Political Discourse And Policy Change: Health Reform In Canada And Germany

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ABSTRACT

Political debates about the reform of health care systems have been ubiquitous in developed nations around the world for well over two decades. However, the extent to which these debates have been translated into substantive policy change is much smaller than their frequency and intensity would suggest. Using matched case studies drawn from health reform initiatives in two countries, Canada and Germany, political discourse is demonstrated to be an important factor in the policy change process. Discourse, defined as the combination of policy ideas and the way in which they are framed within particular policy networks, can serve to reinforce a policy framework or to persuade various publics of the need for significant policy change, even in the absence of changes in institutions and interests. Two types of discourse, namely 'challenging' and 'truth-seeking', are hypothesized to be more conducive to significant policy change than are 'rhetorical' or 'instrumental' discourses. Drawing on the case studies, the research shows that a 'challenging' discourse emerged in both countries, but led to significant policy change only in Germany. Based on the comparison of the two cases, it is argued that a number of factors are relevant for whether a challenging discourse is successful or not, including: degree of consensus on the gravity of the policy problem; the consistency of the discourse with broadly held normative values; and the persuasiveness of the 'social facts' brought to bear in support of proposed new solutions.

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Figures:

Tables:

LIST OF FREQUENTLY USED ACRONYMS

AOK	*Allgemeine Ortskrankenkassen*	General Local Sickness Funds
BÄK	*Bundesärztkammer*	Federal Physicians' Association
BMAS	*Bundesministerium für Arbeit und Sozialordnung*	Federal Ministry of Labour and Social Affairs
BMG	*Bundesministerium für Gesundheit*	Federal Ministry of Health
CAC		Consumers' Association of Canada
CDU/ CSU	*Christliche Demokratische Union/ Christliche Sozial Union*	Christian Democratic Union/ Christian Social Union
CHA		Canada Health Act 1984
CMA		Canadian Medical Association
FDP	*Freie Demokratische Partei*	Free Democratic Party
FOM		Friends of Medicare
GKV	*Gesetzliche Krankenversicherung*	Statutory Health Insurance
GRG	*Gesundheitsreformgesetz* 1989	Health Care Reform Act
GSG	*Gesundheitsstrukturgesetz* 1993	Health Care Restructuring Act
HIDS		Hospital Insurance and Diagnostic Services Act 1957
KAiG	*Konzertierte Aktion im Gesundheitswesen*	Concerted Action in Health Care
KBV	*Kassenärztliche Bundesvereinigung*	Federal Association of Insurance Physicians
KHKG	*Krankenhaus-Kostendämpfungsgesetz* 1981	Hospital Cost Containment Act
KVEG	*Krankenversicherungs-Kostendämpfungs-Ergänzungsgesetz* 1981	Health Insurance Cost Containment Amendment Act
KVKG	*Krankenversicherungs-Kostendämpfungsgesetz* 1977	Health Insurance Cost Containment Act
MCA		Medical Care Act 1966
NDP		New Democratic Party of Canada
PC		Progressive Conservative Party of Canada
SPD	*Sozialdemokratishce Partei Deutschlands*	Social Democratic Party of Germany
SGB V	*Sozialgesetzbuch, Band V*	Social Code Book, 5th Edition

Chapter 1

Introduction

National health insurance is a significant component of modern welfare states. From an economic perspective, health systems comprise, on average, about 10% of the gross domestic product of industrialised democracies in the OECD, the largest category of social spending after pensions. Moreover, health programs are among the most visible and most popular programs of welfare state. At the same time, and for some of these very reasons, health insurance is a profoundly political and hotly debated issue in public policy.

From their origins as a policy idea in Germany during the late nineteenth to their modern and distinctive formations around the world, publicly sponsored national health programs have been in a state of constant flux and contestation, like much of the welfare state itself[1]. However, unlike other elements of the welfare state, national health programs represent an unparalleled degree of intervention in traditionally private, market-based systems of resource allocation. While all social programs have the goal of redistributing societal resources, cash benefits simply offer income supplements to citizens to allow them to continue participating in the market to obtain necessary goods (such as food and shelter), leaving the supply of those goods largely unaffected. National health programs, on the other hand, affect virtually every aspect of the supply and demand for health-related goods and services. They fundamentally and directly alter the market, and thus affect the livelihoods and well-being of numerous and diverse groups, from providers to consumers to insurers, representing virtually every citizen in the polity. They have precipitated the development of highly differentiated state structures for their implementation, as well as the formation and mobilisation of powerful non-state actors. Finally, national health programs represent an underlying (and contested) set of values and beliefs about the sphere of politics: the appropriate division between collective and individual responsibilities, or the domains of 'political contention'; and the division between technical and political spheres, or the domains of 'political control' (Starr 1982; Starr and Immergut, 1987).

It is not surprising, therefore, that national health programs are an aspect of the welfare state which invites considerable debate, assessment and reassessment. Reform and restructuring of health policies is at or near the top of political agendas in most industrialised democracies, irrespective of the specific configuration of the health system. Since the stagflationary shocks of the mid-1970's, the uptake and costs associated with

[1] In this research, 'national health programs' is the generic label used for state-sponsored and/or mandated programs modelled on social insurance schemes (such as Germany's) as well as those based on tax-financed, universalistic principals (such as Canada's and Britain's).

most social insurance schemes have increased as a result of sustained levels of high unemployment in the industrialised world. In the health sector, this, together with the development and diffusion of new medical technologies and the demographic shift in population ageing, resulted in the expansion of health-related public expenditure which far outpaced growth in the economy as a whole and most other sectors of government spending throughout the 1980s and into the 1990s. As a result, governments have been struggling to contain costs and create greater efficiencies in health programs. In addition to, and perhaps because of, these perceptions of a cost crisis, health programs and the welfare state more generally have been subject to criticisms of stifling labour markets and distorting incentives to work, as well as compromising the competitiveness of national economies in an increasingly globalised world. The critics include conservative political and opinion leaders who took power in many western developed nations during this period. These individuals and their supporters questioned the appropriateness and effectiveness of state intervention and extolled the virtues of market mechanisms. Criticisms of the welfare state were also echoed, although somewhat more circumspectly, by traditional allies of the welfare state, who charged that "the edifice of social protection in many countries is 'frozen' in a past socio-economic order that no longer obtains..." (Esping-Andersen 1996:2).

Despite this convergence in and confluence of economic and political circumstances, fiscal situations and demographic trends among nations of industrialised world, their health systems have remained distinctive, as have their policy responses to these pressures. In addition to reforms in delivery systems, such as reductions in hospital beds, shifts to home care and the formation of internal markets, many nations have also engaged in various types of alternative discourses to promote changes. These include ideas about the determinants of health, the limits on the right to health care and roles for private financing and delivery in public health care systems.

Efforts to explain the different pathways of reform have been an important focus of welfare state research in recent years. Studies of policy change and retrenchment in programs of the welfare state in the past decade suggest that government policies are largely the product interests and institutions. Some focus primarily on the interests, suggesting that policy decisions are the result of a rational calculus made by key actors of the political and/or material costs and benefits of reform proposals, and strategies based on the particular institutional capacities and resources at their disposal (Bonoli 1998; Pierson 1994, 2001; Weaver 1999; Ross 1997). Others focus on the institutionalised elements of history, path dependency and feedback which dictate a particular pattern of state-society relations, and thus shape the process and outcome of reform deliberations (Giaimo 2002; Moran 1999; Tuohy 1999; Wilsford 1991). This research suggests that although different governments may develop distinct approaches to the policy making process within different institutional contexts, there are overriding imperatives which all (democratic) governments must consider and which mitigate the

degree of policy success.

However, as illustrated in the two cases examined in this study, neither of these explanations quite captures the reality of health care reform. Some politically powerful and determined actors, with the full range of institutional authority and resources, failed to accomplish their political objectives in health system reform. The government of Alberta in Canada abandoned critical elements of its reform proposals, despite its concentrated authority, the resources of the political executive and the lack of any substantive political and electoral opposition. Furthermore, the influences of history and path-dependency emphasise conservative policy development and fail to account for instances of major departure from the status quo, as illustrated by the case of health reforms in Germany. After decades of failed attempts, the long-standing principles of subsidiarity and solidarity in the German health insurance system were significantly altered in 1992, despite the stability of rules and institutionalised arrangements between key actors in the system.

More recently, scholars have begun to pay more attention to the role of discourse in framing policy debates, creating opportunities and raising obstacles to policy change. Schmidt and Radaelli (2004:192) suggest that "discourse is fundamental in both giving shape to new institutional structures, as a set of ideas about new rules, values and practices, and as a resource used by entrepreneurial actors to produce and legitimate those ideas, as a process of interaction action focused on policy formulation and communication." This development in theorising public policy is attributable to both shortcomings in the explanatory power of existing theories, as well as methodological and epistemological shifts in social scientific thinking, from positivist to post-positivist paradigms, of which discourse analysis is a significant part (Fischer 2003; Mazy 2000; Phillips & Hardy 2002).

This study expands on these developments to examine how policy discourses about health care might be understood as contributing factors to policy change. Following Schmidt (2001), 'communicative' discourses that are directed to a general public by policy elites and are designed to reinforce an existing policy framework are differentiated from 'coordinative discourses' where policy elites reach out to other specific groups in attempts to persuade them of the need for significant policy change. Drawing on case studies of health policy reform in Canada and Germany, this study demonstrates the emergence of coordinative discourses in both countries that challenged the dominant health policy paradigm in the late 1980s and early 1990s. In Germany, this challenging discourse proved to be persuasive and key policy actors came together to agree upon a significant reform of health care policy. In contrast, policy actors in Canada were resistant to the challenging discourse, and little policy change occurred. Successful policy change in the German case was a function of the strength of the challenging discourse presented in that country, whereas the challenging discourse in Canada failed to provide an acceptable and

viable alternative to the status quo.

Based on these findings, a number of criteria or conditions for the success of challenging discourses in changing policy are apparent: the perceived gravity of the policy problem amongst key actors and their willingness to make a political commitment to engage in policy co-ordination; the consistency of the discourse with broadly held normative values; and the persuasiveness of the cognitive argument about new solutions proposed in the discourse.

Examining Policy Change in Germany and Canada

The German and Canadian health care systems share some common normative bases, but these are framed in distinctive ways. In both systems, collective societal responsibility for the health care needs of individual citizens is a paramount objective. However, the German system operates on the basis of a highly regulated model of social insurance which values solidarity within and between groups. In Canada, the tax-financed health care system focuses on universality of benefits and equitable access to needed care for all residents.

In Germany, the principle of solidarity is written into the Social Code Book governing the health care system. Solidarity is operationalised primarily through the separation of contribution rates to statutory health insurance funds from the level of entitlement to benefits: contributions rates (or premiums) are based on income or ability to pay, while entitlements are based on medical need. Until the early 1990s, this principle was strictly compartmentalised; that is, solidarity was limited to redistribution within groups, mainly classes of workers, rather than across groups. Beginning with reform debates in the late 1980s to the enactment of the *Gesundheitsstrukturgesetz* (GSG) in 1993, the principle of solidarity was broadened substantially to include a large majority of the citizenry. This re-conception of solidarity had a significant impact on the organisation of a central feature of the German health care system, the statutory health insurance system (GKV – *gesetzlichen Krankenversicherung*).

A number of theses have been offered about why proposals for significant reforms failed up to and including the 1989 *Gesundheitsreformgesetz* (GRG), and then triumphed only four years later with the GSG. These propositions focus on changes in the structural imperatives of the German economy due to reunification and the planned European Monetary Union, the institutional dynamics of German federalism and corporatist organisation, and the changing needs and demands of Germans for health care. Although all of these explanations have some merit, they do not address the way in which the nature of the problem that health reforms were intended to address changed. Although cost-containment remained a primary goal of health reforms, perceptions of the problems – their sources, causes and solutions – were altered amongst key policy makers. The policy

discourse began to shift in the late 1980s from one that was concerned primarily with maintaining the structural features of the system and making only instrumental adjustments to it, to one that challenged those very structures on the basis of their failure to meet not only long-standing cost-containment goals, but also changing needs and expectations. As a function of this shift in discourse, new policy ideas about the principle of solidarity were able to take root in what had been a firmly established and largely path-dependent set of institutions in the German health care system.

The fundamental foundations of Canada's national system of Medicare have remained largely unchanged since 1965. Five explicit principles are embedded in the structure of the system: universality, accessibility, comprehensiveness, portability, and public administration. The Canada Health Act 1984 (CHA) establishes these principles in law and is used to assess the performance of provincial governments. Although provincial governments have the primary constitutional jurisdiction for health care, the CHA gives the federal government both fiscal leverage and moral authority in shaping Canadian Medicare.

Although there has often been much debate and hand-wringing about these principles over the past two decades, remarkably little has changed in the dominant policy framework that animates the system. All Canadians are covered by provincial health plans, which are financed primarily through general government revenues. All medically necessary care provided by physicians or in hospital is covered, with no additional user charges at point of service. Individuals may also be covered for a range of additional services (such as home care and prescription drugs), although their range and scope vary across provinces. Canada is unique among developed nations in that parallel private insurance for services covered by public plans is virtually prohibited under the CHA.

The perception of a deep cost crisis hit Canada in the early 1990s, somewhat later than many other nations, at which point total health expenditures had peaked at over 10% of the nation's GDP. Talk of 'reform' was largely focused on cost-containment initiatives on the supply-side: re-organisation of system structures to enhance efficiency and effectiveness, and an across-the-board reduction in spending. At the same time, some key political and health system actors also articulated a challenging policy discourse based upon arguments for a greater role for private financing. They suggested that policy instruments such as user charges or a parallel private system of health care insurance and financing would help offset the increasing burden of Medicare on government coffers. This attempt to persuade relevant actors about the need to privatise components of the health care system met with little success. It failed to provide a convincing argument that the principles of Medicare would not be jeopardised or that the system would indeed be improved and more efficient. Unlike the response to a challenging discourse in Germany, Canadians and many system actors strongly resisted the proposed changes, and in fact rallied around a rhetorical discourse to defend and reinforce the dominant Medicare

paradigm.

Plan of the Argument

In order to develop the argument that communicative discourses remained dominant in Canada while coordinative ones gained greater acceptance in Germany, subsequent chapters are organised in the following way. Chapter two begins with a discussion of the role of ideas in policy analysis and how they can play a 'constitutive role' as frames for policy. It proposes a methodology for analysing policy discourse so as to distinguish between different types of communicative and coordinative discourses. Moving into the case studies, chapter three describes and analyses the institutional structures and state-society relations in Germany that had inhibited significant health policy reforms for decades, and lays out the argument that the magnitude of policy shift introduced by the GSG cannot be explained by changes in these variables. Chapter four demonstrates the emergence of a successful challenging discourse in Germany, centred on changes in the framing of the concept of solidarity, which made possible fundamental restructuring of the statutory health insurance system. Turning next to the Canadian case study, chapter five describes and analyses the institutional structures of Canadian federalism and parliamentary government, as well as the nature of state-society relations in the health sphere. It develops the contention that these features of the Canadian polity should in fact have made fundamental reform of the Medicare program in one province eminently possible. Instead, as chapter six elaborates, a challenging discourse was unsuccessful in persuading key actors that the expansion of private financing alternatives would address problems without compromising the core principles of the system. Finally, the concluding chapter suggests several reasons why the challenging discourse enjoyed more success in Germany than it did in Canada, and proposes certain conditions under which challenging discourses are more likely to lead to significant policy change.

Chapter 2

Understanding Policy Change: Linking Policy Ideas and Policy Frames in Discourse

That ideas have a role in politics is generally undisputed: ideas are one of the three legs of the analytic stool upon which much political scientific theorising and investigation rests, along with institutions and interests. What *is* disputed, however, is how they matter, their relative importance or significance, and their relationship with other elements. Generally, as Wendt (1999:93) notes, "[t]he dominant approach in mainstream political science is to treat ideas in causal terms as a (typically intervening) 'variable' that explains some proportion of behaviour beyond the effects of power, interest, and institutions alone... [In essence,] power, interests, and even institutions are treated as idea-free baselines against which the role of ideas is judged."

