

the constraints posed by federalism, national leaders in Canada moved to expand access later than had British leaders, allowing private physician-sponsored plans time to develop and spread. Moreover, through postwar grants to the provinces, the Canadian federal government subsidized the development of a system of technologically sophisticated private hospital care that was among the world's most costly. As a result, Canadian health reformers confronted a different and far more expensive medical framework than had British reformers, and they had to overcome far more energized interest group opposition to their plans. The national program that Canada finally enacted in 1967 amid mounting concerns about the economy and the federal budget firmly locked in place Canada's costly medical framework, setting Canada apart from the British NHS as well as from the increasingly abnormal policy pattern in the United States.

The Health Reform Proposals of 1945

Neither the federal government nor the provinces were much involved in the finance or provision of medical care before the 1940s. During the Great Depression, the federal government prepared a limited health insurance proposal. Yet the Judicial Committee of the Privy Council (the final appellate body for constitutional interpretation until the Supreme Court of Canada assumed this role in 1949) overruled the act on the grounds that health insurance clearly fell within the sphere of provincial powers. Although several western provinces attempted to establish limited compulsory insurance programs before World War II, these efforts came close to fruition only in British Columbia. Nonetheless, numerous municipalities in the rural provinces of Alberta, Manitoba, and Saskatchewan did create so-called municipal doctor systems, in which communities paid doctors a salary to treat residents.¹⁰⁰

As World War II drew to a close, however, Canadians shared in the mood of optimism and unity that helped spur social policy developments in the rest of the industrialized world. Canadian leaders were also influenced by the progress toward the NHS in Britain and particularly by the Beveridge Report, which had a deep impact on Prime Minister Mackenzie King.¹⁰¹ The most immediate influence on the Liberal Government, however, was the growing strength of the socialist Cooperative Commonwealth Federation – a depression-born party that came to power in Saskatchewan in 1944 and launched an insurgent campaign for federal health insurance. With the CCF threatening to erode the Liberal Party's electoral advantage over the Conservatives in parliament, the Liberals reluctantly moved to develop proposals that could be agreed upon at the Dominion-Provincial Conference of 1945.

Carolyn Tuohy has compared the health insurance proposals of 1945 to the "founding moment" of policy change in British health care after World War II.¹⁰² The more telling comparison from a political standpoint, how-

100. Taylor, *Health Insurance and Canadian Public Policy*, 6. 101. Ibid., 9–10.

102. Tuohy, "Response to the Clinton Proposal," 250–51.

ever, might be between the 1945 proposals and the 1911 National Insurance Act. Like British Liberals after 1910, Canadian Liberals in 1945 faced an emergent socialist third party that threatened to upset their delicate electoral standing. Like British doctors in 1911, Canadian doctors were reconciled to, if not enthusiastic about, the passage of government health insurance. They, too, had long contracted with the government to provide health services. They, too, lacked attractive private alternatives to public payment. And they, too, saw little prospect of influencing Cabinet deliberations and parliamentary votes. But in Canada, unlike Britain, advocates of reform had to grapple not just with opposition to the proposal but also with the thorny question of federal-provincial relations. This great question ultimately spelled defeat for the Liberal Government's plans: Conflicts emerged over the financing of the federal government's postwar agenda, the provinces and the government dug in their heels, and the Dominion-Provincial Conference of 1945 adjourned without agreement.

The failure of the conference had several important consequences for subsequent Canadian health politics. The first and most obvious was that Canadians would have to wait another quarter-century for national health insurance. Whether implementation of the 1945 proposals would have brought Canadian health policy to the point it eventually reached is a difficult question.¹⁰³ But the failure of those proposals meant that national health insurance would have to come about through a different route than the one envisioned by federal Liberals in 1945.

It also meant – to move to the second consequence of the conference's collapse – that federal health policy would not, as it did in Britain, start with measures to expand health access and then focus on the adequacy of medical technology. Instead, the only significant proposal to survive the 1945 deadlock was a collection of federal health grants to the provinces, the most significant of which was a matching grant for hospital construction. Thus federal health policy ended up underwriting a transition to costly, technologically intensive hospital care that was already under way in the medical sector, and in the process it helped build up an extensive private hospital system whose costs would eventually have to be underwritten as well.

A third, and more important, consequence of the failure of the 1945 proposals was to clear the field for the development of physician-controlled health plans. Shortly after the Dominion-Provincial Conference collapsed, representatives of Canada's nascent physician-sponsored plans formed a national agency, Trans-Canada Medical Plans (TCMP). These plans were controlled by the profession, patterned after the fee-for-service plans advanced by doctors in the United States, and unapologetically designed to

103. Gray, for example, contends that it "is at least arguable that policy development was advanced as quickly by the successful introduction of comprehensive measures at the provincial level, which were later taken up nationally, as it would have been if the limited federal proposals had been implemented" (Gray, *Federalism and Health Policy*, 34). It remains true nonetheless that federalism posed obstacles to the passage of national health reforms in Canada that were not faced by leaders in Britain.

forestall further movement toward government insurance. Enrollment in the plans grew steadily after 1950, from 5.5 percent of the population in 1951 to 23 percent in 1960.¹⁰⁴ If other private health plans are included, roughly half the population was covered by some form of private insurance by 1960.¹⁰⁵

The growth of private plans effectively ruled out the possibility that Canada would follow British precedent and establish a national health service. The private plans accustomed the Canadians who benefited from them to a largely unfettered fee-for-service system, and by offering coverage to the middle and upper classes, they no doubt decreased public demand for reform. But the most critical effect of the private plans was on the medical profession itself. From its conciliatory position in 1945, the CMA completely reversed itself within a decade and came out against all but the most modest of reforms. The reason behind this about-face is not hard to find: "Each year, as enrollment of the member plans of the TCMP increased, so did the confidence of the profession that the voluntary system might prevail."¹⁰⁶ The failure of the 1945 proposals did not, therefore, simply mean that an opportunity for reform had been missed. It meant that future proposals for national health insurance would face a new and powerful foe.

Yet the immediate consequence of the events of 1945 was to move battles over health care reform to the provincial level. Although the issue would bubble up to the federal level again, the next great development in the saga of Canadian health politics would take place in a very different institutional and political environment.

The Provincial Moment

The nature of Canadian federalism has not remained static, and fortunately for advocates of health care reform, federal-provincial relations evolved after 1945 in a direction conducive to their aims. The acrimony that had marked the 1945 conference subsided in its wake, and the provinces took the lead in promulgating reforms that the federal government had been forced to abandon in 1945. By allowing regional political forces supportive of reform to gain power, Canadian federalism fostered the development of provincial programs that could serve as examples to neighboring provinces and eventually form the basis for national legislation.

The first of such programs was initiated in Saskatchewan in 1946 – a tax-funded plan that paid for the hospital care of all provincial residents. Hospital insurance was not as bitterly opposed by the medical profession as medical insurance was, but it probably would not have mattered had it been. In 1944, the CCF had decisively wrested control of the Saskatchewan

104. C. Howard Shillington, *The Road to Medicare in Canada* (Toronto: Del Graphics Publishing, 1972), 202–3.

105. Robert G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984), 29.

106. Taylor, *Health Insurance and Canadian Public Policy*, 190.

parliament from the long-governing Liberals in one of the most dramatic elections in Canadian history. Saskatchewan's bold experiment was replicated in two other western provinces: British Columbia in 1948 and, on a more limited basis, Alberta in 1950. Ottawa also passed a hospital insurance program, but only with assurances that the federal government would pass a program for federal-provincial cost-sharing, which it did in 1957.

The dust had barely cleared on these developments when CCF leaders in Saskatchewan began gearing up for a far more ambitious goal – a medical insurance plan providing comprehensive care (including, of course, physician services) to all citizens of the province. Here the medical profession *was* bitterly opposed, and implementation of the plan occurred only after a wrenching twenty-three-day medical strike in which most of the province's doctors withheld all but emergency services.¹⁰⁷ In several areas of dispute, the Saskatchewan government was ultimately forced to bow to the new realities that the diffusion of private health insurance had created. It allowed, for example, doctors to use physician-controlled private plans as fiscal intermediaries, it permitted doctors to bill patients insured by the public plan directly and at rates above those paid to the patients by the plan, and it promised to continue the profession's preferred method of reimbursement, fee-for-service payment. Although the socialist government had initially envisioned a program based on local democratic control, the plan essentially froze into place the entrenched fee-for-service insurance system that had evolved since World War II.

Nonetheless, despite physician opposition of the most bitter depth; despite a concerted campaign against the plan by hospitals, employers, and conservative politicians; and despite uncertainties about the possibility of a federal response, the Saskatchewan government became the first Canadian province to provide a government guarantee of medical insurance to all its citizens. Although a significant number of doctors fled the province, those who remained saw an immediate boost in their incomes of 35 percent over 1960 – a result that probably helped alleviate physician fears in other parts of the country.¹⁰⁸ Provincial governments in British Columbia, Alberta, and Ontario moved almost immediately to consider plans that followed the Saskatchewan precedent. But no other province would pass a comprehensive program until after the enactment of a federal medical insurance program in 1966.

Why and how did the provinces take the lead in enacting first hospital insurance and then comprehensive medical insurance? The theories of federalism reviewed earlier suggest that subnational governments would not be hospitable sites for costly redistributive social programs of the sort that Saskatchewan pursued. Fearful of losing scarce capital, both human and physical, to other Canadian provinces, the cash-strapped Saskatchewan government should have been acutely reluctant to risk driving away doctors

107. Badgley and Wolfe, *Doctors' Strike*.

108. Taylor, *Health Insurance and Canadian Public Policy*, 329.

and employers. Yet against great odds, the CCF Government never wavered from its ultimate goal of universal government health insurance.

One obvious answer to this puzzle would highlight the number and size of the provinces. In contrast to the fifty states of the United States, there are only ten Canadian provinces, and most occupy huge swaths of sparsely populated territory. These features of Canadian federalism make collective action by the provinces easier while dampening the potency of exit as an option for owners of mobile resources. Yet this cannot explain why Saskatchewan plunged ahead with its plans for a comprehensive program. For many years, provincial leaders had been trying to *attract* doctors to their rural province, and even in the 1960s, doctors were in short supply. Saskatchewan's doctors, moreover, were highly mobile. Nearly a third had emigrated from Britain to escape the NHS and had thus clearly shown their willingness to relocate if necessary.¹⁰⁹ The threat of a massive exodus of doctors was very real indeed.