Theories that focus on interest-based explanations of politics give ideas little or no emphasis; ideas are residual factors that come into play when actors behave in less than rational, self-interested ways. In these behaviouralist approaches, interests and preferences, usually material, drive the actions and choices actors make in the polity. For example, Weingast suggests that "the role of ideas arises because a shared set of ex ante conventions helps reduce ambiguity..." and thus allows actors to co-operate in the face of uncertainty (Weingast 1995:450). Ideas are ascribed similar roles by Goldstein and Keohane (1993) in the context of rationalistic, material preference-based policy choices: they are road maps or focal points around which actors may structure their choices and decisions. In their discussion of ideas, Goldstein and Keohane are not concerned with which ideas become available and how or why they are persuasive, and in fact seem to be comfortable with the contention that "ideas may become important solely because of the interests and power of their progenitors." (p.13).

However, assumptions of purely self-interested behaviours on the part of either politicians or their constituents are problematic. Self-interest is not always self-evident. Attributing the decisions of policymakers to a calculus based on re-election or personal gain diminishes the importance of deeply-rooted systems of beliefs and values, many of which are also institutionally embedded (Goldstein and Keohane, 1993; Kingdon 1994; Scharpf 1997). There are many instances of policymakers acting against their apparent self-interests or situations in which they may not be clear about what their self-interests actually are. Even when re-election is the primary goal, public opinion seldom offers an unambiguous path to the polls. Instead, people may advocate particular issues or policies because they believe that they are the right

course of action. When ideational phenomena are treated as 'information' simply to reduce uncertainty or maximise utility, "the result is politics without passion or principles..." a far cry from our everyday realities (Finnemore and Sikkink, 1998:916).

Neo-institutional theories of politics more effectively capture the social and interactive components of politics. They give analytic and conceptual primacy to the macro and meso-level structures of society – the rules, roles, and material and social structures around which much of society is organised. According to state theorists, these institutional settings explain a great deal of behaviour and outcomes in politics. A more attenuated perspective on the role of institutions is reflected in the 'new institutionalism':

> "institutions are not just another variable, and the institutionalist claim is more than just that 'institutions matter too.' By shaping not just actors' strategies (as in rational choice), but their goals as well, and by mediating their relations of co-operation and conflict, institutions structure political situations and leave their own imprint on political outcomes." (Thelen and Steinmo 1992:9).

In these approaches, institutions are part of the context in which actors interpret the world. Institutions provide actors with information about appropriate goals, behaviours and strategies. However, although many new institutionalist theorists incorporate a role for ideas, it is often secondary to institutions themselves. Ideas are relegated to the background as having influence when institutions are initially created but having little direct impact on actors and outcomes thereafter. Instead of ideas, actors are constrained by their long-standing institutional roles and resources. Blyth (1997:231) accuses institutionalist analyses of treating ideas as "secondary to the mode of analysis in which they are employed. Their definition, operationalisation, and explanatory power are simply derivative of the wider theory in which they are embedded." Such approaches pay insufficient attention to the way in which ideas may shape behaviour independently of institutions as well as their importance in the iteration and reform of existing institutions and policies.

As Peter Hall (1989:283) notes, policy making occurs not only within an institutional framework but also in the "context of a prevailing set of political ideas. These include shared conceptions about the nature of society and the economy, various ideas about the appropriate role of government, a number of common political ideas, and collective memories of past policy experiences." These ideas constitute the political discourse of a nation, the structure of which becomes embedded in institutions and associations of actors. Ideas are the foundations upon which political goals rest; in a sense, the explicit goals of policymakers are merely the 'tip of the iceberg'. Ideas are more than simply functional hooks on which to hang self-interest and motivations;

they have a formative influence on political goals, institutions, and interests. They establish the basic moral and empirical parameters within which an issue comes to be seen as a political problem, and influence the choice of causal factors and strategies for its solution (Blyth 1997; Goldstein & Keohane 1993; Kingdon 1994; Rochefort & Cobb 1993; Stone 1989).

The Constitutive Role of Ideas

The underlying premise of this thesis project is that politics is a socially constructed phenomenon and as such, it is contingent upon meanings and interpretations actors derive from other actors and the context within which they operate. Ideas play an important, constitutive role in the polity by influencing everything from individual and collective perceptions about right and wrong, to what counts as 'fact', to the formal and informal roles and rules that shape public (and private) life.

The assertion that politics is a socially constructed phenomenon shifts the focus of study from observations of behaviour or action *per se* to the underlying "processes of *meaning* which may subsequently engender choices. Human choice is the result of the attempts of actors to 'understand' and 'interpret' the world" (Braun 1999:12, emphasis original). The implication of this approach for the study of public policy is that policy problems do not just 'exist' – they are socially constructed by the process of interpretation, part of an effort to attach particular meaning to events or issues, and give direction for their resolution. Information, observations and experiences are filtered through moral, legal, and social rules that govern individuals and societies. Through this process, a phenomenon becomes identified as a problem if it in some way deviates from these rules or norms, and is thus given significance and scope, and goals and strategies to address it. The communication and widespread adoption of a particular set of meanings occurs through social interaction and accompanying discourses.

Max Weber, who suggested that "not ideas, but material and ideal interests, directly govern men's conduct, perhaps most famously articulates a constitutive role for ideas in interest formation. Yet very frequently the 'world images' that have been created by 'ideas' have, like switchmen, determined the tracks along which action has been pushed by the dynamic of interest." (Weber 1948, as cited in Fischer 2003:24). To the extent that ideas constitute interests, it becomes apparent that struggles between competing sets of ideas are at the heart of difficult political questions and controversies. Different worldviews bring with them differing notions of the public interest, and consequently, differing policy problems and prescriptions. Distributional struggles arise from these often-conflicting worldviews rather than precede them (Braun 1999; Reich 1988; Stone 1988), because it is these worldviews held by actors

"that determine what they see as being in their interests and, therefore, what interests they perceive as conflicting." (Schön and Rein 1994:29; Wendt 1999)

This is not to suggest that ideas *cause* specific behaviours. Rather, ideas "fall into the category of *reasons for actions*, which are not the same as *causes of actions...*" (Ruggie 1998:22). They are "warranting conditions which make a particular action or belief more 'reasonable,' 'justified,' or 'appropriate,' given the desires, beliefs and expectations of the actors" (Fay 1975:85). Ideas are part of language and discourse, as well as being embedded in institutional structures, roles, and norms. They attach meaning to particular events or actions, which "affect certain actions not by directly or inevitably determining them but rather by rendering these actions plausible or implausible, acceptable or unacceptable, conceivable or inconceivable, respectable or disreputable, etc." (Yee 1996:97; Searle 1995).

Particularly in the context of welfare state politics, the role of ideas as reasons or warranting conditions for action intuitively appeals to a sense of society's larger social purpose, one that encompasses collective aspirations and ideals, and legitimates much social and political action. Many policies, perhaps most policies, "have not been motivated principally or even substantially by individuals seeking to satisfy selfish interests. To the contrary, they have been understood as matters of public, rather than private, interest. And this perception has given them their unique authority... To disregard these motivating ideas is to miss the essential story" (Reich 1988:4). The persistence and polarisation of debate about health and social policies suggest that the conflicts go deeper than differences between alternative means or competing interests. Instead, it is the underlying structures of ideas and beliefs, and their subsequent definitions of policy problems and prescriptions, that are at stake (Reich 1988; Schön and Rein 1994).

In order for ideas to be treated as methodologically distinct factors, they must be distinguished both conceptually and structurally from interests and institutions. While this is a difficult task, it need not be impossible. Ideas are notoriously 'fuzzy' concepts, but they can be at least partially extracted from political phenomena for the purposes of study (for examples see: Berman 1998; Blyth 1997; Hall 1997). In order to do so, the concept of ideas needs to be clearly defined, their role in politics developed into theoretical arguments which may illuminate the reasons for (rather than necessarily the causes of) action (Berman 1998).

Policy Ideas as Policy Frames

The concept of ideas is broad in range, including everything from abstract worldviews and belief systems to specific policy programs and strategies. In the former sense, ideas are highly abstract ontological beliefs or worldviews that permeate our way of thinking

and communicating. These types of ideas have a taken-for-granted character that make them almost imperceptible to those who hold them, and an elusive quality that renders them difficult to contain and label. Moreover, these types of ideas are loosely clustered together, are generally neither systematic nor constrained by logical or functional coherence, and are highly resistant to change (Berman 1998; Goldstein & Keohane 1993; Sabatier 1993; Schön & Rein 1994). Such ideas may consist of beliefs about the inherent nature of human beings, of the relative priority assigned to various 'ultimate' values (such as freedom or power) and the nature of justice or equality (Sabatier 1993:31). They are not amenable to the influence of 'facts' or 'reality' but rather are constitutive of our perceptions of what 'fact' and 'reality' actually are. Since these types of ideas are so inclusive, they are slippery subjects for political analysis. At the other extreme, ideas may be specific and very narrow in that they are relevant in only very particular circumstances, providing neither sufficiently abstract explanations nor clues as to how actors who hold them may behave in different situations (Berman 1998).

A "middle range" of ideas is required, what Berman calls programmatic beliefs, and others alternatively refer to as ideologies, policy core beliefs, causal beliefs, policy paradigms, and institutional action frames (Apter 1964; Berman 1998; Campbell 1998; Goldstein & Keohane, 1993; Hagopian 1978; Hall 1993; Sabatier 1998; Schön & Rein, 1994). In essence, these middle range ideas are systems of beliefs that link "particular actions and mundane practices with a wider set of meanings... [they place] emphasis on the behaviour of individuals in a setting of action-in-relation-to-principle... [and] make more explicit the moral basis of action" (Apter 1964:16-17). In other words, middle range ideas both *give* meaning to particular actions and allow one to *ascertain* meaning from particular actions. Because they link behaviour to underlying norms or beliefs, middle range ideas are particularly relevant for understanding the role of ideas in policy development and change.

In the context of this study, this constellation of ideas and policy prescriptions will be referred to as a 'policy frame'. Policy frames may influence behaviour by directing attention to particular elements or issues and diverting it from others (Bleich 2002; Fischer 2003; Yanow 2000:11). They define the range of acceptable choices and thereby constrain action. They may also be enabling in that they may be used to redefine or reshape problems and generate new strategies for action. The content of policy frames circumscribes the normative and cognitive boundaries of what may be possible or impossible at any given point in time, whereas policy *framing* refers to the process by which an issue is defined or redefined and changed. The framing process consists of the practices and forms of political communication used by supporters and/or detractors of a policy frame (Risse 2000; Schmidt 2000; Schön and Rein 1994; Yanow 2000). It is a discursive process that incorporates the language, symbols and actions undertaken to define a problem, make it salient and have it acted upon.

Together, policy frames and policy framing constitute what we refer to as 'political discourses'.

Following Surel (2000: 496), policy frames in this research

> refer to coherent systems of normative and cognitive elements which define, in a given field, 'world views', mechanisms of identity formation, principles of actions, as well as methodological prescriptions and practices for actors subscribing to the same frame. Generally speaking, these frames constitute conceptual instruments, available for the analysis of changes in public policy and for the explanation of developments between public and private actors which come into play in a given field.

The normative elements of policy frames include ideas about a policy area, which are informed by more broadly shared societal beliefs and values. They are the products of 'collective intentionality' — an intersubjective creation of meaning among actors that is ascribed to particular behaviours through the collective creation of rules and conceptual frames or schemes that make actions or experiences intelligible (Ruggie 1998; Legro 2000; Yee 1996). These normative elements shape perceptions and definitions of policy problems, which are themselves the product of discrepancies between what *is* and what *ought* to be (either based on expectations or desired goals). In turn, these discrepancies, and the causal explanations for them, inform particular policy positions and prescriptions. Policy frames thus also contain cognitive or logical elements. These elements have some consistency and coherence based on what 'makes sense' using existing information, knowledge and experience, and their viability within a given political and institutional context (Braun 1999; Converse 1964; Hall, 1993; Sabatier 1993; Sartori 1969). Together, normative and cognitive elements of policy frames establish the boundaries of what is acceptable and appropriate within a given policy area.

Normative Elements of Policy Frames

Dominant belief systems are collective, societal phenomena. They consist of the social norms and rules espoused by groups of individuals but are not simply the sum or aggregate of individual beliefs. They embody broad-based attitudes and norms about what is acceptable or desirable and what is not (Campbell 1998; Sabatier 1998; Surel 2000). Although individual beliefs and interests will influence collective belief systems, the two levels are distinct and may sometimes be in conflict. Moreover not all members of a society or group will subscribe to the dominant belief system. Nevertheless, although they are far from being a 'monolithic homogenous entity,' dominant belief systems are shared and organised independently of individual actors (Braun 1999; Hall 1993; Legro 2000), and form a 'collective consciousness' or identity shared by a group of actors (Surel 2000). Such broad-based belief systems

influence policy frames by providing social norms and values around which policy actors and ideas coalesce. These ideas shape the definition of policy problems and, subsequently, the range of politically acceptable strategies and solutions.

Policy frames are typically composed of numerous idea elements that vary with respect to their centrality within the system: one or two central ideas, which are very resistant to change, and a few less central ideas that are more likely to change in response to new information or experiences. Moreover, ideas that represent 'ends' are more central than ideas about 'means' (Berman 1998; Converse 1964; Sabatier 1998).

Three key normative elements of a policy frame are particularly relevant for policy analysis: the problem definition, the specification of causal relationships, and the identification of problem ownership. Problem definition is "the process by which an issue (problem, opportunity, or trend), having been recognised as such and placed on the public policy agenda, is perceived by various interested parties; further explored, articulated, and possibly quantified; and in some but not all cases, given an authoritative or at least provisionally acceptable definition in terms of its likely causes, components and consequences" (Hogwood and Gunn 1984:109). Causal relationships, policy strategies and solutions flow from problem definitions. Problem definition is a process of negotiation and political exchange within and between groups of actors concerned within a particular policy area (Hall 1993; Stone 1989). It is a "process of image-making, where the images have to do fundamentally with attributing cause, blame and responsibility" (Stone 1989:282). Within groups, a particular problem definition represents a set of shared beliefs, values and strategies that make coherent and collective action possible. Between groups, problem definitions may engender conflict arising from different beliefs and strategies and competition as groups struggle to influence which frame will guide policy (Braun 1999; Stone 1989)[1].

Causal relationships map the path between beliefs and the outcome or problem being addressed. Often, they are "hypothetical-deductive statements, which allow the operationalisation of values in one...subsystem of public policy." (Surel 2000:497). Causal relationships include the causal story generated about the source of the problem, the assignment of blame and responsibility for the problem, and the goals or expectations to be pursued in resolving the problem. A dominant policy frame will influence how a particular problem is perceived – for example, what or who caused it,

[1] Surel (2000:502) notes an important point: a dominant policy frame does necessarily eliminate conflict, even within the community that supports it. Rather, it acts "more as a bounded space for conflict, between the subsystem and the global community, as inside the subsystem itself... A cognitive and normative frame thus marks out the terrain for social exchanges and disagreements, rather than simply supporting an unlikely consensus."

how extensive and severe it is, whether it is solvable, and perhaps most importantly, who or what group has legitimacy to address it (Rochefort and Cobb 1994). As a result, it will confer authority, responsibility and resources on some groups rather than others, it will establish rules and norms for their interaction and behaviour, it will privilege some types of information or knowledge over others, and it will establish goals and expectations for policy interventions.

Cognitive Elements of Policy Frames

At the cognitive level, a role for ideas implies a problem-solving or social learning approach to policy making. Because policy frames are cohesive systems of beliefs linking abstract principles with actual practice, they express specific interpretations of a problem and suggest what type of solutions may be feasible (Braun 1999; Rochefort and Cobb 1993; Schön and Rein 1994). In this way, they "define the conventional wisdom in the area, set out questions for which evidence is necessary, suggest the alternative policies that are plausibly effective, and (most important), keep alternative formulations of the problem off the public agenda" (Moore 1988:72).

Cognitive elements may take two forms, which Campbell (1998) classifies as those that are either at the foreground or the background of the policy debate. At the foreground, cognitive elements take the form of policy prescriptions that specify particular strategies for action; in the background they are cognitive schema that determine what type of information is considered relevant. In the foreground, actors use cognitive elements deliberately and consciously (Campbell 1998:386). Policy learning, such as drawing from previous experience with similar issues, is an example of how such cognitive elements may influence policy choice (Heclo 1974:315). Policy frames, particularly successful ones, are used as analogies or road maps in new and unfamiliar situations and thus pattern future predictable responses. Moreover, previously unsuccessful frames help to reinforce the salience and power of the dominant and successful frame. When the consequences resulting from the prescriptions of a dominant policy frame are positive and desired, it is likely to continue to prevail. Negative consequences arising from actions proscribed by the dominant policy frame further boost its chances of continuity (Legro 2000).

New policy strategies are judged according to their ability to address various aspects of policy problems that have already been defined and accepted. Their viability depends on their conceptual coherence with dominant belief systems, their political consistency with the overall goals of ruling political parties or other powerful actors, and their administrative feasibility in terms of the mandates and goals of existing institutions and administrative agencies (Hall 1989; Kingdon 1995). Policy proposals that are congruent with the knowledge, past experience and understanding of key actors will be particularly compelling. Furthermore, foreground cognitive elements

that offer clear and concise problem statements and directions for action are more likely to appeal to and be accepted by policy makers and the public than more complex formulations. Successful proposals are often accompanied or illustrated by symbols and language that capture the attention and resonate with key actors and/or the public (Campbell 1998:387-8).

In the background, cognitive elements take the form of "underlying theoretical and ontological assumptions about how the world works" (Campbell 1998:389). These are somewhat different from normative worldviews in that they prescribe the cognitive paradigms or schema – the types and sources of knowledge – that are considered relevant to the issue in question. For example, Peter Hall (1989, 1992) has studied the significance of different academic economic paradigms (namely Keynesian and neo-classical) in the development of economic policy in the post-war years, and Jenny Lewis (1999) analysed the impact of the biomedical paradigm in the evolution of sickness focused, cure-based health systems around the world. Thomas Kuhn also elaborated on the impact of knowledge paradigms in the natural sciences (Kuhn 1996). These background cognitive elements are closely tied to normative elements, insofar as they facilitate the achievement of normative goals through particular types of knowledge and "aim to define clear prescriptions for public policy-making." (Surel 2000:498).

Policy Framing, Policy Discourse, and Policy Change

Policy frames, through their normative and cognitive elements, provide policy stability over time. They do this in part by establishing what is considered 'acceptable' within the given set of beliefs and values, and in part by limiting access to new ideas through supportive systemic rules and structures (Campbell 1998:379). The normative elements broadly scope out the nature of the problem, its causes and with whom the responsibility for it lies. Once these normative elements become accepted and entrenched, they restrict the range of ideas that may be brought into the policy arena for consideration. The cognitive aspects of the policy frame function to reproduce and reinforce the normative elements, such as policy goals, rules and roles. They prescribe the concrete sources of knowledge, mechanisms and pathways, actions and policy instruments that will lead to desired outcomes, and exclude others.

History clearly shows that new ideas do emerge and policies do change, sometimes gradually over long periods and other times much more rapidly. To the extent that ideas have a constitutive role to play in the policy process, the analysis of policy change begins with different questions than have been typically asked. As Wendt (1999:78) observes, "causal theories ask 'why?' and to some extent 'how?' Constitutive theories ask 'how-possible?' and 'what?'" Thus, constitutive questions

about policy change are framed as '*what* does this policy change mean?' and '*how* was this policy change *possible*?'

The successful adoption of a new policy frame will depend in part on its content (the 'what?' question). To address the 'what' question, we examine the content of the particular policy frame adopted by different groups – that is, the particular normative and cognitive elements that comprise the dominant policy frame. The interpretation of a policy frame by a group links the content of the frame with the meaning it holds for that group. Different groups will impute different meanings to the content of a policy frame depending on their perceptions, positions and beliefs.

However, a policy frame and its associated ideas do not by themselves "cause" policy change. Rather, to the extent that policy actors are moved to frame policy problems differently, certain policy choices appear more possible and others less so. In this respect, policy frames "constitute" fields of action within which policy problems are conceived and choices about policy strategies are made (Wendt, 1999: 78). This process of policy change is one "whereby actors, through interaction with broader institutional contexts (norms or discursive structures), acquire new interests and preferences—in the absence of obvious material incentives. Put differently, agent interests are shaped through interaction" (Checkel, 1999: 548). Thus the adoption of a new frame will depend on both its content and the process by which it is framed. The 'how possible?' question is addressed by examining the framing process, which is a form of discourse – a combination of action, language and symbols that convey the perceptions and beliefs of one group to another (Yanow 2000). Framing is a "way of selecting, organising, interpreting, and making sense of a complex reality so as to provide guideposts for knowing, analysing, persuading and acting... [and] leads to different views of the world and creates multiple social realities." (Schön and Rein 1991:263-264).

Language is a particularly important component of framing. "The words a group employs and on which it relies to evoke a response can often be taken as an index of group norms and conceptual frameworks" (Edelman 1976:121; Fischer 2003). On the other hand, it also provides labels that "create different points of reference against which people evaluate alternatives" (Stone 1989:200). Language evokes particular interpretations that provide legitimacy to a course of action and encourage acquiescence with it, or alternatively, discourage defiance through the use of threats. Symbols are also evoked to represent complex and/or abstract sets of meanings that are shared within a group. They are a form of shorthand that embody emotive, cognitive and moral elements derived from the values, beliefs and feelings of the groups that apply them (Yanow 2000:15). Symbols may be of particular use in combining or reconciling two or more apparently disparate or contradictory

alternatives (Stone 1989:201). Finally, actions or behaviours, the traditional purview of rationalist theorising, may also convey specific interpretations of the policy frame.

A Framework for Discourse Analysis

Changes to policy frames take place through processes in which political actors engage each other in *augmentative* discourses that focus on preserving an existing dominant policy frame, or in *transformative* discourses that seek to persuade others of the merits of an alternative frame. Therefore, to understand how policy change comes about, we must analyse the meanings associated with dominant and alternative policy frames in the discourses articulated by various actors in a given policy community. An augmentative discourse is one developed by policy elites and directed toward a broader mass public in an attempt to defend a dominant policy frame or to justify minor adjustments to policies within that frame.[2] As Schmidt (2002:172) notes, this type of "discursive process is therefore often adversarial, as the public, if not convinced of the necessity and appropriateness of the policies, can impose sanctions through periodic elections and protest." Alternatively, policy elites may construct transformative discourses by engaging a wider range of policy actors, in order to convince them of the need to work together to change the core normative and/or cognitive elements of the dominant policy frame.[3]

In order to analyse policy discourses in a systematic, empirical fashion, the following questions must be addressed (see Appendix 1 for a full elaboration of the research methodology used):

- Who is constructing the discourse?
- What is the apparent purpose or action-imperative of the discourse?
- What are the generic elements of the policy frame at stake in the discourse (i.e., the normative or cognitive elements)?
- What are the specific elements of the policy frame at stake in the discourse (i.e., the specific contents of the normative or cognitive elements)?

Based upon the answers to these questions, we have identified four ideal-types of policy discourses, as summarised in Figure 2.1: two augmentative discourses (rhetorical and instrumental), and two transformative discourses (challenging and truth-seeking).

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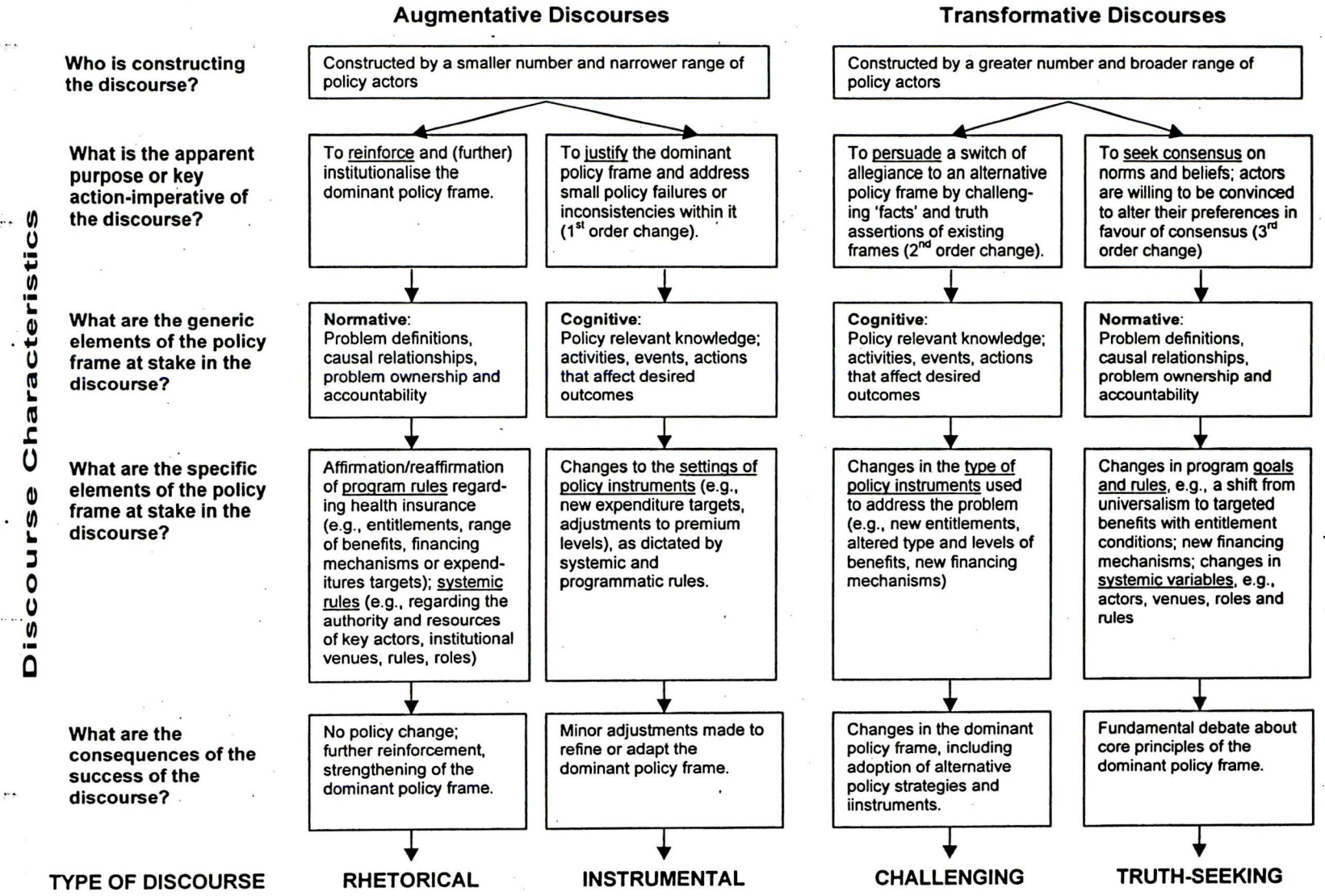
[2] These concepts of augmentative and transformative discourses drew their initial inspiration from Schmidt's (2002) distinction between coordinative and communicative discourses. The discourses in this project are labeled differently from Schmidt's to distinguish between discourses which are categorized according to their purpose (as in this study) and discourses which are categorized according to the institutional context in which they occur (as in Schmidt).

[3] This discussion is drawn from my earlier work (Bhatia and Coleman 2003).

FIGURE 2.1: A Framework for Analyzing Political Discourse & Policy Change



The ***rhetorical*** type of augmentative discourse is used by promoters of the dominant policy frame to *reinforce* and further *institutionalise* it. The generic elements of the policy frame that are at stake are normative: problem definitions, causal relationships, problem ownership and accountability. The language accompanying this discourse is authoritative insofar as it attempts to validate "established beliefs and strengthens the authority structure of the polity or organisation in which it is used" (Edelman 1977:109). It takes the form of exhortations to support the dominant policy frame, or employs terms that classify people according to their merit, competence or other characteristics (Edelman 1977). Policy advocates attempt to encapsulate "entire problems in simple phrases that evoke instant recognition and response" and use symbolic language to find a competitive edge that will capture the attention of their audiences (Rochefort and Cobb 1993:58). Furthermore, rhetorical discourses must be targeted and specific to the audience – the same language and strategies will not necessarily be appropriate for all groups (Schmidt 2000). Edelman (1977) notes that 'presentational forms' – such as governmental processes, ceremonies, settings and ritualistic procedures – may serve to justify actions and policies by invoking routine processes and to provide reassurance by evoking familiar patterns.

Instrumental discourse is an augmentative discourse used to address small policy failures or inconsistencies within the dominant policy frame, which Peter Hall (1993) refers to as first order policy change. These policy failures may include problems of 'efficiency' or 'effectiveness', which may be attended to by making small adjustments in the settings of extant policy instruments, without altering the normative bounds of the dominant policy frame. The main action imperative of this discourse is to *justify* the dominant policy by invoking rules – including formal laws and regulations, social customs and traditions, moral rules and principles, and the rules and bylaws of private associations – and rule-guided behaviour (Stone 1988:231). Rules imply legitimacy on the part of both the rule-makers and the rule-followers, and serve to prescribe actions to be taken in a particular set of circumstances or contexts (Stone 1988:232). Rules also prescribe the organisational roles and role expectations of various groups and individuals within the policy sphere – bureaucratic and political staffs, political representatives, professionals and the public – and thus their capacities and jurisdictions for action (Edelman 1977). Instrumental discourses are thus the most institutionally driven of the four ideal types elaborated here. The focus on following rules narrows the subject of discussion to the cognitive elements of the policy frame insofar as the normative elements (which established the rules) are accepted as legitimate and therefore not discussed. This reliance on rules, the acceptance of the normative bounds of the dominant policy frame, and the focus on incremental adjustments mean that instrumental discourses tend to involve only a few key policy decision makers whose roles and responsibilities are institutionally defined.

Within the transformative discourses, a ***challenging*** discourse is directed outward toward other policy actors in order to persuade them that an alternative course of action should be taken. The main action imperative of this discourse is *persuasion* using 'facts' – that is, the cognitive elements of the frame, such as policy relevant knowledge and information – to challenge the problem definitions, causal relationships and truth assertions promoted by other actors. Disagreements about facts centre on questions about which facts are accurate, which ones are relevant and how a given set of facts is to be interpreted. Persuasion is thus a cognitive process that is contingent upon the discovery and accumulations of empirical and theoretic anomalies in the dominant policy frame (Kuhn 1962). When expectations arising from the normative goals and beliefs underlying a policy frame are unfulfilled and policy consequences are negative, actors may be more likely to engage in investigating the problems, assigning blame, and re-evaluating the policy frame (Hall 1993; Hemerijck and van Keersberg 1999; Legro, 2000). Peter Hall (1993) describes this phase as second order change, during which actors pursue more substantive changes, such as engaging new policy instruments to address the problem.

Cognitive structures may involve different forms of knowledge – such as expert knowledge, scientific knowledge, non-scientific knowledge, or experiential knowledge – and highlight different sets or types of 'facts' (Singer 1990; Stone 1988). Moreover, policy frames do not just exist: they are created and promoted by actors or 'intellectual entrepreneurs'. The actors that advocate a particular frame influence its success. The legitimacy or status of the carrier of the idea may affect the likelihood it will be influential and accepted by a critical mass of other actors. This cannot be equated to the power of the advocates, since the ideas of weaker groups often succeed where those of the more powerful fail (Legro 2000). Legitimacy may depend on a number of factors, such as how long the advocates have been involved in the policy area, how motivated and committed they appear to be, their expertise and their institutional capacities (Berman 1998; Finnemore and Sikkink 1998; Laumann and Knoke 1987). The capacities or organisational platforms of policy elites and experts, in particular, give them the potential to be much more influential than other actors in shaping policy content (Finnemore and Sikkink 1998). In part, institutional roles identify who is a member of these groups and what resources they have at their disposal: individuals who occupy influential niches in state bureaucracies, advisory or regulatory bodies – policy 'insiders' – clearly have a greater opportunity to shape policy than 'outsiders' (Yee, 1996). However, the identity of these key actors also hangs on socially derived perceptions of their legitimacy and reliability – on the prevailing ideas in a particular policy area (Jervis 1976; Lewis 1999; Singer 1990). Hall's (1993) study illustrates the prominence of academic economists in shaping macroeconomic policy, while Lewis (1999) and Starr and Immergut (1987) elaborate on the legitimacy of physicians as technical experts in the health sector. As Stone

(1989:294) notes, science "commands enormous cultural authority as the arbiter of empirical questions."