Two other features of Canadian federalism seem to have been most responsible for provincial experimentation: the opportunities federalism created for regional political movements supportive of reform to gain power, and the evolving nature of federal-provincial relations. In a country as diverse as Canada, federalism raises the possibility that political forces will come to power in a province without enjoying support across the country. Thus in western Canada, where agrarian socialism gained an early foothold, socialist parties could emerge and gain strength even at a time when they had little support at the national level or in other provinces. Third parties were aided in their struggles by the parliamentary organization of provincial governments and by their important role as defenders of regional interests.

The second feature of Canadian federalism that facilitated provincial reforms was the evolving nature of federal-provincial relations. As it became clear that the federal government would not attempt to retain its extensive wartime powers, federal-provincial relations thawed quickly after the acrimony of 1945. The federal government moved into a series of revenue-sharing arrangements with the provinces in which federal grants were made available to achieve specific programmatic aims. These arrangements augmented the fiscal standing of the poorest provinces and raised the possibility that the federal government would soon help finance provincial health programs. In addition, federal grants created a virtuous cycle of policy entrepreneurship, freeing up funds in those pioneering provinces, like Saskatchewan, that had already established programs for which grants became available.¹¹⁰

One can only speculate about when (or whether) Canada would have

109. Ibid., 265.

110. This was extremely important in Saskatchewan: The national government's assumption of nearly half the cost of Saskatchewan's hospital insurance program allowed the CCF to finally pursue a comprehensive plan.

enacted national health insurance if it had been a unitary state.¹¹¹ Perhaps the 1945 proposals would have been enacted, or perhaps, absent the ascendance of the CCF in Saskatchewan, they would never have been proposed in the first place. What is clear, however, is that the influence of federalism on Canadian health policy has been more complex than simple theories of federalism would suggest. Although federalism did retard early movement toward national health insurance in Canada, as orthodox theories would predict, it also created political dynamics conducive to the later passage of provincial and national programs. The conjunction of federalism and regional diversity allowed political movements supportive of reform to gain a political foothold in western provinces and enact programs that could spur other provinces and the federal government to respond. But the probability that these programs would spread to other provinces or influence national policy depended heavily on the evolving nature of federal-provincial relations, which shaped the strategic environment within which provincial governments acted.

The Federal Moment

Yet the story of Canadian policy development does not end at the provincial level. As important as the provinces were to the drama, Canada would not have national health insurance today were it not for the continued efforts of federal politicians to inaugurate a national program. Despite the fiscal advantages enjoyed by the national government, the political hurdles facing national health insurance were in many ways far more daunting at the federal level than they had been in Saskatchewan. During the 1960s, the reach of private medical insurance and the cost and technological intensity of Canadian medical care exploded, leaving the federal government with little choice but to design its program around the expensive, fee-for-service model of private provision that doctors and insured patients had come to expect. These new costs would have to be borne, furthermore,

111. The evidence from other countries of the British Commonwealth is ambiguous on this score, though it, like the Canada-U.S. comparison, suggests that federalism slows the initial adoption of a national health program but also presents opportunities for leadership by subnational governments. In the unitary polity of New Zealand, for instance, the government was able to enact a fairly comprehensive national health service in 1938, albeit one that embodied important concessions to the medical profession. Australia's federal system, by contrast, proved less hospitable to national health reforms after World War II. Like Canada, Australia failed to enact a national health program during the 1940s. Yet the continuing centralization of Australian federalism in subsequent years prevented the Australian states from moving forward in the way that Saskatchewan and other Canadian provinces did during the 1950s and 1960s. As a result, federal politicians in Australia did not face reform demands from subnational governments or regionally based parties, and the ruling conservative coalition instead pursued a federal policy of subsidizing voluntary health insurance through the 1960s. The New Zealand and Australian experiences therefore seem to support the claim that federalism does in fact present barriers to the passage of national social policies but that these barriers may be reduced or even outweighed by countervailing factors, such as the opportunities that federalism creates for policy innovation or the emergence of regional social movements. The implication of this claim is that the net effect of federalism cannot be ascertained *a priori* but rather depends on the specific structure and context of federal institutions.

amid a worsening economic and fiscal climate, with the federal government for the first time in years running large budget deficits and scrambling to raise taxes. And although public medical insurance was passed in Saskatchewan by a socialist government enjoying a legislative majority, it was achieved at the federal level by an embattled governing coalition led by a party whose commitment to national health insurance was far less robust.

The pressure for a national program came from two main sources: the political dynamics created by Canada's parliamentary structure and the demands of the provinces. In 1961, the CCF allied with Canada's increasingly aggressive labor movement to form the social democratic New Democratic Party. Although the NDP had no prospect of controlling the national legislature, its support became crucial to the governing Liberals after they failed to capture a parliamentary majority in 1963 and found themselves forced to form a coalition government. Pressure from the provinces built from 1946 on, as first Saskatchewan and then British Columbia and Alberta passed provincial hospital insurance programs and demanded federal aid to run them. Ontario took the lead in aggressively pressing for federal hospital insurance in 1955, and Saskatchewan for federal medical insurance after 1963. The new era of cooperative federalism launched after 1945 meant that federal leaders who wished to fulfill their commitments needed to gain the periodic support not only of the electorate, but also of the shifting mosaic of partisan forces operating at the provincial level.¹¹²

The independent influence of provincial pressure on federal deliberations is clearly evident in the establishment of federal hospital insurance in 1957. Although the Liberal Government faced an electoral threat from the Progressive Conservative Party and backbiting from the CCF, divisions within the Cabinet would likely not have been overcome if Ontario had not zealously pressed the government for a promise of federal financing. Fearful of repeating the debacle of 1945 and uncertain about the appropriate organization of a federal program, federal Liberals had hoped to stall. By placing the issue at the center of federal-provincial negotiations, the Ontario government made temporizing infeasible.

On medical insurance, however, provincial sentiments were not as conducive to federal innovation. Only Saskatchewan had passed a program, Ontario was not pressing for action (indeed, it was counseling delay), and Quebec had entered a new phase of assertiveness under the leadership of Premier Jean Lesage. Furthermore, the expansion of cost-shared programs after 1945 had begun to create cracks in the friendly façade of federal-provincial relations. With the provinces now running an extensive network of social and economic programs, the 1960s and 1970s became "a period of 'province-building' as provinces built up their institutional structures and administrative capacity."¹¹³ Many provincial leaders believed that cooperative federalism had mutated into a coercive system designed to achieve federal, rather than provincial, objectives. In addition, there were rising

112. Taylor, *Health Insurance and Canadian Public Policy*, 331–32.

113. Tuohy, *Policy and Politics in Canada*, 36.

tensions among the provinces over federal equalization payments to even out spending between wealthier and poorer provinces.

Also militating against the easy resolution of the health insurance issue was the growing juggernaut of committed opponents of government health insurance. The CMA's about-face on the heels of the rapid expansion of private insurance was only the tip of the iceberg. The private insurers had also moved to the forefront of the anti-reform movement, and they were joined by the Canadian Manufacturers Association and Chamber of Commerce. All these groups viewed the expanding private insurance market as an avenue of escape from the "giant monolith" of government insurance.¹¹⁴ And all were willing to deploy ideologically charged arguments decrying the insidious evils of government intervention.

The foes of national health insurance were engaged in a race against time – the time required for the provinces and federal government to act, the time required for private insurance plans to spread. For doctors and insurers, the benefits of the continued expansion of private insurance were obvious. For employers, they were more subtle. The provision of private insurance as a fringe benefit of employment promised employers control over private benefit plans and offered them a means to attract employees and earn their gratitude. Business leaders were also concerned about the costs of a national plan, which they feared would hurt the Canadian economy and bankrupt the treasury. They were not alone in their concerns. Spurred in part by the spread of private insurance and the expansion of government health grants, Canadian health care was moving into a new and more expensive era. Between 1956 and 1966, the intensity of Canadian hospital care increased at an average annual rate of 3.77 percent, and the relative income of physicians increased at an average annual rate of 3.16 percent.¹¹⁵ The comparable figures for the previous decade are 1.9 percent and 0.92 percent, respectively.

Despite all these constraints, however, national health insurance passed in 1966 and, after fierce struggles in the provinces, was fully implemented by 1971. Part of the impetus for the program came from the ringing endorsement of national health insurance by the Royal Commission on Health Services, which ironically had been appointed by the federal Progressive Conservatives in 1960 to delay the implementation of government medical insurance in Saskatchewan.¹¹⁶ Yet the strongest pressures for action came from the exigencies of the Liberal Party's minority status in parliament. Returned to power with only a minority of seats in 1963 after what had unarguably been "the most turbulent period in Canadian politics in a generation," the Liberal Government could not hold together its fragile governing coalition without the support of the NDP.¹¹⁷ Although Cabinet divisions and concerns about Canada's worsening economy coun-

114. Shillington, *The Road to Medicare in Canada*, 139.

115. Evans, *Strained Mercy*, 14. "Intensity" refers to the amount of inputs per patient day.

116. Gray, *Federalism and Health Policy*, 42.

117. Taylor, *Health Insurance and Canadian Public Policy*, 333.

seled delay, the Royal Commission and the demands of the NDP made it impossible to avoid the issue, especially after the passage of Saskatchewan's comprehensive program. The clear lines of electoral accountability created by parliamentary systems also greatly raised the stakes of visible opposition to a national program. Fearful of losing the support of the NDP and the Canadian public, the Liberal Government moved to fulfill its long-standing commitment to national health insurance. With passage of the program assured by party discipline, other parties rushed to grab credit, and in 1966, the program passed through parliament with only two dissenting votes.

Canada thus followed Britain in enacting a national program guaranteeing all citizens access to a comprehensive range of medical services. Yet the Canadian and British programs were very different. Britain created a national health service that was based on public hospitals and paid general practitioners a per capita fee. Canada created a program that underwrote the costs of provincial programs, and the provinces in turn operated much like private insurers, paying hospitals on a per diem basis and physicians on their preferred fee-for-service basis. Both systems essentially froze into place the structure of medicine that existed when they were established. But what existed in Canada was far different, and far more costly, than what existed in Britain. Indeed, the Canadian medical system remains the second most expensive in the world, with only the United States spending a higher proportion of GDP on medical care.