In contrast to this relatively 'reasoned' form of persuasion, Stone (1988) discusses an alternative type of persuasion (which she refers to as 'indoctrination') that relies on appeals to fear, anxiety or insecurity to elicit desired responses. In both instances of persuasion, 'facts' of a sort are relied upon in making the argument compelling. However, in the indoctrination form of persuasion, facts and information are used selectively to tell only part of the story. Furthermore, "not only are the arguments and reasons that are presented partial and one sided, but also, and more importantly, [the persuadee] is not aware of this." (Burnell & Reeve 1984: 404). One of the most compelling metaphors used in challenging discourses, particularly of the indoctrination brand of persuasion, is that of crisis. Crisis connotes an emergency or threat that can and must be dealt with. It is distinct from other problems in its magnitude, immediacy and rarity and in the fact that its occurrence is not the fault or responsibility of political leaders. Moreover, it requires people to make collective and individual sacrifices in order to overcome it (Edelman 1977:44; Lipsky and Smith 1989). Language used in addressing the issue may be characterised by combative terms, referring to action on the issue as a 'war' or 'struggle', or in terms of an 'offence' or 'defence'.

Although the failure of an existing policy frame enables the emergence of new ones, it does not necessarily result in consolidation of a new frame, nor does it reveal an obvious successor from among competing frames. It is entirely conceivable that a stalemate between multiple frames will result in no new policy frame being adopted. Instead, policy makers take recourse in the old one by default. As this discussion of the challenging discourse makes clear, the consolidation of a particular alternative is only partly dependent on its theoretical, political and administrative feasibility. Consolidation and adoption of an alternative policy frame is also linked to the broader social and political context of the policymaking community (Ball 1995; Hall 1993; Legro 2000).

Finally, ***truth-seeking discourses***[4] are directed toward diverse audiences, and include a broad range of actors. They challenge the moral appropriateness and authority of the underlying norms and beliefs of the policy frame, and seek to develop consensus along broad, normative parameters of a policy issue based on no particular preconceived preferences or perceptions. In this type of 'communicative action', "actors try to convince each other to change their causal or principled beliefs in order to reach a reasoned consensus about validity claims. And, in contrast to [the other types of

[4] The 'truth-seeking' label is borrowed from Risse (2000). It is not intended to convey a normative position on the validity of the discourse itself, but rather, on the objectives of the actors engaged in the discourse.

discourses], they are themselves prepared to be persuaded" (Risse 2000:9). Schön and Rein (1994:45) refer to this process as 'frame reflection' – the ability of policy actors to see an issue from the other's perspective or policy frame and thus create a "reciprocal, frame reflective discourse." The product of such discourse is an alternative, mutually agreed upon frame (Edelman 1977; Schön and Rein 1994).

As Hall notes, "the process whereby one paradigm comes to replace another is more sociological than scientific" (1993:280). Thus, consensus in a truth-seeking discourse requires coherence and consistency with higher level worldviews that dominate a society, as well as the actors and groups advocating a particular policy frame. Hall (1993:383) suggests that these worldviews may include

> ...shared conceptions about the nature of society and the economy, various ideas about the appropriate role of government, a number of common political ideals, and collective memories of past policy experiences. Together, such ideas constitute the political discourse of a nation. They provide a language in which policy can be described with the political arena and the terms in which policies are judged there.

To the extent that a particular policy frame is consistent with these deeply held values and responds to broader concerns, it is more likely to be successful. Although worldviews are no simple matter to assess, since they do not "necessarily constitute a coherent, consistent set of issue positions [across issue areas]," (Campbell 1998:392), it is clear that citizens tend to respond to *public* issues on the basis of their values and beliefs rather than their perceptions of self-interest, even though those values may (and often do) come into conflict with one another across and even within policy sectors (Orren 1988). The salience and parsimony of a policy frame are distinct from its cognitive content. Successful new frames "select for attention a few salient features and relations from what would otherwise be an overwhelmingly complex reality. They give these elements a coherent organisation..." (Schön and Rein 1994:26). Salient features may be exogenous events, such as economic crises or external threats, or they may be endogenous to the political system, such as its particular institutional context. Moreover, successful frames transform uncertainty and complexity into certainty and direction by making the diagnosis and the prescriptions seem obvious (Schön and Rein 1994:28).

Conditions for Discourse-Driven Policy Change

The focus of the research in this project is on the role of challenging discourses in facilitating or causing policy change of a third order magnitude – that is, change in the dominant policy paradigm, including the norms, goals and strategies or instruments articulated in the policy frame (Hall 1993). Augmentative discourses are constraining and conservative in that they are intended to either protect the dominant policy frame

or simply make small periodic adjustments to it. Transformative discourses – both challenging and truth-seeking – are developed to effect major changes in the normative and/or cognitive elements of the dominant discourse and move policy in an entirely new direction. Whereas challenging discourses focus on re-ordering policy goals and instruments, without necessarily questioning the underlying norms of the dominant paradigm or policy frame, truth seeking discourses have the express objective of arriving at consensus on an entirely new set of norms and goals. These latter discourses occur most rarely, usually when dealing with an entirely novel problem or issue for which few preconceived ideas exist.

In addressing the research question, 'how was policy change made possible', earlier research on policy framing and discourse suggests there is an important and influential role for communication or interaction, particularly in the form of argumentation and non-coercive persuasion (Ball 1995; Burnell and Reeve 1984; Checkel 1999; Lau, Smith and Fiske 1991; Risse 2000; Schmidt 2001). The two case studies elaborated in subsequent chapters demonstrate that the entry of a challenging discourse can be a precipitating factor for significant policy change, even in the face of long-standing institutional and interest-based barriers, provided certain conditions are met: broad consensus on the nature and severity of the problem among core policy actors, promotion of an alternative policy frame consistent with fundamental values, and the presentation of persuasive social facts indicating the source of failure in the dominant policy frame.

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Chapter 3

Institutional Structures and Health System Dynamics in Germany

Institutional Legacies of Social Insurance

German health care is the original social insurance system, established in 1883 under the government of Chancellor Otto von Bismarck. Since that time, the essential features of that system have changed remarkably little. The most prominent and persistent feature is the organization of the health care system around a network of independent sickness insurance funds that are given statutory authority to manage their programs and benefits. These insurance funds are financed primarily through premiums, which each fund has the authority to set at a level that meets, but does not exceed, its annual expenditures.[1] Second, as under Bismarck, these statutory funds are mandated by federal law to provide a prescribed range of benefits and levels of service. Third, statutory insurance funds are still financed through contributions that are shared by employers and employees, although the proportions have changed over time. Fourth, a strong element of self-administration of the funds remains: governance of sickness funds is shared between employers and employees. Finally, membership in statutory insurance funds is compulsory for the majority of the population, and has traditionally been based on occupational position and/or geographic location. (Stone 1980:23-25).

The contemporary health insurance system is codified in the federal government's Social Code Book, the *Sozialgesetzbuch V* (SGB V), which regulates membership, benefits, relationships between insurance funds and provider groups, as well as the governance, organization and financing of funds. The role of the state is thus focused on setting policy goals and establishing procedural rules and regulations. The management and delivery of services is the responsibility of the statutory sickness insurance funds, the *gesetzliche Krankenversicherung* (GKV), in collaboration with service providers, primarily local hospitals and regionally organized physicians' associations. These latter organizations are recognized as public-law bodies (*Körperschaften öffentlichen Rechts*), which gives them special legal status and privilege to provide services, but also obligates them to fulfill statutory and public responsibilities respecting the health system (Giaimo and Manow 1999).

[1] These expenditures include the fund's outlays for services to its clients, administrative costs, as well as federally required capital reserves.

These corporatist arrangements reflect two important organizing principles that order the German health care system. The first is the principle of self-administration by organized interest and professional associations (*Selbstverwaltungsprinzip*) which is exercised most prominently in the negotiation of service delivery contracts between associations representing insurance funds and others representing insurance physicians. These latter associations have been granted significant binding authority to govern and remunerate their members, and membership in the associations is compulsory for all non-hospital based practicing physicians.

The second is the principle of subsidiarity (*Subsidaritätsprinzip*) which "expresses the political intent of marshaling the expertise and initiative of the main social sectors under the auspices of state administration." (Katzenstein 1987:59). The role of government, therefore, is to "orchestrate" interest groups in such a way as to enable them to implement policies, but within the broad parameters of government aims (Döhler 1995:388). Once again, representative organizations of insurance funds and physicians are the dominant groups offering their expertise in the policy making processes of government, and have been accorded legitimacy in the form of joint committees such as the *Konzertierte Aktion im Gesundheitswesen* (KAiG – Concerted Action in Health Care Committee) to advise on government health policies.

Both of these organizing principles – self-administration and subsidiarity – were strongly contested in the debates and decision-making processes leading to the *Gesundheitsstrukturgesetz* (GSG) in 1992. The challenging discourse that accompanied the debates questioned the legitimacy of these principles given the purported failure of corporatist groups (mainly physicians) to actually address many of the most pressing problems in the health care system. Based on their appeal to the 'facts' – the unabated rise in health expenditures and incomes of providers, and ever-higher insurance premiums for the average German worker – supporters of the challenging discourse were able to legitimize and promote more forceful and more visible state intervention in the health system than had been apparent in the past.

Solidarity, or the *Solidaritätsprinzip*, is another fundamental principle guiding the social insurance system, and is reflected in the risk-sharing arrangements of individual sickness funds. Premium contributions of fund members are calculated as a proportion of income and are independent of health status or individual risk profiles. Furthermore, membership in a statutory sickness fund is compulsory for employees below an established income level (excluding the self-employed), that in 2000 was set at a total household income of EUR 40,000. Consequently, about 74% of Germans are mandatory members of the GKV, an additional 14% are voluntary members of the GKV, and 9% have private insurance (European Observatory 2000). In practice, social solidarity is manifest through cross-subsidization of risk between rich and poor, healthy and sick, and young and old members *within* an insurance plan.

Accompanying and tempering the solidarity principle is the *Gliederungsprinzip*, which requires that membership in the GKV be structured or compartmentalized according to geographic location and/or occupational position of the members. As a result, there have traditionally been a number of different types of insurance funds within the GKV system: factory funds or *Betriebskrankenkassen* for companies with more than 450 employees; guild funds or *Innungskrankenkassen* for people in trades, crafts and services; agricultural funds or *landwirtschaftliche Krankenkassen* for workers in the agricultural sectors; separate funds for miners (*Bundesknappschaft*) and mariners (*Seekasse*); and local funds or the *Ortskrankenkassen* for those who did not fall into the above categories. Finally, a separate class of funds is the *Ersatzkassen* or substitute funds, which provide coverage according to geographic location and class of worker (that is, blue-collar or *Arbeiter*, and white collar or *Angestellte*). These funds have a voluntary membership, and are prohibited from turning away new members who meet their geographic and occupational categories. Further, since many of their members have high incomes and thus the choice of private insurance or the *Ersatzkassen*, the *Ersatzkassen* compete with private funds, and offer a wider range of optional benefits than the other GKV funds. Private funds or *Privatkassen* exist entirely outside of the GKV (Alber 1992a).

Traditionally, solidarity was circumscribed by the *Gleiderungsprinzip* and existed, therefore, predominantly within social or occupational groups or within the membership of individual insurance funds, rather than more broadly across larger populations. This highly institutionalized membership structure was strongly contested by the challenging discourse that accompanied the reforms of the late 1980s and early 1990s. This discourse was successful in promoting a substantial restructuring of the GKV system that broadened the principle of solidarity to include much larger and less stratified segments of the population.

The health care benefits offered by the GKV are based on the *Sachleistungsprinzip* – that is, the principle of in-kind benefits. All benefits (with the exception of income replacement) are provided in-kind, rather than as cash reimbursements. They include all hospital and medical care, most dental care, home care, rehabilitation services, and prescription drugs and medical devices. The range and scope of benefits have also been the subjects of contentious political debate, with notable changes occurring after 1977. The introduction and subsequent expansion of user charges for most services, medications and devices as well as a reduction in the range of mandatory services covered by sickness insurance were an integral part of the instrumental discourse that accompanied the spate of reform proposals put forward by federal governments from 1970 to 1992. These reforms were aimed at establishing cost containment measures without altering the principles and essential institutional features of the GKV system.

Together, these *Strukturprinzipen* – self-administration, subsidiarity, solidarity, structured membership, and benefits-in-kind – constitute what Döhler (1993, 1995) calls the 'sectoral policy paradigm' that governs the German health care system. This paradigm is embedded both in constitutional law and in long-standing institutional structures and conventions, to which the discussion now turns.

Institutional Dynamics and Policy Immobility

The most trenchant explanations for the remarkable stability of the health care system in Germany (at least until 1992) have been based on the characteristic institutional structures of the German polity. In these interpretations, the 'reform blockades' that have been encountered with almost predictable regularity in the post-war period are attributed to the following institutional features (Blanke and Perschke-Hartmann 1994; Giaimo and Manow 1999; Perschke-Hartmann 1994; Rosewitz and Webber 1990):

1) the predominance of coalition governments, which have typically included a junior partner closely allied with powerful interests in the health sector;
2) the federal system of parliamentary government, which divides competencies for health care between the federal and Länder governments, and accords substantial decision-making authority to the Länder-dominated Bundesrat (senate or upper chamber of parliament);
3) the self-administration structures of the statutory health insurance system, which are jointly governed by associations of physicians, insurance funds, employers and employees.

In their study of German health reforms attempts in the ambulatory sector, Rosewitz and Webber (1990:299) conclude that these factors "impose decision rules upon participating actors that rule out major reforms and result in either 'mini-reforms' or nothing at all being decided or passed."

Similarly, and more generally, Peter Katzenstein (1987) describes these factors as the "three institutional nodes" of policy networks governing almost any policy sector in Germany – namely, political parties, cooperative federalism and para-public institutions. In health care, this network bridges state and societal actors but "is at the same time both accessible to organized groups and closed to other social actors." He goes on to say that "the interaction between policy and politics is shaped by specific West German institutions that in linking state and society as well as different levels of government encompass political opponents in a tight policy network. Such interdependence makes large-scale departures from established policies an improbable occurrence." (Katzenstein 1987:35)

In the next sections, the dynamics of each of these three institutional characteristics will be described and their implications for health system reforms discussed.

Coalition Government

The German state may be characterized as a *Parteinstaat* or 'party-government' state, meaning that the ideas of political parties give direction to the government agenda, and that governments themselves are manifestations of the parties of which they are comprised (Lees 2001; Roberts 2000). Furthermore, given the nature of the electoral system and the preponderance of coalition governments in the post-war era, political parties are the primary arenas in which many political struggles are mediated (Katzenstein 1987).

In contemporary Germany, virtually all federal governments since 1948 have been coalitions comprised either of the union of the politically conservative Christian Democrats and Christian Socialists (the *Christlich-Demokratische Union Deutschlands/Christlich-Soziale Union* – CDU/CSU)[2] or of the left-of-centre Social Democrats (*Sozialdemokratische Partei Deutschlands* – SPD) as the senior partner. The right-of-centre Liberals (*Freie Demokratische Partei* – FDP) have most often been the junior partner of federal coalitions. Given the diverse ideological positions and constituencies of the parties, most coalition governments have been built on political compromises that must accommodate the interests of very different social and economic groups.[3] Not surprisingly, many of these coalitions have been characterized by 'policy-imobilisme' – that is, a reliance on lowest-common-denominator policies which produce little or only incremental change, particularly during times of economic constraint (Schmidt 1983). Rosewitz and Webber (1990) argue that this requirement for inter-party and intra-government compromise has had an important veto effect on substantive health system reform, largely due to the important position of the FDP.

The base of electoral support of the FDP is small, ranging from 5% to 13% of the federal electoral vote, resulting in its persistent minority status in the Bundestag. Unlike the two larger parties, the FDP is characterized by its lack of a core electoral constituency and weak internal party apparatus. Nevertheless, the party managed to

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[2] The CSU is viewed as the 'sister party' of the CDU; it is mainly a Catholic party from Bavaria, and runs candidates only in that state. The party represents Bavaria's powerful social and economic interests within the federal government through its alliance with the CDU (Roberts 2000). However, as Padgett and Burkett (1986:126) note, the CSU "is both autonomous and different" from the CDU in both its organisational structures as well as its political and ideological beliefs.

[3] A number of analysts have argued that the spectrum of political ideology occupied by German parties is deliberately centrist. In part this is due to the shunning (and outright criminalisation) of extremist parties at either end of the spectrum, thus truncating the ideological range, and in part due to the political opportunism and strategic compromise that are necessary in coalition government (for example, see Braunthal 1998; Lees 2001; Poguntke 2001).

be in government longer than either of the two larger parties between 1948 and 1998 (see Table 3.1).

Table 3.1 – Governments of the Federal Republic of Germany

Year	Constitution of Coalition Government
1949-53	CDU/CSU – FDP – DP [*Deutsche Partei*]
1953-56	CDU/CSU – FDP – DP – Refugee Party
1956-57	CDU/CSU – DP – FVP [*Freie Volkspartei*]
1957-61	CDU/CSU – DP
1961-66	CDU/CSU – FDP
1966-69	CDU/CSU – SPD
1969-82	SPD – FDP
1982-98	CDU/CSU – FDP
1998-	SPD – Greens

Source: Roberts (2000):125

This relative success may be attributed in part to the party's internal schism between two different normative ideas: economic liberalism, i.e., the support for and strengthening of free enterprise, and 'national' liberalism in which individual freedoms and rights to social protection by the state are paramount. The former placed the FDP somewhere to the right of the CDU/CSU's more tempered economic liberalism, while the latter aligned it with the SPD on issues relating to the role of the state in raising sufficient taxes to fulfill its duties, and protecting the rights of all its citizens equally. In particular, the ideas of national liberalism included a deep mistrust of the Church and of any form of state-sanctioned organized power. Each of these two ideas has dominated the party in various periods of its history, and explains the capacity of the FDP to form coalitions with parties of different political stripes (Padgett and Burkett 1986:156; Poguntke 2001; Schmidt 1983). Moreover, as 'king-maker' in these coalitions, the FDP has had disproportionate power to influence policy. On health care issues, as with many other social and economic issues, the FDP has espoused a liberal free-market ideology and generally aligned itself with members of the independent professions, such as physicians and dentists, and with middle class groups, particularly business and the self-employed (Roberts 2000; Rosewitz and Webber 1990). As such, it consistently resisted or adamantly opposed any health reform package that, in the views of its members, would compromise the material welfare or autonomy of physicians, including both the 1989 GRG and the 1992 GSG and their predecessors. In particular, the FDP opposed greater state intervention into the corporatist relations that governed the health sector (Behaghel 1994; Rosewitz and Webber 1990).

The policy direction of coalition governments cannot, however, be attributed solely to the normative ideas and strategic influence of the junior partner. Schmidt (1983:47)

demonstrates that the ideas and political agendas of governing parties did have an impact on the direction of policy development and change in Germany. The strategic veto of the FDP in coalition governments was mitigated by the ability of coalition members to establish firm ground-rules and agree on policy trade-offs and pay-offs that made bargaining possible and defection unlikely.[4] This was much more easily accomplished during periods of economic expansion, during which such bargains were generally not of a zero-sum nature (such as in the early years of the SPD-FDP coalition), or when coalition partners shared political goals (such as in the CDU/CSU-FDP coalition of the 1980s). Governments dominated by the CDU/CSU have pursued a 'social capitalism' model that promoted 'bourgeois issues', whereas those led by the SPD tended toward a model of Keynesian welfare capitalism, at least until the mid-1980s (Lees 2001; Schmidt 1983). The pursuit of these distinct policy models by each party is rooted in its particular ideational and institutional history.

The CDU/CSU began as a post-war alliance of Christian and conservative groups who rallied together around some shared ideals but also, perhaps more significantly at the time, against the power of left-wing parties. Its roots as a party of moderately allied groups were reflected in the party's loose internal organizational structure, and in divisions between the party's social and conservative wings. Not surprisingly, intra-party policy agreements were difficult to achieve, and so in its early years, the CDU/CSU had no coherent policy agenda or program. Much of its early success, despite its internal weaknesses, is attributed to the political acumen and popularity of its first leader, Konrad Adenauer. The electoral success of Chancellor Adenauer rendered programmatic and policy development "electorally superfluous" (Conradt 1972:8).

Broadly speaking, early CDU/CSU-dominated coalitions pursued policies that would encourage the reconstruction of a strong market economy, supported by strengthened social security measures (Schmidt 1983). Although the coalition lacked a distinctive health policy frame, health sector reforms were part of and consistent with the government's instrumental discourse which focused on strengthening "private initiative" and preventing the development of a "welfare society". However, the internal divisions within the governing coalition, and indeed within the CDU/CSU itself, mitigated against consensus on the direction of reform. The proposed legislative package was an amalgam of cost containment strategies and benefit improvements

[4] The formal coalition agreements negotiated between coalition partners have the status of legal-constitutional convention, even though they are not legally enforceable. These agreements inhere a 'natural obligation' that binds the two (or more) parties to their promises and minimise political opportunism by one of the partners (Manow 1994:7). Manow (1994) discusses at length internal coalition dynamics relating to these agreements, including the allocation of policy sectors and portfolios amongst the coalition partners, the Cabinet decision-making process, and the Chancellor's constitutional authority.

that attempted to satisfy all but managed instead to satisfy no one; the result was a "Grand Coalition of the Dissatisfied" (Naschold as cited in Murswieck 1985:98). Moreover, the wrath of a key constituency of both the CDU/CSU and FDP, namely "70,000 physicians, who each saw 30 patients every day," seemed to doom the package to failure (Adenauer, as cited in Rosewitz and Webber 1990:182, footnote 38). The reform bill "turned out to become one of the longest and roughest health policy discussions since the foundation of the Republic." (Murswieck 1985:96). In the end, despite the absolute majority of the CDU/CSU in the Bundestag, the health reform package was completely abandoned by the government.

By the late 1960s its rather passive approach to policy development, which had not substantively altered the traditionally privileged position of middle-class elites, became a political handicap for the CDU/CSU, particularly in light of the growing political maturity and popularity of the social democratic SPD. The SPD, one of only two political parties to survive the political upheavals of WWII, began to reconstruct itself as a *Volkspartei* in the late 1950s and early 1960s by moving away from its deep Marxist roots toward a more pragmatic idealism. The party differentiated itself from the CDU/CSU by engaging in a political discourse that advocated Keynesian economics and social policies that were consistent with promoting social security and freedom (Padgett and Burkett 1986). With this agenda, it managed to attract the electoral support of a wide range of societal groups, including blue-collar workers and an emerging economic middle-class. By the mid-1960s, the SPD was a serious contender for political power and in 1969 led a coalition government with the FDP that was to survive for the next 13 years (Padgett and Burkett 1986; Roberts 2000).

The early years of this coalition were marked by welfare state expansion in a prosperous economic climate. Although the social-liberal wing of the FDP had gained greater influence within the party and made this expansion easier to accommodate, the glue holding the SPD-FDP coalition together was agreement on foreign policy and security issues (i.e., *Ostpolitik* under Chancellor Willy Brandt). Although the two parties remained ideologically divided on issues of social and economic policy, the FDP seemed willing to take a neutral stance on welfare state expansion while the economy continued to grow (Murswieck 1985). The mid-1970s ushered in an international economic crisis that exposed the thin compromise in the coalition, and began its ultimate disintegration. Moreover, economic difficulties forced the SPD's pragmatic idealism to become more pragmatic than idealistic, raising considerable internal party strife. In the health sector, the SPD-FDP coalition put forward a cost containment policy frame that attempted to shift expansionary expenditure trends toward more stable or no expenditure growth by introducing controls on provider groups as well as some cost-sharing by patients in its 1977 Health Insurance Cost Containment Act (discussed in Chapter 4). This legislation successfully solidified the dominant position of the cost containment policy frame and was in keeping with the

instrumental discourse that had been prevalent in discussions of health system reform since the 1950's.

In the meantime, during its years in opposition, the CDU/CSU had developed a policy agenda that came to be associated with conservatism, individualism and free-market politics. This programmatic agenda helped return it to power in 1982 under the leadership of Helmut Kohl and in coalition with the FDP (Heidenheimer and Kommers 1975; Padgett and Burkett 1986; Roberts 2000). The exodus of left-leaning liberals from the FDP in the early 1980s facilitated this coalition's stability in a number of important policy sectors over the next 16 years (Saalfeld 1999). This CDU/CSU-FDP government "shared an antipathy to state intervention in the health care as well as other sectors", but lacked a concrete plan to reform the system (Webber 1992:213). Throughout most of the 1980s, it promoted an instrumental discourse aimed at containing costs within the existing parameters of the GKV. It presided over a series of incremental reforms that were entirely consistent with the system's organizing principles of subsidiarity and self-administration; the most prominent of these reforms was the *Gesundheitsreformgesetz* (GRG) of 1988. More surprisingly, this very same government also presided over the *Gesundheitsstrukturgesetz* (GSG) four years later – a reform package that fundamentally challenged and permanently altered the organizing principles it had so long defended.

German Federalism

German federalism has traditionally been of a functional nature, dating back to the unification of Imperial Germany. It was rooted in a desire for uniformity of conditions across Länder and a unitary approach to economic and international affairs at the federal level but counter-balanced by administrative autonomy at the Land level (Lehmbruch 1978). In post-war Germany, the reconstruction of federalism was "concerned less with the *decentralisation* than the *deconcentration* of political power among different institutions of government. It was primarily a post-dictatorship device for the dispersal of powers in a country emerging from the arbitrary abuse of central power in the Third Reich." (Jeffery 1999:133; original emphasis). This characteristically interlocking nature (*Politikverflechtung*) of German federalism is the result of three main institutional features: the functional division of powers between the federal and Land governments, the highly integrated system of taxation and fiscal transfers, and the significant role of the Bundesrat in parliamentary politics (Katzenstein 1987; Wassener 2001). Together, these three institutional characteristics lead to "a relatively high degree of political consensus and stability between the various levels of government. But the complex consensus mechanisms also tend to obstruct policy initiatives aimed at solving the complicated problems that are most likely to be found in the welfare system." (Wassener 2001:71).

Although the Basic Law of 1949 lays out a broad range of independent jurisdictional competencies for both the federal and Land governments, German federalism quickly evolved into a system of functional interdependence. The result is that the federal government is responsible for the majority of policy-planning and policy-making authority, while the Länder are responsible for the administration of virtually all federal policy. The Länder do retain some exclusive competencies, but these are limited in number and scope (Altenstetter 1974; Jeffery 1999; Roberts 2000).

The majority of health-related responsibilities reflect this functional interdependence. The federal government regulates statutory sickness insurance, which is the cornerstone of Germany's health care system, through the *Sozialgesetzbuch V* (SGB V). In addition to establishing the basic principles of the health care system, the SGB V also governs corporatist relations amongst key insurance and provider groups (which will be discussed in more detail in the next section). The bureaucracy of the federal Ministry of Health is responsible for ensuring corporatist bodies fulfill their statutory obligations at the national level. At the state level, Länder governments are responsible for supervising contracts between providers and insurers within their respective Land, for maintaining hospital infrastructure, for public health-related services, and for the education and training of health professionals (European Observatory 2000). Policy integration and coordination between the two levels of government occurs through hundreds of intergovernmental committees and agencies, giving Germany its peculiar form of 'cooperative federalism' (Altenstetter 1974; Katzenstein 1987; Roberts 2000; Wassener 2001).

Fiscal federalism further complicates the interdependent nature of the relationship between the federation and Länder. Differential tax bases in each Land necessitate a system of horizontal equalization payments in which tax revenues are redistributed from the richer to the poorer states. Vertical transfer payments are also made directly from federal government revenues to poorer Länder. Although these transfers are neither conditional nor targeted toward certain programs or services, there is an implicit expectation that the resources will be applied toward equalizing the standard of living across all Länder. This expectation is grounded in the constitutional requirement in the Basic Law for uniformity of living conditions across the nation (Jeffery 1999; Roberts 2000).

Perhaps the most important of the institutions of federalism for health care policy is the Bundesrat. Federal bicameralism – that is, the representation of constituent states in a second legislative chamber – is the underlying principle of the Bundesrat, whose delegates are nominated by and represent Land governments at the federal level (Bräuninger and König 1999). Unlike many upper chambers, the German Bundesrat has a great deal of power and influence in the legislative process. It has the authority to provide input and give opinion on draft legislation before the legislative process of

approval begins; it has an absolute veto over any legislation that has direct impact on the powers or finances of the Länder; and it has a suspensive veto on all other legislation (Roberts 2000).[5] Given the functional distribution of powers in the federation, the Länder governments that constitute the Bundesrat can exercise an absolute veto authority on more than half of all legislation proposed in the Bundestag (Jeffery 1999; Sturm 2001). In the health sector, this veto includes legislation dealing with hospital planning and financing issues, which are primarily Land responsibilities. However, because the federal government retains an interest in regulating hospital services under the aegis of the GKV and the relationships between service providers and insurers, hospital sector reforms have generally been among the more protracted intergovernmental policy concerns. In the words of one Land Minister, "It is the Land governments, not the federal government, that are the whipping posts if a hospital is closed somewhere or hospital beds are reduced" (as cited in Rosewitz and Webber 1990:308). As a result, reforms to hospital planning and services have been made through legislative packages and processes separate from other health sector reforms, and much more incrementally incorporated into the broader regulatory framework governing the health system (Döhler 1995).

Partisan politics further complicate the interdependence of the Bundesrat and Bundestag. The party system at the Land level mirrors the federal party system: it is largely dominated by the main federal parties, but also supports parties with limited regional support bases (Jeffery 1999; Roberts 2000:80).[6] Party memberships and programs of the Land and federal levels are often shared, and reflect a federalized organizational structure. Due to the high degree of integration between Land and federal party organizations, elections at the Länder level are generally viewed as 'mid-term' elections in national politics (Gabriel 1989:69). There is a strong tendency for voters to express their dissatisfaction with the federal governing coalition by voting against it at the Land level. Therefore, the party in opposition at the federal level tends to win more seats at the Land level and is more likely to dominate the Bundesrat (Gabriel 1989; Silvia 1999). As a result, the two chambers are often dominated by opposing parties or coalitions of parties, as was the case from 1970 to 1982, when the SPD-FDP coalition in the Bundestag was faced with a CDU/CSU majority in the Bundesrat, and the reverse was true from 1990 to 1998 (Sturm 2001).

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[5] A suspensive veto means that a Bundesrat rejection of a piece of legislation can force the issue back to the Bundestag for a second vote. The Bundesrat's rejection can be overruled in the Bundestag by a two-thirds majority vote in support of the legislation. An absolute veto is exercised by the *Bundesrat* on specific issues by virtue of a simple majority opposing the legislation. Constitutional amendments require two-thirds majority support in both chambers. (Bräuninger and König 1999)

[6] The fragmentation of federal-Land party organisation and support is noticeably greater since German reunification in 1990 (Jeffery 1999).

Despite the marked potential for reform gridlock that is institutionalized in the bicameral and often partisan structures of German federalism, the Länder-dominated Bundesrat has refrained from exercising its veto in the vast majority of cases. Although the numbers of bills that were vetoed and subsequently sent to mediation were highest during the years of opposing majorities, even during these periods, the numbers of bills that were ultimately defeated were rather small, ranging from between 2.5% to 5.7% (Sturm 2001).