The contours of Canadian health politics were shaped by the conjunction of national parliamentary institutions and an evolving federal structure that fundamentally changed the dynamics of parliamentary politics. Federal policy changes became hostage to the evolving character of federal-provincial relations. Yet at the same time the provinces served as important catalysts for federal action, both through their status as regional bases of socialist power and through their efforts to enact demonstration programs and lobby for them nationally. The existence of a social democratic challenge kept the health insurance issue on the national agenda, and the uncertainties of party competition and need to maintain governing coalitions created incentives for establishment parties to accommodate the demands of insurgent parties. In the end, the exigencies of retaining power impelled the minority Liberal Government to press for a comprehensive program despite the objections of senior ministers, the opposition of private interests, and the worsening state of the Canadian economy.

Yet this outcome was not foreordained. For while provincial developments and parliamentary politics were increasing the pressures for action, the outcomes of past political struggles were creating an environment far less hospitable to comprehensive reform. The failure of the 1945 Dominion-Provincial Conference left the field open for the rapid expansion of physician-controlled insurance plans, and as these plans spread, the medical profession emerged as the most energetic foe of government insurance. Joining with insurers and employers against a national program, the CMA reversed its earlier conciliatory posture toward government intervention and argued instead that the aim of Canadian policy should be

limited to subsidizing and supplementing the growing voluntary insurance system. Moreover, the expansion of private insurance and the provision of grants for hospital construction led to a spiraling rise in the cost of Canadian medical care, increasing apprehension about the budgetary expense of a comprehensive program. The proposal finally passed in 1966 represented a concession to these new realities and froze into place a framework of medical delivery that would make Canadian health care among the world's most costly. Nonetheless, Canada was able to enact national health insurance before increasing political opposition and growing budgetary and economic concerns helped bring to a close the era of welfare state expansion that followed World War II. The United States, as we shall soon see, was not.

THE UNITED STATES

The theme of American exceptionalism hangs like a brooding ghost over discussions of American politics and society. Alexis de Tocqueville marveled in 1835 that "everything about the Americans . . . is extraordinary."¹¹⁸ Decades later, Werner Sombart famously asked, "Why Is There No Socialism in the United States?"¹¹⁹ And scholars have been asking similar questions ever since: in debates about the character of American political culture, in discussions of the absence of social democracy in the United States, and in explanations of the peculiar development of the U.S. welfare state.¹²⁰ But despite continuing interest in American exceptionalism, the notion itself has come in for harsh criticism, with many scholars contending that it rests on unjustified teleological assumptions and overstates the difference between the American welfare state and its European counterparts.¹²¹

In at least one area, however, the claim of American exceptionalism seems undeniable – the absence of national health insurance in the United States. The United States is the only wealthy developed nation without a universal health care program. Six times in this century – in the 1910s, the

118. Alexis de Tocqueville, *Democracy in America* (1835; New York: Harper & Row, 1969), 280.

119. Werner Sombart, *Why Is There No Socialism in the United States?* (1906; White Plains, NY: International Arts and Sciences Press, 1976).

120. On American political culture, see Louis Hartz, *The Liberal Tradition in America* (New York: Harcourt, Brace, 1955); and Gordon S. Wood, *The Creation of the American Republic, 1776–1787* (New York: Norton, 1969); on the failure of social democracy, see Richard Oestreicher, "Urban Working-Class Political Behavior and Theories of American Electoral Politics, 1870–1940," *Journal of American History* 74 (1988): 1257–86; and on the American welfare state, see Paul Pierson, "The Scope and Nature of Business Power: Employers and the American Welfare State, 1900–1935" (Harvard University and Russell Sage Foundation, photocopy, 1995); Steinmo, "American Exceptionalism Reconsidered"; and Skocpol, *Protecting Soldiers and Mothers*.

121. See, for example, Sean Wilentz, "Against Exceptionalism: Class Consciousness and the American Labor Movement, 1790–1920," *International Labor and Working Class History* 26 (1984): 1–24; and Jens Alber, "Toward a Comparison of Recent Welfare State Developments in Germany and the U.S." (University of Konstanz, photocopy, 1996).

1930s, the 1940s, the 1960s, the 1970s, and the 1990s – American health reformers tried to enact policies guaranteeing health insurance to all Americans or a substantial portion of them. Only once, however, were reformers successful – in 1965, with the passage of Medicare and Medicaid.

The United States is thus a crucial negative case for comparative historical analysis – a country sharing many similarities with Britain and Canada (including most importantly fierce struggles over government health insurance) yet lacking an elemental feature of British and Canadian public policy. Comparing the United States with these two otherwise similar nations suggests that many of the commonplace explanations for the absence of national health insurance in America are incomplete or wrong. And it demonstrates once again the utility of an explanatory perspective emphasizing policy feedback, historical sequence, and the opportunity structure created by political institutions.

From this perspective, the distinctive U.S. medical system – with its high costs, substantial reliance on private finance, and large gaps in coverage – is not simply a product of antigovernment values, the weakness of organized labor, the power of the medical profession, or even the fragmented structure of U.S. political institutions. These factors, and particularly the organization of American government, were important determinants of the policy choices political leaders in the United States made during critical historical junctures. Over time, however, the feedback effects of those choices increasingly came to drive U.S. health policy, as policymakers, interest groups, and the public all grappled with the enormously costly and disjointed medical complex that prior policy interventions (or noninterventions) had helped create. Massive subsidies for medical technology and infrastructure, tax and labor policies promoting employment-based insurance, and a framework of government health insurance that removed from the market the most vulnerable and difficult to insure segments of society – these public initiatives gave rise to a costly, complex, and deeply embedded private insurance market that resisted government efforts at reform while slipping from the control of the medical profession and into the hands of profit-driven corporations. By the time President Clinton launched his historic effort to reform American health care, the vested interests and budgetary dilemmas presented by America's ever more unsatisfactory medical care arrangements had come to represent a challenge that any democratic government, much less the fragmented, veto-ridden polity of the United States, would have found virtually impossible to meet. And, indeed, in the wake of Clinton's crushing defeat, the private medical industry proved far more resilient and adaptable than the thoroughly discredited governing majority that had tried to reform it.

Early Defeats

In the United States, as in Britain, compulsory health insurance became a prominent political issue during the early 1910s. Among progressive activists, the passage of the British National Insurance Act was watched closely,

and in the years after 1911 a number of books extolling the British legislation appeared in the United States.¹²² In 1912, Theodore Roosevelt, running on the plank of the newly formed Progressive Party, campaigned on a platform that endorsed a wide range of social reforms, including compulsory health insurance. But although Roosevelt's 27.4 percent of the popular vote represented the strongest result by a third-party candidate in U.S. history, Roosevelt lost to Democrat Woodrow Wilson, and the Progressive Party wilted from the national political scene. The fact that Roosevelt's impressive showing had resulted in scant legislative seats for his party – and, indeed, had split the Republican vote and led to a Democratic victory – underscores the dilemmas faced by third parties in the American political context.¹²³ In the same year that Roosevelt lost his insurgent bid for the presidency, the Socialist Party attracted 6 percent of the vote. This showing was almost identical to the 6.4 percent received by the British Labour party in 1910.¹²⁴ But thanks to winner-take-all elections and the separation of congressional and presidential elections, the Socialist Party's 6 percent resulted in no congressional seats and had meager national political impact. The Labour Party's 6.4 percent, by contrast, resulted in forty-two seats in parliament and, as we have seen, provided an important impetus for the passage of the National Insurance Act of 1911.

In the states, too, third parties faced nearly insurmountable hurdles – a feature of U.S. federalism that set it sharply apart from the Canadian experience. Electoral systems in the American states were almost without exception dominated by one or both of the major national parties. Progressive Era electoral reforms designed to weed out corruption and limit the number of candidates further solidified the position of the major parties, establishing rules for ballot access and candidate selection that generally disadvantaged new and third parties. Even more important, the predictable failure of third parties at the national level prevented the rare regional movements that did emerge from having the kind of national impact that locally rooted Canadian parties enjoyed. Whereas in Canada provincial parties were able to gain seats in the national parliament and agitate on behalf of regional causes, in the United States the weakness of third parties at the national level left state third-party movements isolated and largely impotent. State-based third parties did, of course, influence the agenda of the two major parties, and they experienced notable successes in the midst of the Great Depression, when the Farmer-Labor Party picked up the governorship in Minnesota and the Progressive Party captured both the gover-

122. See I. M. Rubinow, *Social Insurance with Special Reference to American Conditions* (New York: Henry Holt and Company, 1916); and the discussion in Skocpol, *Protecting Soldiers and Mothers*, chap. 3.

123. Roosevelt's Progressive (Bull Moose) Party had "minimal success at the state and local levels, winning approximately 13 House seats but electing no senators or governors." And those thirteen or so seats comprised a motley band of Progressive legislators representing different factions within the larger movement. *Congressional Quarterly's Guide to U.S. Elections*, 3d ed. (Washington, DC: Congressional Quarterly Inc., 1994), 267.

124. Oestreicher, "Urban Working-Class Political Behavior," 1270.

norship and the state legislature in Wisconsin and filled the majority of the state's seats in the U.S. Congress. But these electoral victories were short-lived, and unlike in Canada, they came just as political power was shifting away from the states and toward the federal government. In the years after the Great Depression, the electoral presence of third parties in the states ranged from dismal to nonexistent.

But the difficulties faced by third parties were only the beginning of the institutional obstacles faced by American health reformers in the early twentieth century. The United States during this period was emerging from the shadows of what Stephen Skowronek felicitously calls a "state of courts and parties" – a government distinguished by its lack of national administrative capacities and dominated by patronage-oriented parties and powerful federal and state courts.¹²⁵ But what was coming to replace this state of courts and parties was not a European-style administrative state, but rather a state of courts and states. National party competition declined sharply after the Republicans' rise to predominance in the critical election of 1896, and the two major parties became increasingly regionalized. In the South, local Democrats consolidated their hold on power, disenfranchising blacks and holding the national party hostage to regional interests.¹²⁶ At the same time, the patronage activities of the parties were challenged by Progressive reformers, who won changes in the electoral process that weakened the capacity of the parties to mobilize voters.

This pattern of political development contrasts sharply with the institutional changes taking place during this period in Britain. Like political reformers in Britain, U.S. Progressives struggled against patronage and sought to orient the national parties toward social reforms. But in a decentralized federal system that already had universal white male suffrage and well-developed patronage parties, the political changes that U.S. reformers sought took a very different form than they had in Britain. Whereas reformers in Britain sought to strengthen existing parties and open them up to newly enfranchised voters, reformers in the United States challenged the existing party structure as corrupt and anti-democratic.¹²⁷ In Britain, the battle for the extension of the franchise and the emergence of labor-backed parties prodded the establishment parties to support social insurance programs. In the United States, by contrast, labor unrest did not translate into serious third-party challenges, and the extent of lower-class political participation was actually decreasing in the early 1900s as parties lost their hold on voter loyalties.

With national party competition attenuated and the federal government dominated by the business-backed Republicans and hemmed in by the Supreme Court, state governments became the primary object of social reformers' attention. This is the crucial difference between Britain and the

125. Stephen Skowronek, *Building a New American State: The Expansion of National Administrative Capacities, 1877–1920* (New York: Cambridge University Press, 1982), 1970.

126. James W. Ceasar, *Reforming the Reforms: A Critical Analysis of the Presidential Selection Process* (Cambridge, MA: Ballinger, 1982), 18.

127. Steinmo, "American Exceptionalism Reconsidered," 118–19.

United States during this period. Advocates of social insurance in Britain were either officials within or outside actors trying to forge links with a centralized, administratively competent national state. In the United States, by contrast, progressive reformers had no choice but to push for social insurance programs at the state level, where conditions were far less propitious than they were in Britain, or than they would in the Canadian provinces after World War II. In the first place, reformers had to coordinate their efforts across forty-eight far-flung states, each with different political and social characteristics. Even when interest groups and elites in a state were favorably disposed to a social program, the barriers to its passage were enormous. Advocates had to move their proposals through bicameral legislatures, past independently elected governors, around extremely powerful (and business-friendly) state courts – and, at times, past such roadblocks as state referenda as well. Most important, reformers had to overcome fears that social policies raising taxes or imposing new mandates on employers would lead firms to relocate or precipitate a decline in private investment.¹²⁸ In contrast with provincial governments in Canada, state governments in the United States could neither rely on federal equalization payments to mitigate the chronic fiscal problems faced by poorer regions nor expect the national government to step in to assume the cost of subnational programs. The potent dangers that redistributive social reforms posed for state economies and budgets meant that “reforms that threatened to raise costs significantly for a large number of firms engaged in interstate competition were very unlikely to pass.”¹²⁹

Nonetheless, the mantle of reform was taken up after Roosevelt’s defeat by the American Association for Labor Legislation (AALL), an organization of reform-minded social scientists and philanthropists that persistently campaigned for European-style social policies during the Progressive Era. In 1916, the AALL pledged to campaign for the passage of a health insurance proposal modeled after the British and German schemes. Although the AALL started its crusade with impressive speed, the momentum of its campaign soon stalled and opponents quickly throttled its proposals in state after state. Leading the fight against compulsory health insurance were employers and local medical societies.¹³⁰ The AALL’s decision to include a small funeral benefit in the bill raised the hackles of the insurance industry. In California, even Christian Scientists joined the chorus of opposition. After the Bolshevik revolution and America’s entrance into World War I, the opposition took to denouncing the AALL bill as “pro-Bolshevik” and “pro-German.”¹³¹ In California, a referendum on a consti-

128. David Brian Robertson, “The Bias of American Federalism: The Limits of Welfare State Development in the Progressive Era,” *Journal of Policy History* 1 (1989): 261–91.

129. Pierson, “The Scope and Nature of Business Power,” 24.

130. According to Lubove, “Employers condemned health insurance as un-American and inequitable, a further imposition on businessmen already overlaid with taxes. The unfair burden it imposed on employers would drive industry from the state” (Lubove, *The Struggle for Social Security*, 85).

131. *Ibid.*, chap. 4; Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920* (Baltimore: Johns Hopkins University Press, 1978), chap. 7.

tutional amendment enabling the proposal was crushed amid “wartime hysteria.”¹³² In New York, the AALL bill managed to gain Senate approval but was then promptly muzzled by the Assembly Speaker, a conservative Republican industrialist who swore never to let the bill reach the floor.¹³³

Much has been made of the political ineptitude of the AALL and the stridency of the rhetoric surrounding the debate.¹³⁴ But it is hard to see how either mattered very much given the institutional constraints the AALL faced. The members of the AALL were not, as were reformers in Britain during this period, powerful leaders within a centralized national state. They were not, as were provincial reformers in Canada after World War II, representatives of disciplined political parties. Few integrative mechanisms besides patronage linked political actors across the various levels and branches of state governments. Nor were there mechanisms for federal-state cost-sharing in the United States similar to those that helped Canada’s provincial leaders overcome the constraining effects of federalism. The AALL desperately tried to raise simultaneous interest in its bill in as many states as possible, but in only two – New York and California – did the AALL proposal come anywhere close to passage. Perhaps if the war had not interceded, the AALL campaign would have fared better. But considering that no other major social insurance programs passed at the state level during this period, this seems highly unlikely.¹³⁵

To be sure, the political opposition to the AALL proposal was fierce and the rhetoric ideologically charged. But the extent of the mobilized opposition can be overstated, and the ideological character of the debate seems to have been as much a symptom as a cause of the proposal’s slow and messy death. Although, as many commentators on this period note, the American Federation of Labor led by Samuel Gompers did oppose the AALL bill, many state labor federations offered their support, as did an extensive assortment of philanthropic and women’s organizations. The AMA in fact initially supported the bill, although its position seems in retrospect to have largely reflected the views of the profession’s leadership. Like doctors in Britain in 1911, doctors in the United States felt at first that there was “no escape from social insurance” and “simply resigned themselves to making

132. Starr, *The Social Transformation of American Medicine*, 253.

133. Numbers, *Almost Persuaded*, 91.

134. The American public’s culturally grounded opposition to compulsory health insurance during this period has also been overemphasized. It is true that strong public support for the AALL campaign never existed. But, as we have seen, there is no evidence that such support was of crucial importance in the passage of the National Insurance Act in Britain. The difference between Britain and the United States was that the AALL campaign *needed* such support to have any chance of success. As for the results of the California referendum, it should only be noted that the referendum took place at the height of the war amid a fervent propaganda campaign against the bill, that referenda favor the organized over the apathetic, and, most important, that no such referenda were ever held or needed to be held in Britain, Canada, or many other European nations and that where they were held, as in Switzerland, opponents of reform gained the upper hand (see, for example, Immergut, *Health Politics*, chap. 4).

135. On the fate of other social policy proposals, see Pierson, “The Scope and Nature of Business Power,” 23.

the best of it.”¹³⁶ Once it became clear that compulsory insurance was not inevitable, however, doctors quickly realized that their interests would be better served by its defeat. Indeed, the most bitter medical opposition and propaganda emerged only after it was clear that most states would not act on the AALL bill.¹³⁷

The rhetoric did, however, serve at least one important purpose: It helped define the orientation and alliances of the American medical profession for decades to come. American doctors, it now seems clear, were ripe for the sharp turn against government that occurred in their ranks during this period. Of all western countries in the early twentieth century, America had perhaps the most underdeveloped government presence in medical care. Government hospitals were rare; public health was largely a state responsibility and never very diligently pursued; and doctors operated as independent solo-practitioners and prided themselves on their entrepreneurial spirit.¹³⁸ What experience doctors had with government was almost invariably negative. During the war, for example, many states expanded workmen's compensation laws to include medical benefits, and doctors complained that the insurance benefits were inadequate.¹³⁹ More important, American doctors did not face the great problem that British doctors did of having to struggle against powerful, lay-controlled purchasers like friendly societies. Instead, doctors generally set their own fees, adjusting them up or down to reflect the income of their patients. And during the debate over compulsory health insurance, their incomes rose rapidly.¹⁴⁰

The campaign against the AALL proposal was a turning point in the development of the American medical profession and its leading representative organization, the AMA. During and after the war, “physicians’ incomes grew sharply; and their prestige, aided by the successes of medical science, became securely established in American culture.”¹⁴¹ In 1920, the AMA set out its famous official policy declaring the medical profession unalterably opposed “to the institution of any plan embodying the system of compulsory contribution insurance against illness.”¹⁴² The AMA was also officially opposed to voluntary insurance, although local medical societies began setting up their own private plans in the 1930s and the policy was later dropped. Membership in the AMA rose from about 7 percent of physicians in 1901 to more than 50 percent in 1915 to 65 percent in 1930.¹⁴³ As a national representative organization, the AMA was based on local and state medical societies, membership in which automatically conferred membership in the national organization.¹⁴⁴ This “widespread federated” structure, coupled with physicians’ considerable resources and ca-

136. Numbers, *Almost Persuaded*, 113. 137. *Ibid.*, 81–82.

138. Odin W. Anderson, *Health Services as a Growth Enterprise in the United States Since 1875* (Ann Arbor: Health Administration Press, 1990), chaps. 2, 4.

139. Numbers, *Almost Persuaded*, 114. 140. *Ibid.*, 113.

141. Starr, *The Social Transformation of American Medicine*, 260.

142. Quoted in Anderson, *Health Services as a Growth Enterprise*, 79.

143. Numbers, *Almost Persuaded*, 27; Starr *The Social Transformation of American Medicine*, 273.

144. Numbers, *Almost Persuaded*, 28.

capacity for mobilization, gave the AMA unusually extensive leverage in the regionally elected and organized U.S. Congress.¹⁴⁵ This leverage helped the AMA convince Congress in 1927 to discontinue the Sheppard-Towner Infancy and Maternity Protection Act of 1921 – “one of the few government programs enacted over the AMA’s protests.”¹⁴⁶ And it would become crucial to the AMA’s political prospects when American governmental power was nationalized during the Great Depression.

The New Deal

The Great Depression fundamentally transformed American politics. It led to a dramatic shift in the voting pattern of the American electorate, stunningly reviving the once-moribund Democrats and bringing to the polls a host of disaffected groups with little else in common besides their dissatisfaction with existing policies.¹⁴⁷ The election results were truly overwhelming: In the 1932 elections, the Democrats gained a 313 to 117 seat advantage in the House and a 59 to 36 seat advantage in the Senate, and their seat shares only went up in the next two elections. Although Franklin Roosevelt arrived in office unsure of how to proceed, he was committed to using the national government to fight the Great Depression and to building up the executive establishment to handle these efforts.