The fact that most Bundesrat decisions do not explicitly fall along party or territorial cleavages is explained by the consensual style of politics that is demanded by both the institutional structures of the German polity as well as by its popular political culture (Jeffery 1999; Silvia 1999). The negotiation of partisan disputes occurs through a number of venues, including high-level bipartisan talks between senior politicians, bipartisan working groups on various issues, and informal consultations between federal ministers and Land politicians (Braunthal 1998). An informal 'grand coalition' of parties and federal and constituent governments is involved, through the Bundestag and Bundesrat, in the drafting of virtually all legislation as well as in the legislative approval process. This *de facto* unanimity rule for decision-making leads to a bargaining style of policy making that very often results in sub-optimal or limited incremental policy change (Jeffery 1999; Scharpf 1988). It is typically dominated by a small number of actors and, because it is done behind closed doors, is generally not held to public scrutiny and accountability. The public discourse that accompanies this style of policy-making is augmentative – it is usually one-way, constructed by policy elites and directed toward the public. Furthermore, it is either rhetorical or instrumental, aimed at reinforcing or justifying existing policies to the electorate, because more often than not, substantive changes are ruled out under the unanimity constraints of bargaining.

In the health sector, a bargaining style of decision making has been strongly implicated in the watering down or failure of many reform proposals during the 1970s and 1980s, in hospital services as well as other health sectors (Rosewitz and Webber 1990). This resistance to reform did not necessarily follow party affiliations, as evidenced by the fact that several of these reforms originated during a period in which the CDU/CSU-FDP dominated both the Bundestag and Bundesrat. In fact, much of the bargaining was done within parties to bridge territorial differences which, due to the centrist ideological positions of the two largest parties, often loomed larger than partisan ones (Braunthal 1998; Webber 1992).

In contrast, the much more substantial reforms imposed by the 1992 GSG came about during a period of opposing majorities in the Bundesrat and Bundestag. Notwithstanding the relatively narrow ideological gap between parties, an even greater potential for partisan stalemate between the two chambers might have been expected.

As Braunthal (1998:159) notes, much drama "is staged to convince the public that each party has the right answers to pressing issues and that it is most competent to govern after the next election." Therefore, it is not surprising that the SPD put forward a strong united front in the Bundesrat to oppose the government's initially proposed legislation, and launched a credible challenging discourse. What is noteworthy is that the two sides were able to find agreement on significant structural changes to the health system that had been invariably emasculated in earlier reforms. In the past, agreements within the 'grand coalition' of political parties and governments had resulted in lowest-common denominator policies that focused on making adjustments to the existing arsenal of policy instruments – what Hall (1993) refers to as first order change. The GSG was a different magnitude of policy change that was highly exceptional and unexpected in the particular configuration of institutions of German federalism. A number of analysts have explained this surprising outcome by pointing to the diminished role of powerful interest groups from the decision making process of the GSG (Manow 1994; Döhler and Manow 1995). The role of key actors in the corporatist structures of the German health care system will be examined next. The details of the process leading to the GSG will be explored in the next chapter.

Corporatist Self-Administration: Insurers and Physicians

In addition to the state, the central actors in the health care system are physicians (who are the primary providers of services)[7] and insurers (who are the primary third-party payers). Each of these actors are organized into self-governing associations that are delegated the authority for ongoing implementation of health policies, with very little direct state intervention.

Self-administration takes the form of three different types of regulatory activities in the health sector (Alber 1992a:157-8). The first is regulation by autonomous associations of physicians and insurance funds of their own members. The state grants the associations of office-based physicians (the *Kassenärztliche Vereinigungen* – KV, and their federal peak association, the *Kassenärztliche Bundesvereinigung* – KBV),[8] and

[7] Hospitals, the other large group of providers within the statutory sickness insurance scheme, are not recognised as public law bodies but do have legal status to enter into contractual relations with both physicians and insurance funds. However, since hospital service contracts involve a number of other actors as well, including Land and local governments, they are not typically characterised as corporatist relations (Giaimo 1995)

[8] Physicians as a group are by no means united. In addition to the associations of office-based physicians who provide insured health services are voluntary associations of private-practising physicians (the *Hartmannbund*), and hospital physicians (the *Marburgerbund*). These latter two associations have often been at odds with the KV and the KBV (Burau 2001; Giaimo 1995; Stone 1980).

associations of insurance funds,[9] the authority to set fees on behalf of their members. In the case of the KV, this authority extends to collecting and disbursing payments to their members for their services. In order to be paid for insured services, physicians must belong to a KV. In addition to setting fees, both the KV and the insurance fund associations oversee the conduct of their members and ensure that they abide by collective agreements.

The second form of self-administered regulatory activity is the negotiation of service contracts between associations of physicians and insurance funds. These negotiations take place within the parameters of federal law (the SGB V), and include issues of payment and volume of services (Alber 1992a; European Observatory 2000; Schneider 1991).

The third, and perhaps most important, type of regulatory activity is the collective authority of both types of associations for managing the system. In contrast to contract negotiation which tends to be confrontational, this last activity is more consensual and oriented toward collective problem solving, above and beyond the material interests of individual groups (Alber 1992a:157-8). This collective decision making is institutionalized in the form of numerous state and federal committees of physician and insurance fund representatives that monitor everything from service contracts to fee schedules to national expenditure patterns and targets (Schneider 1991). Furthermore, government officials consult both groups in policy formulation and development, before the beginning of the legislative process. Physicians in particular carry a great deal of influence both within the bureaucracy as well as in Parliament, and have "an unofficial status as negotiator with the government on the content of health care legislation." (Giaimo 1995:361).

In short, the state grants associations the authority and autonomy to regulate themselves and to contract with one another to deliver mandatory services, but within the parameters of broader public goals and policies (Giaimo 1995; Streeck and Schmitter 1985). In this mode of 'private interest government', the state allows associations to independently pursue the private interests of their members in exchange for the assurance that their members will conduct themselves with professionalism and in accordance with the public good.[10] The threat of coercive

[9] Sickness insurance funds are organised into federal peak associations according to the type of fund (e.g., the *Ortskrankenkassen* are represented by the AOK-Bundesverband).

[10] Streeck and Schmitter (1985:12) identify the resources these associations have in order to participate: "guaranteed access, compulsory membership and/or contributions, institutionalised forums of representation, centralised co-ordination, comprehensive scope, jurisdiction and control over member behaviour and delegated tasks of policy implementation," all of which depend on the state, "which must be willing and able to use its key resource: legitimate control over coercion and authoritative distribution of positions, to promote and/or protect such developments."

intervention by the state ensures that associations do not allow broader policy goals to be subsumed by the interests of their members (Alber 1992a; Giaimo 1995; Streeck and Schmitter 1985).

These types of corporatist relations have dominated Germany's health sector since the early 1900s. Not surprisingly, insurers and providers have been resistant to government interventions that would compromise their autonomy or authority, either by introducing greater state regulation or by increasing market mechanisms and incentives (Webber 1992). State actors themselves have been reluctant to disrupt corporatist relations for a number of reasons. First, corporatist governance is an important manifestation of the subsidiarity principle, which has particular resonance with the Catholic social doctrine of the CDU/CSU and the SPD ideals of codetermination and democratization (Döhler 1995; Giaimo and Manow 1999:978).

Second, corporatist governance relegates many potentially contentious issues to the sphere of 'low politics', which Moran (1999:40) characterizes as: "the supremacy in policy language of a technocratic discourse where concerns with organizational efficiency and medical effectiveness [are] the dominant mode; a policy-making world dominated by decentralized networks of policy actors drawn, mostly, from the oligarchies of public law organizations; and a power structure where the medical profession[is] dominant." Government actors are able to avoid or deflect public blame for difficult decisions, such as premium levels and service quality, because they are a function of managerial processes and technical decisions engaged in by thousands of insurers and service providers in highly decentralized organizations (Giaimo and Manow 1999; Moran 1999).

Finally, corporatist governance accommodates the interests of employers and employees who are involved in the governance of insurance funds. Thus business and labour also have a voice in health policy issues, which, given the implications of the social insurance model for wages, they are not willing to relinquish (Giaimo and Manow 1999).

The health care reforms proposed by the federal government from the 1970s to the late 1980s were consistent with this pattern of corporatist governance. In fact, Döhler (1995) and Giaimo and Manow (1999) compellingly argue that these reforms deliberately strengthened the corporatist order by enhancing the self-administration authority of a number of groups, particularly against the dominance of physicians. Furthermore, while large-scale structural reforms were difficult, cost containment policies that relied on organized interests in the ambulatory care sector for their implementation had proven to be relatively successful in the short-term in reining in expenditure growth.

By the late 1980s, however, the perceptions of a cost crisis in health care were shared by many government and societal actors. Much of the blame for the problems was laid at the door of corporatist actors who were accused of failing to abide by past agreements and of sacrificing the public good in pursuit of their own interests. The government used these arguments to justify a radical shift in the traditional policy making process. In drafting the GSG, the government, led by the Minister of Health "adopted a policy of disassociation particularly from the medical and dental health care organizations...The tradition of negotiating agreements between policy makers and the health care organizations...was continued on paper. However, in practice it was effectively discontinued..." (Blanke and Perschke-Hartmann 1994:237). The result was a set of reforms that not only excluded powerful groups in the formulation stages, but also allowed the government to intervene in corporatist self-governance to an unprecedented degree. Blanke and Perschke-Hartmann (1994) and others (for example, Döhler and Manow 1995; Manow 1994) explain this phenomenon as the result of a confluence of external factors (economic crisis) and changing motives within the health system. However, what led to the changing motives and selection of the specific new strategies remains unexplained.

Summary

The preceding sections have explored the institutional explanations for the 'policy imobilisme' that was so typical of German health policy from the 1970s to the early 1990s. None of the institutional factors explored – coalition governments, federalism or corporatist governance – appear to come adequately to terms with the major structural reforms heralded by the GSG legislation in 1992. Although all of these factors very clearly did have a direct impact on the policy process, there were no obvious realignments or changes in the institutional structures governing the health care system that might logically explain a shift in the dominant policy paradigm. For the most part, it was politics as usual but in late 1992, with very unusual results. The GSG brought a shift in the sectoral policy paradigm that had governed the health care system for over a century. Not only did it challenge the organizational principles of the system (self-administration and subsidiarity), it also altered the interpretation of the solidarity and structured membership principles that were the foundations of the sickness insurance system.

The most suggestive clue to a deeper explanation comes from the decision of the government to take a more interventionist strategy. What motivated the government and opposition to pursue this approach? In the next chapter, we examine in more detail the processes and events leading to the GSG, and suggest that a gradual shift occurred in the perceptions of the nature of the policy problems in the health care system. These changes are explored through the policy discourse in which policy actors were engaged, using the framework developed in Chapter 2.

Chapter 4

The Reform of Statutory Health Insurance: Beyond Incrementalism in Germany

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The 1992 *Gesundheitsstrukturgesetz* represented a major departure in German health politics in two ways. First, it came about despite the institutionalised 'reform blockades' that had plagued the system for decades. Second, it resulted in significant changes to the dominant policy frame that governed health policy. The opposition SPD and its supporters put forward a challenging discourse that became instrumental in shifting the problem definition concerning health care from the need to contain costs to the need to protect and enhance the core principle of social insurance: solidarity.

This challenging discourse reinforced solidarity as a fundamental principle of the system, but argued that the cost explosion in the system was compromising solidarity by raising premium levels and resulting in greater premium differentials between *Arbeiter* and *Angestellte* funds. Drawing on facts and figures to bolster the argument, the SPD additionally argued that the government's attempts to address costs were diminishing solidarity further by raising and adding new user charges. This challenging discourse persuasively used the language of crisis to emphasise the extreme severity of the problem and demand substantial restructuring of the system rather than incremental reforms. The SPD, widely perceived to be a strong and genuine proponent of social democratic values, provided a credible alternative for reform of the GKV system that was both politically feasible and consistent with the principle of solidarity. This discourse created both an opportunity and an imperative for the ruling coalition government to take unprecedented action on health reform. After decades of impasse, the GSG legislation was crafted, partisan negotiations were held, and the reforms passed into law within a few short months.

The following sections of this chapter will develop this argument in more detail. First, the dominant policy frame prior to the GSG reforms will be described and early reform attempts analysed. These attempts, it is argued, were largely incremental in scope and accompanied by instrumental discourses that did little to change the underlying dysfunctional structures of the system. Next, the 1988 *Gesundheits-Reformgesetz* will be examined. The GRG was widely believed to have been a failure in addressing the rising costs of health care. Nevertheless, this failure created a window of opportunity in which the SPD's challenging discourse was invoked and given impetus. Finally, the debates leading up to the 1992 GSG reform will be analysed using the discourse framework developed in Chapter 2. In this section, the SPD's challenging discourse will be elaborated, as well as the conditions which made it

successful in shifting the dominant policy frame animating the statutory health insurance system in Germany

Health Reforms From 1970-1985: The Dominant Policy Frame and Problem Definition

The early 1970s were a period of rapid economic growth in Germany The policy paradigm that had long dominated the German health care system – based on the principles of self-administration, subsidiarity, solidarity, structured membership, and benefits-in-kind – continued to thrive. However, the stagflationary shocks of 1974-75 – sustained levels of high unemployment and high inflation – quickly turned the expansive economic climate sour, resulting in increased pressure on the state to intervene to curb the rising costs of health care.

As in many industrialised nations with maturing welfare states, rising health care expenditures prompted numerous German governments to try to rein in costs beginning in the 1970s. From 1970 to 1985, Germany's health expenditures as a proportion of GDP rose from 6.3% to 9.3% (see Table 5 1) Due to the social insurance structure of health system financing, concerns with health costs were not focused on overall expenditures as a proportion of GDP, which rose only 1% from 1970 to 1975 Rather, cost containment of health expenditures was viewed as an issue of wage costs, which rose much more dramatically in the same period (European Observatory 2000; Moran 1999). Between 1970 and 1975, average premiums rose from 8.1% to 11.2% of wages and then more slowly to 12.9% by 1989 (Alber 1992b; Behaghel 1994).

Table 4.1. Germany – Health Expenditures as a % of GDP

Source	1970	1975	1980	1985	1990	1995	1998
Public	4.6	6.9	6.9	7.2	6.7	8.0	7.8
Private	1 7	1.9	1.9	2.1	2.0	2.2	2.5
Total	6.3	8.8	8.8	9.3	8.7	10.2	10.3

Source: OECD 2001

These cost increases triggered perceptions of a 'cost explosion' among policy actors, and many advanced the view that the health care system was quickly reaching the limits of sustainability (Bandelow 1998; Lamping 1994) The increase in premiums had begun to alarm both workers, whose incomes were being whittled away through stagnant wages and rising premiums, as well as their employers, who feared their international competitiveness would be compromised as a result of rising wage costs. A primary cause of the problem was felt to be the weakness of the corporatist self-governance structure of the system. Physicians, in particular, were singled out for their apparent inability or unwillingness to curb their high and rising incomes and expenditures. Hospital services were also consuming increasingly larger portions of

overall health expenditures. Although this latter change was due in part to a deliberate strategy to increase hospital capacity, there were also concerns that poor economic management and weak incentives for efficiency were inherent in the highly decentralised negotiations between insurance funds and local hospitals (Altenstetter 1980; Döhler 1990). Finally, as the primary payers, many GKV fund representatives argued that they lacked sufficient regulatory or structural power vis-à-vis physicians and other providers to effectively control overall expenditures (Rosewitz and Webber 1990:239-240).

In addition to the high premium rates in the GKV, almost as troubling was their wide variation between different types of insurance funds and across different classes of workers. Due to the mandatory distribution of members (the *Gliederungsprinzip*), solidarity was largely confined within certain groups of workers – blue-collar (*Arbeiter*) and white-collar (*Angestellte*). Without exception, blue-collar workers were required to join a designated sickness insurance fund based on job classifications or geographic location. All of these *Arbeiter* funds were part of the GKV system. White-collar workers earning above an established salary limit had the choice of a number of statutory and private sickness insurance funds. Those within the salary limit had their own statutory funds (the *Ersatzkassen*). As a result, insurance funds formed distinctive social class and risk profiles in their membership. Members of the *Arbeiter* funds generally tended to have lower health status and more health problems than members of the *Angestellte* funds, with resulting higher levels of service utilisation. In order to compensate for differential risks and still offer the full range of mandatory benefits, contribution rates varied substantially between funds, ranging anywhere from 8% of wages to 16%, for virtually identical benefits (Alber 1992a; Stone 1990; Wysong and Abel 1996). The resulting paradox was that, contrary to the principle of social solidarity, individuals with the highest risk profiles and lowest incomes paid the highest premiums (Lamping 1994).