Yet as dramatic as the New Deal transformation was, the political opportunities it created were not unlimited. Although the Democratic Party decisively controlled Congress, the party was split between its northern and southern wings. Within Congress, southern Democrats benefited the most from the Democratic landslides of the 1930s. Most came from safe one-party states and districts, and the seniority system in Congress ensured that they occupied powerful positions within the congressional hierarchy. The structure of Congress activated legislators’ territorial interests, particularly the distinctive interests of southern politicians, who feared any challenge to the white power structure in the South. Although the electoral success of the Democratic Party created incentives for party cohesion, the party and its popular chief executive lacked the inherent institutional advantages conferred on party leaders in parliamentary systems. Most of Roosevelt’s actions after 1932 can be understood as an effort to build up the presidency and pursue his aims while at the same time attempting to prevent defections within his party’s conservative southern wing and to forestall a backlash in Congress or the Supreme Court against the expansion of executive authority.¹⁴⁸

The members of the Committee on Economic Security (CES) who were charged with developing the Social Security Act were well aware of these

145. Skocpol, *Protecting Soldiers and Mothers*, 55.

146. Starr, *The Social Transformation of American Medicine*, 260.

147. James L. Sundquist, *Dynamics of the Party System: Alignment and Realignment of Political Parties in the United States*, rev. ed. (Washington, DC: Brookings, 1983), chaps. 10–12.

148. William E. Leuchtenburg, *Franklin D. Roosevelt and the New Deal, 1932–1940* (Ithaca, NY: Cornell University Press, 1963).

constraints. Although they studied the feasibility of including compulsory health insurance alongside old-age pensions, they ultimately decided against it. Even an off-hand call for a study of health insurance in the Social Security bill drew a firestorm of protest from the AMA, which convened an extraordinary emergency meeting of its delegates and mobilized local societies – and, through them, members of Congress – against the legislation.¹⁴⁹ According to Edwin Witte, the staff director of the CES, the opposition of doctors, “plus the fears which this opposition aroused in Congress, doomed all hopes for early enactment of health insurance legislation.” The southern-dominated House Ways and Means Committee unanimously struck the reference to health insurance from the bill and “time and again thereafter members of Congress received protests from medical associations and individual physicians against the economic security bill, all based on the [mistaken] assumption that this bill provided for health insurance.” Witte and other committee members were understandably convinced that any mention of health insurance in the final legislation “would spell defeat for the entire bill.”¹⁵⁰

The decision to leave health insurance out of the Social Security Act, though politically wise, ensured that health insurance would not pass through the window of opportunity opened by the Great Depression. In the 1938 congressional elections, New Deal Democrats suffered significant losses. After the election, southern Democrats and conservative Republicans forged the notorious “conservative coalition” that would stymie Roosevelt’s ambitions until his death. The AMA emerged from the battles of the New Deal with an aura of political invincibility, an expanded membership, and an unshakable claim to dominance within the medical sector.¹⁵¹ The threats of the 1930s and the rapidly rising cost of medical care had finally impelled AMA leaders to allow local medical societies to develop profession-sponsored prepayment plans as an alternative to either government or lay control. But leaders of the newly created Social Security Administration would continue to view government health insurance as the great unfinished business of the New Deal. Allied with labor and a handful of liberals in Congress, they would lead the charge for compulsory health insurance almost from the day the SSA was established. These three forces – the conservative coalition, organized medicine, and the emerging pro-reform alliance – would define the boundaries of American health politics for the next three decades.

After the War

World War II had similar effects on American society and politics as it did in Britain and Canada. Yet the United States emerged from the war not only as a growing economy, a strengthened bureaucratic state, and a mo-

149. Starr, *The Social Transformation of American Medicine*, 269.

150. Edwin E. Witte, *The Development of the Social Security Act* (Madison, WI: University of Wisconsin Press, 1962), 184, 185, 188.

151. Starr, *The Social Transformation of American Medicine*, 273.

bilized national community, but also as the undisputed economic and political leader of the western world. Many liberals believed America's new global responsibilities would unify Americans in support of expanded government programs much as the Great Depression had before.¹⁵² The war itself led to the passage of government health programs for military personnel and their dependents, and preinduction physicals revealed that a high proportion of young men were not fit for military service. Perhaps most important, public support for national health insurance rose during the war: In 1942 more than 74 percent of Americans said they supported such a program.¹⁵³

Yet not all developments during the war improved the prospects for national health insurance. In 1942, the War Labor Board allowed firms to offer fringe benefits to attract employees in the tight wage-controlled labor market. Enrollment in employer-sponsored hospital insurance plans rose quickly thereafter and then further expanded after the war as unions won the right to bargain collectively for health benefits and employee health benefits were exempted from federal taxation. The number of Americans with some form of private insurance increased from 12 million in 1940 to 32 million in 1945 to 76.6 million in 1950.¹⁵⁴ This emerging "private welfare state" was supported indirectly by government through the tax code and federal mediation, but its main champion was a mobilized labor movement frustrated by the hostility of Congress to labor's aims.¹⁵⁵

The years after World War II were a turning point in the political development of American labor. Aided by the New Deal's Wagner Act, "the number of unionized workers had increased more than fivefold to over 14 million. About 30 percent of all American workers were organized, a density greater than at any time before and a level that for the first time equaled that of northern Europe."¹⁵⁶ The degree of unionization in the United States was also higher at this time than it was in Canada.¹⁵⁷ The labor movement that emerged from the war eschewed the voluntarist outlook that had characterized its national political activities before the New Deal and now wholeheartedly embraced a reformist political agenda centered around tripartite bargaining, government-guaranteed full employment, and an expansion of the welfare state.¹⁵⁸ Not until after the political fail-

152. Alonzo L. Hamby, *Beyond the New Deal: Harry S. Truman and American Liberalism* (New York: Columbia University Press 1973), 4.

153. Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia, MO: University of Missouri Press, 1979), 29–31.

154. HIAA, *Source Book of Health Insurance Data*, 24.

155. Beth Stevens, "Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector," in *The Politics of Social Policy in the United States*, ed. Margaret Weir, Ann Shola Orloff, and Theda Skocpol (Princeton, NJ: Princeton University Press, 1988).

156. Nelson Lichtenstein, "From Corporatism to Collective Bargaining: Organized Labor and the Eclipse of Social Democracy in the Postwar Era," in *The Rise and Fall of the New Deal Order*, ed. Steve Fraser and Gary Gerstle (Princeton, NJ: Princeton University Press, 1989), 139.

157. Meltz, "Labor Movements in Canada and the United States," 315–18.

158. Lichtenstein, "From Corporatism to Collective Bargaining," 125.

ures of the late 1940s would organized labor turn wholeheartedly toward private-sector collective bargaining.

Harry Truman thus had strong backing from organized labor when he became the first American president to throw his support unreservedly behind national health insurance. The proposal Truman advocated was an ambitious mix of health initiatives, but its core feature was a comprehensive health insurance program modeled after Social Security. Although Truman did not press actively for the program in 1945 and 1946, it became a major theme of his 1948 reelection campaign and emerged as a leading political issue after he stunned the nation by winning the election and leading Democrats back into the congressional majority.

But national health insurance met the same fate as most other ambitious social programs Truman pursued between 1948 and 1950.¹⁵⁹ Although Truman ostensibly enjoyed a party majority, he had no hope of overcoming the cross-party conservative coalition of Republicans and southern Democrats. Enraged over Truman's support of civil rights, southern Democrats "remained overwhelmingly opposed to his all-inclusive health insurance proposal or to any other major new adventures on behalf of labor-supported, urban-oriented social and economic reform."¹⁶⁰ It did not help Truman's reform campaign that the AMA launched a multi-million dollar lobbying blitz linking the president's proposal to Cold War fears about socialism.¹⁶¹ But the reality is that "national health insurance was simply one more Fair Deal program that never came close to passing."¹⁶²

The power of the conservative coalition and the southern Democrats who led it reflected the distinctive organization of national political institutions in the United States. The separation of executive and legislative elections and the dominance of Democrats in the South weakened any incentives for southern Democrats to go along with presidential initiatives that threatened their interests. Moreover, the oligarchic structure of Congress reinforced legislators' geographic parochialism and gave conservative Democrats from safe one-party regions disproportionate power. President Truman had the misfortune of pressing for national health insurance at a time when Congress was becoming increasingly institutionalized and slow-moving.¹⁶³ Congressional turnover was decreasing, seniority was becoming an unbreakable norm of advancement, committees did most of the legislative work and fiercely guarded their jurisdictions, and legislators were running highly localized campaigns. Party leaders and the president simply had few resources to bring recalcitrant party members in line. Between

159. Richard E. Neustadt, "Congress and the Fair Deal: A Legislative Balance Sheet," in *Harry S. Truman and the Fair Deal*, ed. Alonzo L. Hamby (Lexington, MA: D.C. Heath, 1974).

160. Poen, *Harry S. Truman versus the Medical Lobby*, 164–65. 161. *Ibid.*, chap. 6.

162. James A. Morone, *The Democratic Wish: Popular Participation and the Limits of American Government* (New York: Basic, 1990), 259.

163. Nelson W. Polsby, "The Institutionalization of the U.S. House of Representatives," *American Political Science Review* 62 (1968): 144–68; Samuel P. Huntington, "Congressional Responses to the Twentieth Century," in *The Congress and America's Future*, ed. David B. Truman (Englewood Cliffs, NJ: Prentice-Hall, 1965).

1939 and 1955, the conservative coalition won more than 92 percent of the votes on which it emerged.¹⁶⁴

Still, not all health legislation was bottled up in Congress. Congress eagerly passed the Hospital Construction Act of 1946, and in the 1950s it poured funds into medical research and education. These measures were supported by the medical industry and conservative legislators. They distributed funds widely as identifiable bundles of “particularized benefits” for which members of Congress could easily “claim credit.”¹⁶⁵ And they augmented the already impressive technological arsenal of American medicine, which was fast emerging as the most costly and sophisticated in the world. In Canada, too, the federal government funded hospital construction after World War II. Yet in Canada, political institutions created incentives for the passage of provincial and then federal insurance programs. In the United States, the institutional landscape pushed decisively away from more comprehensive reforms.

The abject failure of Truman’s proposal finally prompted health reformers within the executive branch to reevaluate their strategy. It was clear that national health insurance could not pass and that the expansion of private insurance was weakening public and political pressure for a universal program. One politically important group of Americans, however, was not sharing in the benefits of private insurance – the aged. Elderly Americans were poorer and sicker than the rest of the population, but they rarely enjoyed health insurance after retirement. Truman’s executive officials hoped that a program focusing on the elderly could create an “opening wedge” for a truly universal government program.

By the 1950s, therefore, the legacies of past political struggles over health insurance had created a dense thicket of interests and constraints through which any health care reform proposal would need to pass. The medical profession had emerged as the dominant actor within American medicine, and its formidable lobbying organization had become the most feared pressure group in U.S. politics. Allied with employers and the burgeoning medical industry, the AMA and local medical societies were actively promoting private plans that protected the profession’s income and prerogatives. They were aided inadvertently by American labor, which had turned away from the political arena in frustration and was concentrating its energies on private-sector negotiations to obtain valuable fringe benefits such as health insurance. The private-sector welfare state that was being constructed did not, however, resemble the universal welfare states that were emerging in Europe. Private health insurance was reaching the employed, the wealthy, and the well organized. It was leaving behind the unemployed, the poor, and the unorganized. In a reluctant recognition of these emerging realities, advocates of health care reform had chosen to limit their initial focus to the most politically appealing of these newly vulnerable groups – the elderly.

164. David R. Mayhew, “Innovative Midterm Elections” (Yale University, photocopy, 1995), 11.

165. Mayhew, *Congress*, 52–61.

The Passage of Medicare

In 1965, a window of opportunity for health care reform opened yet again in the wake of President Lyndon B. Johnson's landslide electoral victory. The 1964 elections ushered in a two-to-one Democratic majority in Congress and, for the first time, gave reform-minded northern liberals within the Democratic Party a decisive edge over their southern brethren. The 1964 sweep meant that some kind of program for the elderly was a "legislative certainty."¹⁶⁶ The question was what form it would take. In keeping with the incremental strategy outlined more than a decade earlier, reformers were still pressing for federal hospital insurance for the aged – a program they were now calling "Medicare." But southern Democrat Wilbur Mills, chair of the House Ways and Means Committee, recognized that such a limited program would create pressures for programmatic expansion, just as reformers secretly hoped it would. Thus he proposed expanding Medicare to include physician services as well as hospital services while enlarging and partially nationalizing a state-based program passed by Congress in 1960 to provide medical care to the poor (the enlarged program was called "Medicaid"). The Johnson administration delightedly agreed, and the program sailed through Congress despite Republican opposition.

The Medicare program was a reflection of the constricted political opening through which it passed. The bill itself promised that "nothing in this title shall be construed to authorize any federal official or employee to exercise any supervision or control over the practice of medicine."¹⁶⁷ The program would operate as physician-sponsored Blue Cross/Blue Shield plans did, reimbursing doctors on their preferred fee-for-service basis and at rates that were "reasonable and customary." (Indeed, Blue Cross plans could act as fiscal intermediaries under the program.) Not surprisingly, the cost of the program outstripped even the most expansive expectations voiced before passage. In the decade following Medicare's passage federal health outlays rose from less than \$10 billion to more than \$40 billion and from 2.6 percent of total federal spending to nearly 9 percent.¹⁶⁸

The United States had thus charted a distinctive course on health policy. It had a private welfare state oriented toward the needs of the employed middle class, it had a system of uneven coverage for the poor tied to state and federal public assistance, and it had a comprehensive program for the elderly and disabled under its popular pension system. Unlike Britain, the United States had not started by covering the working and lower-middle classes – groups that comprised a majority of the population and whose labor was vital to the economy. Unlike Canada, it had not started by covering all citizens for one class of medical services. Instead, it had ended up with a distinctly categorical and incomplete system that divided Americans into separate groups with unequal access to the fruits of medical science. That system largely excluded the workers who had initially been the target

166. Marmor, *The Politics of Medicare*, 59.

167. Quoted in Morone, *The Democratic Wish*, 263.

168. The former figures are from *ibid.*, 266; the latter, from Congressional Budget Office, *Trends in Health Spending: An Update* (Washington, DC: Congressional Budget Office, 1993), 76.

of reforms in Europe, and it left the state bearing the medical costs of the most expensive segments of the population – the elderly, the disabled, and the very poor.

Partly for these reasons, Medicare would not, as reformers had hoped, serve as a stepping stone to national health insurance. The huge initial costs of the program and the turmoil of the late 1960s pushed any expansion of the program off the immediate political agenda. But the more significant and enduring barrier to an enlarged government role was the changing economic and political climate for reform. For in the 1970s the expansion of the medical industry that Medicare had abetted would collide with America's declining economic fortunes and with new political forces determined to roll the welfare state back.

The Struggles of the 1970s

The 1970s dawned with the widespread recognition of a “crisis” in American medicine. This was not a crisis of access or quality. It was a crisis of costs – untenable, explosive, unstoppable health care costs. In truth, the real rate of medical inflation actually dropped between the 1960s and the 1970s.¹⁶⁹ But now a large portion of that inflation was being financed by government, the economy was worsening, and private employers and insurers were finally attempting to control costs on their own. As Table 3 shows, neither Canada nor Britain entered the 1970s with a large privately financed health care market. They confronted the economic troubles of that decade already having enacted national programs to provide health care to all their citizens. And the medical systems they had frozen into place were relatively simple, involving stable organizational forms and few central actors. In the United States, however, the pressures of rising costs were transforming the organization of medicine, splintering the interests of medical stakeholders, and, in the process, pushing health care reform back onto the national agenda.

The loser in this new political and economic climate was the medical profession. The expansion of private insurance and the defeat of national health insurance had been the profession's escape from the penury of government control. But the expensive medical industry that the profession had helped construct was not the profession's alone to manage. Not only government, but also business firms and commercial insurers had their own stake in the finance and delivery of medicine, and their interest in controlling costs was not congruent with the profession's interest in maintaining income and autonomy. One example of the new challenges to the profession within the private sector was the growth of prepaid group practice, which doctors had fought bitterly against for years. Prepaid group plans integrated the finance and delivery of medical care, organizing panels of doctors and paying them either a salary or a fixed fee per patient

169. Growth in real health spending per capita fell from 6.5 percent in the 1960s to 3.8 percent in the 1970s (Joseph P. Newhouse, “An Iconoclastic View of Health Cost Containment,” *Health Affairs* supplement [1993]: 156).

Table 3. Cost Characteristics of the British, Canadian, and U.S. Medical Systems, 1960–1990

	Britain	Canada	United States
1960			
Per capita spending (in current U.S. dollars) ^a	79	109	143
Percent paid by government	85.2%	42.7%	24.5%
Public spending per capita (in current U.S. dollars) ^a	67	47	35
Percent of population eligible for public benefits ^b	100%	68%	20%
1970			
Per capita spending (in current U.S. dollars) ^a	147	253	346
Percent paid by government	87%	70.2%	37.2%
Public spending per capita (in current U.S. dollars) ^a	128	178	129
Percent of population eligible for public benefits ^b	100%	100%	40%
1980			
Per capita spending (in current U.S. dollars) ^a	458	743	1063
Percent paid by government	89.6%	74.7%	42%
Public spending per capita (in current U.S. dollars) ^a	410	555	446
Percent of population eligible for public benefits ^b	100%	100%	42%
1990			
Per capita spending (in current U.S. dollars) ^a	985	1811	2600
Percent paid by government	83.5%	72.2%	42.2%
Public spending per capita (in current U.S. dollars) ^a	822	1308	1097
Percent of population eligible for public benefits ^b	100%	100%	44%

^aAt purchasing power parity.^bPercent of population eligible for a public program covering general medical expenses.

Source: Calculated from Organization for Economic Cooperation and Development, OECD Health Systems: Facts and Trends, 1960–1991, Volume 1 (Paris: OECD, 1993), Tables 7.1.1, 7.2.1, and A2.1.2.

treated. Recast by business and insurance leaders as “health maintenance organizations” (HMOs), these plans gained the support of the Nixon administration in 1970, and a bill to aid their development was passed by the Democrat-controlled Congress in 1973.

Rising health care costs and the political demands of liberals created a new opportunity to enact a government insurance program in the early 1970s. This time, however, the president advocating reform was a Republican, Richard Nixon, and the plan he was advocating would not have created a universal government program but rather mandated employers to provide private coverage, offering residual public coverage for the rest of the population. The proposal reflected Nixon’s own political instincts, but it also accurately reflected the system of health care finance that had arisen in the absence of national health insurance. Coverage for the employed would come through the private sector; for the rest of Americans, it would come through the public sector. The federal government would institutionalize the bifurcation in American medicine that its failure to act in the immediate postwar era had created.

Yet Nixon’s proposal was not greeted warmly by congressional Democrats, many of whom were still committed to a single federally operated insurance system and believed that Nixon would soon be forced from office by the emerging Watergate scandal. Although Senator Edward Kennedy and Representative Mills tried to forge a Democratic compromise, their effort fell through when labor leaders called for delay until after the 1974 midterm elections in the hope of achieving a large enough liberal majority to pass the Democrats’ preferred plan over Nixon’s veto. Proposals for reform were revived by Nixon’s immediate successors, Gerald Ford and Jimmy Carter, but compromise within Congress and between Congress and the White House proved impossible. The worsening economic and budgetary climate after 1974 doomed all attempts to pass a comprehensive health insurance bill in the late 1970s.¹⁷⁰

The influence of formal institutions on political debates about health care was more complex in the 1970s than it had been in previous decades. The liberal landslide of 1964 had brought to a close the era of the conservative coalition, and in the early 1970s liberal Democrats promulgated a series of institutional reforms in Congress that expanded the number of subcommittees, weakened committee chairs, and increased the power of party leaders.¹⁷¹ These reforms helped diffuse power within Congress and increased the ability of rank-and-file members to develop legislative initiatives and service their constituents.¹⁷² They also contributed to a rise in incumbents’ electoral margins and a continued weakening of the link between incumbents’ electoral success and the fortunes of their party.

170. Starr, *The Social Transformation of American Medicine*, 411–17.

171. David W. Rohde, *Parties and Leaders in the Postreform House* (Chicago: University of Chicago Press, 1991).

172. Mark A. Peterson, “Congress in the 1990s: From Iron Triangles to Policy Networks,” in *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. Morone and Gary S. Belkin (Durham, NC: Duke University Press, 1994), 125–31.