Instrumental Discourses and the Politics of Adjustment

The mid-1970s ushered in the beginning of a series of reforms aimed at containing the overall costs of the sickness insurance system. In the 1970 to 1985 period, health sector reforms were 'structure neutral,' focusing primarily on attempts to stabilise contribution rates and rein in expenditures (Bandelow 1994; Döhler 1990; Perschke-Hartmann 1994; Webber 1989). These reforms introduced an 'income-oriented expenditure policy' approach that narrowed the problem definition to expenditure management, rather than fundamental structural deficiencies in the system (Lamping 1994). Governments of different political stripes pursued instrumental discourses that justified the dominant policy paradigm, and sought to make only small adjustments to reduce or control overall costs. This preoccupation with health costs began what some

analysts have described as a "permanent process of law making" on the issue of cost control (Schwartz and Busse 1997:112).

Cost Containment Through Self-Governance

The first strategy of the ruling social-liberal coalition to contain costs was to use "moral suasion" to appeal to corporatist actors to act more responsibly. GKV fund managers complained bitterly about the open-endedness of their budgets, and that they had no means to effectively steer or even predict their overall expenditures (Rosewitz and Webber 1990). As monopolistic gatekeepers to virtually all health care and ancillary services, insurance fund physicians had the greatest impact on GKV expenditures.[1] The government called upon physicians to exercise greater restraint in their negotiations with insurance funds. Responding to the appeal, and the unstated but nonetheless tangible threat of government intervention, physicians' associations volunteered to limit spending for ambulatory care in their 1976 contract with insurance funds. Spending increases were to be capped at 8% for non-hospital services, representing a significant restraint on the 13% to 14% increases seen in the preceding two years (Stone 1980:152; Rosewitz and Webber 1990).

By 1977, it was clear that this attempt at moral suasion had failed to have lasting impact on overall costs. It became difficult for the government to remain on the sidelines, as perceptions of serious problems in the GKV became widespread among government officials and societal groups (Rosewitz and Webber 1990). However, the implementation of cost control mechanisms which would involve the government directly were considered an anathema to both state and societal actors, given the institutionalised traditions of self-governance and subsidiarity. Although the SPD was willing to consider mechanisms to keep the incomes of physicians more in line with national average wage increases, FDP members of the governing coalition, as well as the opposition CDU/CSU which controlled the Bundesrat, were adamantly opposed to any such changes. Moreover, the government had little appetite for engaging in a very public and unwinnable conflict with physicians, who, with the backing of the CDU/CSU, had already begun to mobilise in opposition to planned reforms (Rosewitz and Webber 1990:243).

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[1] Insurance fund physicians have a monopoly on the provision of medical services to GKV clients because insurance funds can only contract with this group of physicians; statutory insurance funds are prohibited from arranging service provision with physicians who are not members of the KV. As gatekeepers to the system, physicians are directly or indirectly responsible for prescribing a broad range of health related services, including prescription drugs, hospitalisation, rehabilitation, assistive devices, etc. Most of these services require a physician's authorisation in order to be considered medically necessary and therefore paid for by statutory sickness insurance.

Instead, the government introduced reform legislation in 1977 that was a compromise with both the FDP and the CDU/CSU. The *Krankenversicherungs-Kostendämpfungsgesetz* (KVKG – Sickness Insurance Cost Containment Act) had the primary objective of shifting toward an 'income-oriented' expenditure policy, particularly in the ambulatory care sector. It represented an instrumental discourse aimed at stabilising contribution rates for sickness insurance within the dominant policy paradigm.

The KVKG initiated new and increased *Selbstbeteiligung* – user charges – that were a concession to the market-oriented ideals of the FDP and key groups within the CDU/CSU (namely, members of the CSU and the economic wing of the CDU) (Döhler 1990). They were intended to proffer a normative ideal as well as having an instrumental purpose. Supporters believed that user charges would enhance solidarity by increasing the moral accountability of users for their (mis)use of the system. At the same time, user charges were an immediate cost containment measure: they would raise funds to defray costs for prescription medications, some dental services and for health-related transportation costs. Although the effectiveness of user charges in defraying system costs was uncertain, they were an important symbol of the normative value of individual responsibility (Döhler 1990).

The reform also focused on strengthening and expanding existing corporatist structures in the health system. Instead of pursuing structural reforms, the government attempted to rebalance the bargaining power of different actors in the system, primarily in favour of the less well organised, and therefore less influential, associations of insurance funds (Döhler 1995). The KVKG required that all new contracts between insurance funds and provider associations include a prospective cap on total expenditures in three sectors: physicians' services, dentists' services and prescription drugs (Rosewitz and Webber 1990; Stone 1980). The caps were to be tied to average wage increases and other economic indicators. Recommendations about the precise level of the caps were to be the purview of a newly appointed body: the *Konzertierte Aktion im Gesundheitswesen* (KAiG – the Concerted Action in Health Care Committee). Finally, the KVKG included mechanisms to increase the accountability of physicians for the prescription drugs and diagnostic tests they prescribed (Altenstetter 1980; Hurst 1991; Murswieck 1985).

The creation of the KAiG was a significant element of the KVKG reform. This new committee reinforced the structural principles of the health policy paradigm that had dominated Germany for decades: namely subsidiarity and self-governance. Moreover, it was the result of partisan compromise, which is inherent in the workings of Germany's governing institutions. The KAiG was the brainchild of the opposition CDU/CSU, which exerted the force of its majority in the Bundesrat to push for the creation of the committee in the KVKG. It reflected the essence of corporatist governance and comprised about 60 representatives from all groups involved in the

health care system, including insurance funds, physicians, nurses, dentists, pharmacists, pharmaceutical manufacturers, hospitals, trade unions, employers, and governments from the federal, Land and local levels. In the expectation of resistance from a number of key players to the expenditure caps (particularly physicians), the government signalled through the creation of the KAiG that it was not interested in actively intervening in the health sector. Instead, it would co-operate with corporatist actors to facilitate 'business as usual', albeit with some specific goals. The health minister[2] at the time stated that the creation of the KAiG demonstrated the willingness of the state to co-operate, and reassured participants that the KAiG was "not contradictory to the principles of self-governance" (Ehrenberg, as cited in Döhler and Manow 1995:40). As a means to rein in expenditures, however, the KAiG was not particularly successful. Its non-binding recommendations for expenditure targets carried very little weight in the negotiation of contracts between insurance funds and physicians. Furthermore, Land governments disputed the constitutionality of any recommendations of the KAiG concerning hospital services, which fall under their constitutional purview. Hospital services represented a large proportion of rising expenditures, and had to be dealt with in separate legislation (Altenstetter 1980, 1989; Döhler 1995).

By late 1979, physicians' associations abandoned their voluntary restraints on ambulatory health care expenditures, which had once again begun to increase at rates above the growth in wages and GDP (Lamping 1994; Rosewitz and Webber 1990). Just prior to its dissolution in 1981, the social-liberal government introduced the *Krankenversicherungs-Kostendämpfungs-Ergänzungsgesetz* (KVEG) to expand upon its reforms in the KVKG. Consistent with an instrumental discourse, the KVEG focused on fine-tuning the settings of policy instruments. It included increases in user charges and greater controls on the price of prescription drugs. The federal health minister also hinted at controversial plans to introduce a legislative cap on the incomes of physicians and dentists, as well as structural reforms to address the troubling inequalities between different types of GKV funds (Pershcke-Hartmann 1994:54). However, before the Minister's resolve could be tested, the FDP, historically an ally of physicians' groups, defected from its coalition agreement with the SPD, resulting in the dissolution of the government. A new government was formed by the CDU/CSU, with the FDP as the junior partner (Rosewitz and Webber 1990).

[2] Until 1990, the *Bundesministerium für Arbeit und Sozialordnung* (BMAS) – the Ministry of Labour and Social Affairs – was responsible for health policy. In 1990, a separate *Bundesministerium für Gesundheit* (BMG – Ministry of Health) was created. For convenience, the BMAS Minister will hereafter be referred to as the health minister, and the BMG Minister will be referred to as the Minister of Health.

Strengthening* Eigenverantwortung *and Reducing Demand

In late 1981, the CDU/CSU returned to power after a 12-year absence. In coalition with the FDP, the new government pursued an aggressive cost-containment strategy under the emerging *Standort Deutschland* rubric – that is, concern for the competitive position of Germany within the international economy (Lieberman 2000:31). Furthermore, the Christian-liberal coalition espoused a normatively conservative approach to the welfare state, which it laid out in its 1983 *Sozialbericht* to the Bundestag. In light of the challenges posed by projections of weak economic growth, population ageing, and problems within the institutional structures of the social insurance systems themselves, the government foresaw a need to rebalance the principles of solidarity and subsidiarity. This instrumental discourse was used to open up the possibility of introducing new policy instruments by pairing the concept of solidarity with subsidiarity more explicitly. The government recognised that in a modern industrialised nation, "the collective responsibility for the major risks of life, such as unemployment, old age, illness and accident, is essential." However, it argued that this solidarity had to be accompanied by a strengthening of societal capacity and initiative promoted by another, related principle: subsidiarity. "Solidarity and subsidiarity belong together in a balanced relationship" (BMAS 1983:7).

True to its Christian conservative ideology, the government focused in on individual and community as the primary sources of social support, with the state a distant third:

> The understanding and behaviour of individual members of each solidarity community must be impressed with the awareness that the community cannot pay for all personal risks, and that whether the insurance system remains affordable, efficient, effective, and accessible depends on his or her own actions. Collective responsibility, individual initiative and appropriate foresight must be given renewed importance. Families, neighbours, other social supports, support and self-help groups, as well as social service providers can be more appropriate and accountable to the needs of citizens than large and anonymous institutions can possibly be (BMAS 1983:7).

The Christian-liberal coalition committed itself, "over the next few years, to give priority to financial stability in the statutory health insurance system and to improve their economic efficiency" (BMAS 1983:20).

The cost-containment strategies of the previous social-liberal government had been aimed primarily at changing the settings of policy instruments by placing constraints on the supply-side of health expenditures – namely, reducing the incomes of providers and increasing the planning effectiveness and efficiency of hospitals and insurers. In contrast, the new Christian-liberal government focused on demand-side strategies aimed primarily at altering the behaviour of the users, through such new policy

instruments as cost-sharing arrangements and user-charges (Döhler 1991; Perschke-Hartmann 1994).

In these respects, the new government's instrumental discourse stressed *Eigenverantwortung* (individual responsibility) as an important component of the *Subsidiarität* principle. Individuals were to be responsible for doing their share to contain health care costs. Accordingly, the government increased patient cost sharing and at the same time reduced some benefits in the *Haushaltsbegleitgesetze* (Budget Amendment Acts) introduced in 1983 and 1984 (Altenstetter 1989; Bandelow 1998; Döhler 1990; Lamping 1994). Each enacted progressively larger user-charges for various services within the catalogue of benefits. They included new or higher charges for prescription drugs, hospital stays, medical devices and dental care (Hurst 1991). The government justified these measures as necessary for averting the impending "financial collapse of the social insurance system" (BMAS 1986:6).

Both laws had only short-term effects in stabilising expenditures in the GKV. By 1984, health expenditures in the GKV had again begun to rise faster than the GDP. The government expected that in 1986, the average premium contribution rate would be 12.2% – the highest level to-date. Talk of crisis and looming disaster was rampant in the political discourse surrounding health care. The SPD referred to a "cost explosion" in the GKV that the government had been negligent in addressing. The health minister declared that, in the face of the "tidal wave" of rising premiums, the stability of insurance contributions was of highest priority (Deutscher Bundestag 1984:7097-8). Recognising that past cost containment measures and reliance on corporatist administration had been effective only in the short-term, the government committed itself to addressing the "structural problems" of the system (BMAS 1986:31-32). Thus the stage was set for the GRG of 1988.

The *Gesundheitsreformgesetz* 1988: Instrumental Discourse and Incremental Policy Change

Despite the government's rhetoric about major structural reform, the GRG only reinforced 'business as usual' in German health politics. The process leading to the GRG was the embodiment of institutional decision traps that had made health reform virtually impossible in the past. The government's reform plans were watered down by the demands of institutionally powerful actors, namely Land governments represented in the Bundesrat and corporatist provider groups. Furthermore, the ideological weaknesses in the CDU/CSU-FDP coalition were magnified, since the health reform debate forced core social norms and principles of the dominant policy paradigm to the forefront. The ruling coalition, under the leadership of health minister Norbert Blüm, redeployed its instrumental discourse about the need for cost containment in the health care system to protect and enhance the core principle of

within-group solidarity. The cognitive elements of this discourse focused on traditional policy instruments rather than new ones.

However, in the later stages of the policy making process leading up to the GRG, there began a subtle shift in the accompanying discourse. The minister, frustrated by the strident opposition he encountered, openly questioned the integrity and willingness of corporatist groups to genuinely tackle the problems of the health care system. By doing so, he drew attention to the failure of the subsidiarity principle in addressing the problems of the health system. The SPD and its allies emphasised this particular failure, and built an argument about the need for deeper structural rather than incremental reforms. Thus, the problems with the GRG provided an opening for the SPD to promulgate a nascent challenging discourse in which a more 'balanced' approach to subsidiarity – with stronger representation of labour, insurers and other providers – was key. Once the seeds of this discourse had been planted, later developments gave the SPD the impetus it needed to more openly and effectively challenge the dominant paradigm.

The Dominant Policy Frame circa 1985

From its formation in 1982, the Christian-liberal coalition government promulgated the view that the problems of the health system – namely, high costs and rising premiums – were the result of inefficiencies in the system and of weak economic incentives for the actors within it. However, health minister Norbert Blüm made clear that his government was committed to the corporatist structure of the system:

> But the search for a system that is self-managed and thereby avoids relentless encroachment by the state – this search we cannot abandon. The more that internal controls can be created, the more that self-governance elements can integrated into social policy, the more immune the system is from manipulation, from the ambitions of lawmakers... (Blüm 1982, as cited in Lauer-Kirschbaum 1994).

In 1985, Minister Blüm promoted an instrumental health reform discourse in which he laid out "Ten Principles" that would guide the adaptation of the health system. The minister focused on the economic shortcomings of the health insurance system and the need for greater financial stability. He suggested that reallocation of resources to priority areas, greater efficiencies in the system, and a focus on macroeconomic and social indicators would remedy many of the system's ills, including its rising costs (BMAS 1985:8). Blüm's principles for reform converged on adjustments to existing policy instruments without challenging the underlying principles of the system itself. The minister stressed the importance of the normative principles of solidarity and subsidiarity and committed to stand by them:

> Collective risk-sharing remains the grounding principle of statutory sickness insurance. In future, the strengthened principle of subsidiarity must take its place alongside the principle of solidarity. This does not mean that social risks are to be privatised, but rather:
> - That the collective provisions of statutory health insurance should be limited to what is genuinely socially and medically necessary;
> - That self-governance in statutory health insurance should be strengthened, and the divisions between the state and the self-governed social insurance system be more clearly drawn. (BMAS 1985:8)

Blüm implied the cause of the expenditure problems was the lack of incentives for providers and users of the system to act responsibly. He suggested that the public and providers needed to be more aware of and responsible for the costs of health care (Deutscher Bundestag 1985a). In keeping with the principles of solidarity and subsidiarity, he proposed to strengthen the accountability of all parties by (a) increasing the transparency of planning and decision-making by corporatist actors; (b) enhancing the accountability of providers and insurers by increasing market competition and using scientific evidence to determine which services should be provided; and (c) placing greater responsibility on beneficiaries for their own health status and for the costs of marginally beneficial services (BMAS 1985:8-10). There was no mention of changes to corporatist governance or restructuring of the GKV system itself. On the contrary, Blüm pointed out that he was offering his co-operation to corporatist groups to address the problems of the health care system (Deutscher Bundestag 1985a). He endorsed the dominant policy paradigm and its principles by acknowledging that "the accountable and independent self-governance in the autonomous governing bodies of health insurers, physicians and hospitals, as well as in other health professions..." and "the structured membership of the social insurance system, in which the principle of collective community was anchored," were indispensable foundations of the health care system (Deutscher Bundestag 1985b).