The catchword for these changes among political scientists was “fragmentation” – and it was a fragmentation that was mirrored in the political turmoil surrounding U.S. health policy.¹⁷³ Although Members of Congress had greater incentives and resources than ever to appeal directly to their constituents, they were also more accountable for their individual records in office than ever before. With 90 percent of the public covered by private or public health insurance, efforts to assuage public alarm about health care costs or provide insurance to the remaining 10 percent of population had to tread gently around existing private and public arrangements, lest angry voters turn out against incumbents in the next election. Indeed, since most Americans received health insurance as a fringe benefit of employment, any shift of the privately insured into the public sector would almost certainly be seen as a loss by people who had formerly enjoyed private coverage. Moreover, Medicare and Medicaid created new interests with a stake in existing policy, the most formidable of which was the emerging interest association representing the elderly, the American Association of Retired Persons. Reconciling these conflicting interests would have been difficult in any polity. It proved too much for the fragmented American political system, wracked as it was by the institutional transformations of the 1970s.

The United States might have universal health insurance today if propitious political circumstances and able leadership had come together in the early 1970s before the stagflation and resurgent conservatism of that decade stalled further progress toward reform. But if a compromise had been reached, it almost certainly would not have resembled the publicly sponsored health insurance systems found elsewhere. By the 1970s, the complex legacy of past political struggles had left the United States with a costly patchwork of public and private health insurance over which no interested party could exert control. This complicated structure divided erstwhile opponents of government action, but it also divided advocates. It created new public demands for government intervention, but it also split Americans into warring factions. It moved medical costs to the center of public debate, but it gave public and private authorities no means to control them. These dilemmas bedeviled the fragmented American political system and stalemated progress toward health care reform for more than two decades. Yet the building tensions in American medicine were also creating a new set of political pressures that would shape the greatest battle over national health policy yet fought in the United States.

The Clinton Reform Initiative

The formation of American health policy, like that of Canadian and British policy, has been characterized by three separate but intertwined dynamics:

173. Anthony King, “The American Polity in the Late 1970s: Building Coalitions in the Sand,” in *The New American Political System*, ed. Anthony King (Washington, DC: American Enterprise Institute, 1978); Roger H. Davidson, “The New Centralization on Capitol Hill,” *Review of Politics* 50 (1989): 350–51.

the development of the medical system, the evolution of political institutions, and the emergence of opportunities for policy change. These three dynamics have formed a complex political mosaic, defining the boundaries of the possible during critical junctures and then feeding back into subsequent political struggles through a path-dependent process of policy adaptation and response. In the early 1990s, all three came together to push health care reform back to the top of the national political agenda.

Within the medical sector, the pressures for reform stemmed from the destructive competitive logic of private health insurance. As costs continued to rise during the 1980s, business firms sought to minimize the expense of employee health insurance. Some moved employees into HMOs and other such "managed-care" plans; others required that workers share a greater portion of the costs of their insurance; still others chose not to offer health insurance at all. As a result, the number of uninsured Americans began to rise in 1980 and continued to grow throughout the decade. Even insured Americans, however, were more uncertain than ever about the cost and security of their private health plans.

Public sector programs also faced new challenges. The ballooning of the federal deficit in the 1980s made Medicare and Medicaid – the fastest growing components of the federal budget – obvious targets for reform. But although Congress changed Medicare's payment structure in the 1980s, political leaders found it difficult to control expenditures effectively because most of the cost-abetting incentives originated in the private medical sector, which lay largely beyond their control. Members of Congress were also wary of provoking the wrath of the well-organized elderly beneficiaries of Medicare, the wealthiest of whom had precipitated the repeal of a progressive tax passed in 1988 to expand Medicare's benefits.

These new exigencies resonated in a political system that had stabilized since the unsettled fragmentation of the 1970s. Struggles over the budget had a centralizing influence on congressional deliberations, and the parties were moving farther apart as the sectional split within the Democratic Party abated and the Republican Party, led by its insurgent southern wing, grew more conservative. Party cohesion and polarization increased markedly during the 1980s and reached an all-time high in the early 1990s. This new cohesion allowed the congressional Democratic leadership to take increasing advantage of the institutional resources granted the majority party by the reforms of the 1970s. At the same time, the links between the president and Congress were growing weaker, with the presidency and Congress held by different parties during much of this period.

The immediate catalyst for the return of reform to the national political agenda was the surprise victory of Democrat Harris Wofford in a special 1991 Senate race.¹⁷⁴ Campaigning in support of universal health insurance, Wofford climbed back from a forty-point deficit in the polls to beat a popular former governor and U.S. attorney general. His victory sent shock

174. Jacob S. Hacker, "National Health Care Reform: An Idea Whose Time Came and Went," *Journal of Health Politics, Policy and Law* 21 (1996): 647–96.

waves through Washington and made health care reform a leading issue of the 1992 presidential campaign. When Democrat Bill Clinton captured the presidency, ushering in unified Democratic government for the first time since the Carter administration, no one doubted that he would soon introduce a proposal for universal health insurance.

So much has been written about the Clinton reform effort and its fate that a comprehensive summary is unnecessary.¹⁷⁵ What needs to be emphasized, however, is how deeply the political dilemmas Clinton faced were shaped by the failure of past political efforts to enact national health insurance in the United States. First, the very structure of Clinton's reform proposal represented a concession to the structure of medical finance and delivery that had arisen in the United States in the absence of a universal government program.¹⁷⁶ The Health Security plan attempted to lock into place a disintegrating private financing system while furthering the movement toward managed care that had been under way for the previous two decades. For most Americans, insurance would be funded largely through employer contributions. Americans would choose among private health plans and be encouraged to select managed care plans. Medicare was explicitly left out of this new system, although much of the funding for the plan came through decreased Medicare payments to doctors and hospitals.

Ironically, the failure of the Clinton plan left the field clear for the type of radical market changes that detractors of the proposal had warned would result from its implementation. Partly in anticipation of the Clinton plan, insurers and corporations accelerated their movement toward managed care plans in the early 1990s, nearly doubling the number of Americans in such arrangements between 1992 and 1995.¹⁷⁷ Although this dramatic transformation did nothing to address the worsening plight of the uninsured, it did slow the rate of medical inflation and lessen cost pressures on employers and public programs. In the rest of the industrialized world, cost-containment efforts had been spearheaded by government authorities. In the United States, responsibility for cost control fell by default to the private sector. Indeed, as private actors moved to reshape medicine, government leaders were left scrambling to respond. This reversal of fortune is perhaps the strongest evidence yet that the United States has followed a fundamentally different path of health policy development than have other nations – one that will almost certainly not culminate in the passage of European-style national health insurance.

A second historically inherited constraint that stood in the way of health care reform was fiscal. Comparative experience suggests that a publicly

175. For that, see Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics* (New York: Norton, 1996); Haynes Johnson and David S. Broder, *The System: The American Way of Politics at the Breaking Point* (New York: Little, Brown, 1996).

176. Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton, NJ: Princeton University Press, 1997), 14–15, 58–60, 86–99, 162–70.

177. Mark A. Peterson, "Introduction: Health Care into the Next Century," *Journal of Health Politics, Policy and Law* 22 (1997): 297.

financed system with clear lines of fiscal responsibility is most able to control medical costs.¹⁷⁸ But adopting such a system in America would require moving a large portion of private medical spending onto the public ledger. This was not an option in the United States as it had been in Britain and Canada. Not only was American medicine vastly more expensive and complex than British and Canadian medicine had been when national programs were introduced, but it would also have had to be underwritten in a much harsher fiscal and economic climate. Thus the Clinton administration sought to do the opposite of what Britain and Canada had done: keep as much of the cost of medical care as possible in the private sector. To do this and still restrain spending, however, the administration had to propose an elaborate regulatory apparatus centered around a network of new government purchasing agents. This regulatory framework became the central focus of interest group and Republican attacks on the president's program.

Third, and most important, the Clinton administration had to navigate around the fragmented collection of private interests activated by current arrangements. These interests not only included countless interest groups that campaigned against the plan but also, and more important, various segments of the American public that differentially benefit from the present structure of medical financing. The challenge Clinton confronted was to move all Americans into a new regulatory framework without appreciably harming the standing of any. This challenge was analogous in many ways to the one opponents of the welfare state face when trying to move citizens *out of* public programs – the need to avoid opposing immediate losses that are likely to incite political opposition.¹⁷⁹ The task was immensely complicated by the fact that the chief beneficiaries of Clinton's proposal – uninsured Americans – were diffuse and unorganized, while the chief opponents were concentrated and well organized.¹⁸⁰ Budgetary constraints ensured, moreover, that Clinton would not be able to provide generous "side payments" to affected interests to ease them into the new government-regulated system.

Whether the American political system is less capable of imposing losses than are parliamentary systems is a subject of some dispute.¹⁸¹ Although the concentration of legislative powers in parliamentary systems gives gov-

178. This is well illustrated by the contrasting records of the United States and Canada after 1971 – the year Canada consolidated its national insurance program. Although Canadian and U.S. levels of health spending followed almost identical paths for much of the twentieth century, they diverged in the early 1970s, and Canada now spends significantly less as a percentage of GDP than does the United States. The limits of Canadian cost control relative to the European experience are often noted. But Canada, as we have seen, institutionalized a much more costly medical system than did most European nations. The relevant comparison for judging Canadian success at controlling costs is the United States, and by this measure Canadian national health insurance has had an impressive record.

179. Paul Pierson, *Dismantling the Welfare State*.

180. James Q. Wilson, *Political Organization* (New York: Basic Books, 1973), 330–37.

181. Paul D. Pierson and R. Kent Weaver, "Imposing Losses in Pension Policy," in *Do Institutions Matter? Government Capabilities in the United States and Abroad* (Washington, DC: Brookings, 1993), 111–12.

ernments greater freedom to enact loss-imposing policies, it also makes it easier for citizens to hold them accountable for their actions. On balance, the evidence would seem to suggest that the greater discretion governments have outweighs the problem of increased accountability.¹⁸² But the point to be made is that neither Britain nor Canada enacted national health insurance under the stark conditions Clinton confronted. If leaders in those countries had been faced with a medical system as costly and complex as that of the United States, if they had been forced to seamlessly move two-thirds of the public from private and public insurance plans into a common public framework, and if they had faced the challenges that all welfare states faced after the mid-1970s, then perhaps the United States would not be the only country without national health insurance.

Contrary to the claim of Sven Steinmo and Jon Watts that "It's the Institutions, Stupid!" sole or even preponderant blame for the defeat of health care reform in 1994 cannot be assigned to U.S. political institutions.¹⁸³ American government clearly was not up to the task of passing comprehensive reform, but the immensity of that task reflected the complexity, cost, and fragmentation of the medical system that reformers of the 1990s inherited. Of course, American political institutions were crucial in pushing U.S. health policy down the ill-fated track it took. But the failure of reform in the early 1990s was as much a reflection of the inherited legacies of distant political struggles as it was of the distinctive organization of American political power.

CONCLUSION

National health insurance is among the most popular and politically secure elements of the modern welfare state. Yet it also among the most controversial. In every country with national health insurance, fierce political battles preceded the passage of programs to finance medical care for all citizens. The nature of these battles differed over time and across countries, and the programs that countries ultimately adopted reflected the distinctive constellation of forces that led to their passage. The British NHS remains a monument to the programmatic achievements of the postwar Labour Government and to the remarkably widespread optimism about the potential of the welfare state that captured Britain in the 1940s. Canadian Medicare is Canada's great social policy triumph, a policy whose popularity had made it part of the very fabric of Canadian society and whose unique decentralization embodies the distinctive social and political context from which it arose. The American Medicare program stands out as a popular policy

182. *Ibid.*, 143. In the case of the Clinton plan at least, advocates of reform found it exceedingly difficult to coordinate their efforts around a single proposal, and legislators backed away from comprehensive measures as the 1994 elections approached for fear of individual electoral reprisals.

183. Sven Steinmo and Jon Watts, "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America," *Journal of Health Politics, Policy and Law* 20 (1995): 329–72.

success as well, but its limits also serve as a reminder of the very different political fate that movements for national health insurance met in the United States. These three programs seem to crystallize in their contrasts the different political forces that animated struggles over national health insurance in Britain, Canada, and the United States.

Yet these three contrasting political histories, I have argued, are connected by a unifying logic. The very different political forces that led to the establishment of the NHS, the creation of Canadian Medicare, and the failure of national health insurance in the United States can all be understood through a common theoretical lens. This lens requires that we look at the development of health policy not as a series of discrete political struggles, but as an ongoing historical process in which past public policies and political battles shape what is possible in the future. It requires that we pay attention to the sequence of policy change and to the relationship between that sequence and changes in the structure of the medical sector and in the larger political climate surrounding health and social policies in advanced industrial democracies. And it requires that we examine the formal political institutions that shape the windows of opportunity through which major policy changes must pass.

This perspective also requires that we cast a critical eye on some of the prevailing accounts of health policy development. National health insurance programs are not simply an outgrowth of industrialization or the growth of medical complexity. Nor are they simply a reflection of distinctive national cultures or the power of prominent societal groups. These factors all have played a role in shaping government responses to the problem of providing medical care to all citizens at an acceptable cost. Yet their effect depends crucially upon the organization of the political institutions through which national health policies must pass. The great difficulty of altering established arrangements in medical care means that opportunities for fundamental change in health policy arrive rarely and momentarily, frequently because of major partisan shifts or significant external shocks. The prospects for policy change during these critical junctures hinge on two factors: the incentives and constraints created by political institutions, and the inherited legacies of past policies, which structure the medical sector, set the intellectual agenda for reform, shape the resources and interests of key societal groups, and influence public perceptions of the costs and benefits of policy change. Changes in public policy made (or not made) during these critical junctures in turn influence future political struggles by locking into place particular constellations of interests and institutions and setting in motion self-reinforcing, path-dependent processes that delimit the scope of future policy change.

The emergence of national health insurance programs in advanced industrial democracies should therefore not be seen as a one-time event that occurs because of a particular constellation of political and social factors. Rather, it should be conceived of as an ongoing historical process whose sequence critically determines eventual outcomes. Three questions of sequence are particularly important in determining the path countries even-

tually take: whether governments fail to enact national health insurance before a sizable portion of the public is enrolled in physician-dominated private insurance plans, whether initial public insurance programs are focused on residual populations such as the elderly and the very poor, and whether efforts to build up the medical industry precede the universalization of access. Countries that do all these things, as the United States did, are left facing virtually insuperable political barriers to the passage of national health insurance. Also important, however, is the relationship between the sequence of policy change and the overall economic and political environment facing the welfare state in advanced industrial democracies. As the nature of the health care debate has changed across the industrialized world, countries with different health policies and medical systems have faced very different political constraints. In particular, the failure of the United States to pass a national program before the rise of new budgetary and ideological challenges to the welfare state in the late 1970s left it simultaneously unable to either control rising health care costs or enact a universal public program that would allow it to do so.

To understand interactive effects such as these, I have stressed, institutional analyses must consider the relationship between political institutions and other critical factors, particularly the legacy of past public policies. The effect of government institutions is not constant. It depends on the goals actors are trying to pursue, as well as on the conditions under which they must pursue them. Nor are political institutions static. They change over time both in response to purposive efforts to alter them and as a byproduct of social and political change. The need to consider interactive effects is revealed in the contrasting role played by federalism in United States during the Progressive Era and in Canada after World War II. In Canada, federal institutions did not represent the barrier to health insurance programs that they did in the United States, in part because they were situated in a different social and political context, in part because the federal government entered into revenue-sharing agreements with the provinces that attenuated provincial fears about the negative fiscal and economic effects of policy innovation. Similarly, the distinctive development of U.S. health policy created thorny political dilemmas that even the more favorably configured political institutions of recent decades proved unable to solve.

An emphasis on interaction effects is emblematic of the more general methodological message of this article – that concepts such as path dependence, policy feedback, and critical junctures can indeed be profitably employed in political analysis so long as researchers use multiple analytic methods and expand the range of observations and outcomes they are interested in exploring. This article has sought to show not only that comparative health policy provides fertile ground for applying established and emerging arguments about the political effects of institutions and the place of history in political analysis, but also that methodological approaches combining cross-national comparison, historical inquiry, and counterfactual reasoning allow historically minded political scientists to navigate between the twin dangers of overgeneralized or monocausal explanations, on

the one hand, and atheoretical or descriptive accounts, on the other. By integrating comparative, historical, and counterfactual methods, it is possible to develop complex yet suitably general answers to multifaceted research questions, even questions that are often viewed as analytically problematic, such as the crucial puzzle of why the United States lacks national health insurance.

The analysis of comparative health policy also suggests that institutional analyses need to consider the constraints and opportunities that *private* institutions pose for policymaking. In Britain, Canada, and the United States, battles over national health programs took place at the intersection of market and state, and the outcomes of those battles reshaped not only public policies but also market relations. The critical influence of market structures on health care politics is in part a result of the special economic characteristics of medical care. These features – asymmetric and imperfect information, extreme risk aversion, uncertainty about the efficacy of services, and significant positive externalities – give rise to common functional exigencies with which all industrial democracies have had to grapple in the twentieth century. Yet government health policies also form and re-form the medical marketplace, shaping the interests of patients, doctors, and other medical stakeholders. We have seen, for example, that U.S. policies exempting fringe benefits from wartime wage controls and then privileging employment-based health benefits in tax and labor law created the large private insurance market that is perhaps the most significant barrier to national health insurance in the United States. This reciprocal and ongoing interaction between market and state suggests the need for a full-fledged *institutional political economy* of policy development that takes into account the way in which policies influence market relations and are in turn influenced by them.¹⁸⁴

This reciprocal interaction also implies that dominant traditions of scholarship on the welfare state require qualification or expansion. Although scholars no longer equate the welfare state with direct government spending, this view nonetheless remains the implicit frame of reference in welfare state research. Despite recent attention to tax expenditures and other indirect policy instruments, these forms of state intervention have not been well integrated into traditional paradigms, and there has been almost no attempt to examine the relationship between the welfare state and voluntary and charitable organizations or private fringe benefits.¹⁸⁵

184. Promising movement in this direction has been made by Esping-Anderson in *Three Worlds*.

185. Important recent works on indirect spending and “third-party” government include Christopher S. Howard, *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States* (Princeton, NJ: Princeton University Press, 1997); Benjamin Gidron, Ralph M. Kramer, and Lester M. Salamon, *Government and the Third Sector: Emerging Relationships in Welfare States* (San Francisco: Jossey-Bass, 1992); Michael Lipsky and Steven Rathgeb Smith, “Nonprofit Organizations, Government, and the Welfare State,” *Political Science Quarterly* 104 (1989–1990): 625–48; Lester M. Salamon, ed., *Beyond Privatization: The Tools of Government Action* (Washington, DC: Urban Institute, 1989); Donald F. Kettl, *Government by Proxy: (Mis?)Managing Federal Programs*

Moreover, those scholars who *have* addressed these subjects have generally embraced a pluralist view of social welfare in which government, private employers, charitable organizations, and families are simply alternative loci of social provision.¹⁸⁶ The development of national health policies strongly indicates, however, that welfare state scholarship must consider the important political and technical constraints that private networks of social provision create for government regulation or spending. As the U.S. experience with private insurance reveals, embedded networks of institutions and actors can form just as easily around private provision as they do around public programs – and present just as daunting challenges for those who would see them changed.

The history of health policy development in advanced industrial democracies is remembered for bold strokes of change initiated during transformative moments. Yet as important as these critical moments have been, the groundwork for them has almost always been laid by past political struggles and public policies. The heavy hand of history thus hangs over even the most transformative of policy breakthroughs, a silent partner in the dance of politics. It is reflected alike in the dramatic passage of the British NHS, the creation of Canadian Medicare, and the long and trying struggle for national health insurance in the United States.

(Washington, DC: CQ Press, 1988); Stevens, "Blurring the Boundaries"; Herman B. Leonard, *Checks Unbalanced: The Quiet Side of Public Spending* (New York: Basic, 1986); Barry P. Bosworth, Andrew S. Carron, and Elisabeth H. Rhyne, *The Economics of Federal Credit Programs* (Washington, DC: Brookings, 1985); Stanley S. Surrey and Paul R. McDaniel, *Tax Expenditures* (Cambridge, MA: Harvard University Press, 1985); and Dennis S. Ippolito, *Hidden Spending: The Politics of Federal Credit Programs* (Chapel Hill, NC: University of North Carolina Press, 1984).

186. See, for example, Neil Gilbert and Barbara Gilbert, *The Enabling State: Modern Welfare Capitalism in America* (New York: Oxford University Press, 1989); and Richard Rose, "Common Goals but Different Roles; the State's Contribution to the Welfare Mix," in *The Welfare State East and West*, ed. Richard Rose and R. Shiratori (New York: Oxford University Press, 1986).