In its annual report, an influential expert economic advisory group to the government gave further credence to the government's position on health care. The advisory group attributed a significant portion of the rising costs of health care to the lack of appropriate financial incentives for all participants in the system to behave responsibly, and recommended the government consider strengthening such incentives by introducing market-oriented elements as part of its reforms (Deutscher Bundestag 1985c). The report resonated particularly well with the business wing of the CDU/CSU and the FDP members of the governing coalition. Representing the FDP in the Bundestag, MDB Julius Cronenberg agreed that the best way to encourage people to act responsibly would be to "motivate them through their pocketbooks" (Deutscher Bundestag 1986:15956).

Finally, in his opening address to the Bundestag following the 1987 federal election, Chancellor Helmut Kohl endorsed his minister's position and reiterated the broad parameters of his government's plans for health care:

> Among the urgent problems in social policy is the reform of our health care system. Here we face significant structural problems.... We lack incentives for efficient and responsible behaviour. Economy is often not rewarded, waste is frequently taken too lightly... We need a major overhaul of social health insurance, with the objectives of greater efficiency and sustainable contribution rates (Deutscher Bundestag 1987a).

Thus, the government's discourse leading up to the *Gesundheitsreformgesetz* was primarily instrumental. It reflected a continuation of the policy paradigm that had been in place since the beginning of the post-war era. Cost containment would be achieved within the existing parameters of the system, through adjustments to expenditure targets and strengthening of incentives for greater accountability.

The Instrumental Discourse of Health System Reform

Shortly after its re-election in early 1987, the Christian-liberal government promised to enact health reform legislation by the end of the calendar year, but continued to employ an instrumental discourse. Although it drew on the rhetoric of 'structural' reform of the system, the government ruled out changes to the principles of subsidiarity and self-governance. Indeed, the Minister lauded corporatist self-governance, particularly in the form of the KAiG, as the only appropriate means to effectively manage the system (Deutscher Bundestag 1986:15954).

In the summer of 1987, a working group comprising members of the governing coalition was struck to prepare a draft plan outlining strategies for reform. Agreement on detailed plans proved to be virtually impossible, given the diverse positions of working group members, each of whom championed the often conflicting interests of their particular constituent groups. For example, the labour wing of the CDU (*Christlich Demokratischen Arbeitnehmerschaft* – CDA) argued strongly against any reform that would create "unfair benefit differentials" and disproportionately burden workers. It opposed "cost containment that was primarily dependent on user charges for the insured." Taking direct aim at their coalition partners, the group argued that "those who, like the FDP, advocate a market economy and by that actually mean a user-pay model that would create additional income sources for providers, act socially irresponsibly." (Kudella 1987:12)

In stark contrast, the economics wing (*Wirtschaftsrat*) of the CDU argued that "more direct financing by the insured for specific benefits is, in the interest of greater economy in the health care system, urgently needed. This means that a reform of the

GKV must not include only regulatory control measures vis à vis so-called service providers" (Ruf 1987:13). Furthermore, FDP leader Julius Cronenberg made the case that "engaging the material interests of the insured, through socially-adjusted user charge regulations, will promote economical use of resources and, above all, more prudent concerns regarding their own health." (Deutscher Bundestag 1987b:208).

By late 1987, far behind the original schedule, the coalition working group outlined a draft reform plan that was necessarily short on detail, given the lack of consensus between the coalition parties. The plan proposed *Grundsätze* – general principles – for reform that would "bind together more tightly solidarity and individual responsibility in the GKV, and through this make possible the unburdening of premium payers and the tackling of new tasks" (BMAS 1987:1). Rather than pointing to substantive reform, these principles augmented the normative aspects of the dominant health policy paradigm and offered up only selected cognitive elements of the dominant paradigm for possible adjustments.

The draft plan articulated "a new definition of solidarity," which moved discussion away from the issue of *whom* solidarity should include to *what* scope of benefits should be covered. Solidarity defined this way could be used to narrow the scope of benefits to only those services that were 'medically necessary' and 'socially responsible'. Minister Blüm argued that a social insurance system should not have to bear the burden of paying for everything that people *want*, but only for what they *need*.

> Solidarity [means] one who is ill must be helped. This basic principle is not dispensable...No person should fear that he will not be helped because he does not have money; he will receive the best medical care. [But] social health insurance will not pay for luxury or petty items. Collective responsibility should not be called upon for wants, [only for needs]" (Blüm, BMAS 1987:1).

Normatively, this approach entailed a reduction in the range and scope of benefits that could reasonably and morally be expected of a socially responsible system. Cognitive elements of the approach included reference pricing (*Festbeträge*)[3] for prescription medications and assistive devices, which the Minister justified in terms of solidarity: "Collective health insurance is for no-one, including providers, an unlimited milking machine. Necessary [items] will be paid for, not at any price and not for each and every possible alternative... Solidarity: reference prices pay for what is required." (Blüm, Deutscher Bundestag 1987b: 3255)

[3] Reference pricing establishes a fixed price for a family of products with similar effects. The price is based on cost of the most effective and least expensive product available; any other, more expensive product is only paid for or reimbursed at the fixed price, and the patient must pay the difference.

The Minister also declared that the "health insurance system will be unburdened from medically unnecessary benefits." The government would "exclude from the GKV catalogue of benefits those...items which have limited medical impact or whose daily use, if anything, is undetermined" (Blüm, Deutscher Bundestag 1987b), such as spa cures, transportation costs for medical appointments, and burial costs. At the same time, the government pledged to include coverage for some necessary home care services and place greater emphasis on educational and preventative health services (Blüm in Deutscher Bundestag 1987b). The minister appealed to the principle of subsidiarity to justify these benefit reductions and increases in copayments for insured services by associating subsidiarity with *Eigenverantwortung* – individual responsibility. Like the corporatist interest groups that governed the system, he argued, insured members of the GKV also had to be accountable for their own health and their use of services (Deutscher Bundestag 1987b). The changes would make people more conscious of and responsible for the services they used, particularly those that were wasteful or unnecessary (BMAS 1987).

The new definition of solidarity and the expanded understanding of subsidiarity were joined together in the government's main directions for reform. Blüm argued that: "We seek a new balance between solidarity and individual responsibility; they belong together... Individual responsibility is a part of humane health policy" (Blüm in BMAS 1987:2). Furthermore,

> Justice is the new concern of solidarity. And it is for the sake of justice that we must ask: Who pays for the social [insurance] system? Otherwise, the system will degenerate into a major self-exploitation of premium payers. It must be made clear, therefore, which responsibilities the solidarity community of premium payers should undertake, and which lie with individuals. It is about bringing solidarity and individual responsibility into a new balance. This is the federal government's goal for structural reforms of the GKV. (Blüm 1987)

To avoid the appearance of a one-sided reform that targeted only the insured, Minister Blüm acknowledged the need to at least appear to spread the burden of the reforms more fairly (Webber 1988). Bowing in part to pressures from his own party's CDA (of which he was the chairman at the time) as well as to the opposition Social Democrats (SPD), he identified a *Solidargemeinschaft* – solidarity community – which included not only those who paid for and received services (in the more traditional conception of solidarity), but also those who provided services, such as physicians, dentists, insurers, and pharmaceutical and medical devices manufacturers:

> All interest groups must bear the burden of proof for their contribution to the common good. No one should assume, for oneself or one's group, that what they do is enough... We must not allow the common good to become the spoil of interest groups... Our modern social system requires a balance between burdens and benefits. This is an imperative of social justice. (Blüm 1987).

Using this social justice argument, the government announced mandatory price and budget controls on service providers, an anathema to provider groups who had actively and successfully resisted them in the past. Other cognitive elements of the instrumental discourse included efficiency improvements within the parameters of the self-governing corporatist system, such as better physician human resource planning, reductions in the over-supply of hospital beds, greater price competition in the system, and more transparency in the way GKV resources were allocated and used. Premium differentials between GKV funds were to be reduced as part of the "modernisation of the insurance system," but these reductions were to occur within certain types of funds, respecting the principle of structured membership (BMAS 1987). Together, benefit reductions, copayment increases, and budget and price controls would amount to a total savings of DM14.5 billion. This "preliminary draft" of the government's reforms was to be the basis for consultations with stakeholder groups, including health care providers, industry representatives, and Land governments. From this would emerge draft legislation to be tabled in the Bundestag in the spring of 1988, and enacted into law no later than January 1, 1989.

Rise of a Challenging Discourse

The *Solidargemeinschaft* concept signalled the a new direction in the discourse of reform. It created an opportunity for a challenging discourse, based on a still broader conception of solidarity, to take hold. First, it implicated and at least rhetorically held very powerful groups to account, not only for their own self-interested behaviour but also for the lacklustre performance of the health care system. Second, by championing the collective good and invoking a *Solidargemeinschaft*, the Minister initiated debate about the central normative elements of the policy paradigm governing the health system, particularly the nature of solidarity. By doing so, he invited questions about the structural inequalities inherent in the GKV.

Responding to the announcement of the *Grundsätze* in the Bundestag, Rudolf Dreßler, the SPD health policy critic, charged that the government had failed yet again to reform structural elements of the system that were responsible for many of its problems.

> On the central questions of a structural reform of our health care system – correction of the biased structures of health insurance funds, the elimination of inequities between insurance funds and providers..., the elimination of unequal treatment of different insured groups – [the government] simply has no answers or only inadequate answers (Dreßler, in Deutscher Bundestag 1987b: 3256-7).

Instead, Dreßler argued, the government had given in to the interests of the powerful health lobby, and had resorted to a short-sighted and morally unjust strategy: overburdening the poor and ill through arbitrary savings targets and copayments. Dreßler pointed to the gathering storm of opposition amongst the government's key stakeholders – particularly physicians and the pharmaceutical industry – who were becoming increasingly vocal in their protest against a reform bill that had not as yet even been formally announced. These groups, he observed, would undoubtedly block the already limited reform strategies that might adversely affect them, as they had done so effectively in the past.

The pharmaceutical industry was the main target in the government's proposed reforms. Given its champions amongst the parties of the governing coalition, particularly the FDP, the industry had not reckoned with becoming the prime target of cost containment initiatives. It had, until then, successfully resisted government attempts to regulate the price of medications, which in Germany were among the highest in the world. In addition to the reference-pricing scheme that would force a reduction in the price of non-generic pharmaceutical products, the government also demanded a one-time DM1.7 billion 'solidarity contribution' from the industry. Industry representatives adamantly opposed both ideas, threatening significant job losses among the 90,000-strong workforce and reductions in research and development investments in Germany (Handelsblatt 19 January 1988). The industry's preferred cost containment strategy was larger patient copayments to control utilisation (BPI 1985; Webber 1989). Physicians, who had been assured by the coalition that there would be no "reform against them," were also angered by the government's plans (Webber 1989). In a letter to the Minister and association members, the head of the KBV wrote that many elements of the reforms plans would "regiment, control and encase patients, physicians and the well-functioning self-governance by physicians and insurers, in excessive bureaucracy" (Häußler, as cited in Bonner Rundschau 13 January 1988). The KBV charged that the reforms would thrust deep into the heart of self-governance (Die Neue Ärztliche 10 February 1988).

In response to these criticisms, Minister Blüm blasted 'special interests' for sabotaging the collective good in favour of their own gains. He charged:

> Health insurance reform is threatened not by too many choices, but rather by the sum of small objections. From many small vetoes emerge the chains of immobility... Today, interest associations must be brought to account for the collective good. We need a reversal in the burden of proof. The State should not have to justify that it satisfies their interests, but rather, interest associations must prove that their demands are consistent with the collective good (Blüm 1988a).

At times, however, it must have seemed that the criticisms of organised interests were among the least of the Minister's worries. Members of the coalition government itself, particularly the FDP, publicly expressed their own doubts about the reforms. Shortly after it was presented in the Bundestag, members of the FDP made clear that the reform proposal was, in their view, far from ideal. Aligned with its key constituents, the FDP distanced itself from the proposal, referring to it simply as a 'discussion paper' that required further work, rather than a concrete plan for action (FDP 1988). On a number of the key reforms, the FDP and CSU were united in their opposition, characterising them as "socialism in practice" and as "bureaucratising rather than humanising" (Brandt 1988). Nor did the government find support in the Bundesrat, where Land governments, including those headed by the CDU/CSU, pressured the government to exclude the hospital sector from the reforms. Although a CDU/CSU-FDP majority governed the Bundesrat, almost 250 revisions were proposed to the government's proposals (Perschke-Hartmann 1994:86). This internal opposition led Minister Blüm to chide his colleagues for being co-opted by industry lobbying:

> Parties, parliament and governments must exercise a renewed sovereignty... It is not good that the FDP announce in dentists' newsletters that 'Our opponents berate as the dentists' party – we don't object' and in the same advertisement give their account number for donations. Health insurance reform will not fall under the hammer of the highest bidder (Blüm 1988a).

In the midst of this widespread denunciation of the government's reform plans, the SPD proposed an alternative set of structural reforms. Characteristic of a challenging discourse, these proposals provided a new cognitive perspective on existing normative principles, opening a window for more fundamental reform. In contrast to the Minister's *Solidargemeinschaft*, which focused on which *benefits* the insurance system should cover, the SPD proposed to define solidarity in terms of *whom* should be covered by the system. The SPD's proposals would eliminate the *Gliederungsprinzip,* and include all Germans, regardless of their income, employment or demographic group in a single, solidaristic social health insurance system. They demanded the removal of distinctions between blue and white collar funds, for an equal right for all workers to exercise freedom of choice between funds, and for risk sharing across all insurance funds (Dreßler 1988b:24-25). Further, the SPD challenged the subsidiarity principle, suggesting that it allowed the government to place system governance by corporatist elites ahead of the need for greater equity and solidarity amongst its beneficiaries. According to the SPD, the government's reform proposal was nothing more than "a blatant cash grab" (Dreßler 1988a). It was "inconsistent with the expectation that a real reform of [the] health care system must be proposed. It hardly contains elements of structural change; it is more about a one-sided re-allocation of burdens onto the insured and the ill... For us, [reform is] not about an arbitrary savings target, but rather the creation of appropriate structures that meet peoples' needs" (Dreßler 1988b: 24).

The SPD proposal, widely supported by many of Germany's powerful labour unions, was otherwise poorly received. GKV insurers opposed restructuring of the insurance system and were reluctant to offer their members unrestrained freedom to choose between funds (Börngen & Heinz 1988:157; Daniels 1988; Verband der Angestellten-Krankenkassen und Verband der Arbeiter-Ersatzkassen 1988). Furthermore, with the exception of the local insurance funds, they also opposed the idea of risk equalisation between funds. Land governments, employers' organisations, and unions in the richer, southern Länder, which happened to be governed by the CDU/CSU, also backed the insurers (Webber 1989:294).

Faced with turmoil within the coalition, the negative reactions of the Länder in the Bundesrat, and pressure from its traditional allies in the health care system, the government retreated to 'politics as usual.' Acceding to the demands of these various groups, it revised the reform bill. The final version, the *Gesundheitsstrukturgesetz* (GRG), contained no provision for a *Solidarbeitrag* from the pharmaceutical industry. Although the reference-pricing scheme remained, its implementation schedule was significantly protracted, deferring substantial effects for a number of years. Physicians were appeased by reducing the number of random audits and offering them a role in hospital service restructuring. Genuflecting in the direction of individual responsibility, the GRG substantially increased patients' user charges and reduced the range of statutory GKV benefits. It also contained a token structural change in the GKV by extending free choice of funds to all workers above the salary limit (affecting 337,000 people), and allowed for voluntary risk-sharing only within similar funds (Webber 1989:296). Finally, limited expansion of home care was also included.

Although the new law made only minor changes in the system, the GRG debates reflected a subtle shift in the policy discourse. The Minister's emphasis on the state's obligation to meet the collective needs of society, and the SPD's persistent criticisms of the government's failure to protect the most vulnerable, created an opportunity for an alternative to the government's solidarity discourse. Furthermore, the resistance of corporatist groups to the reforms and their self-serving participation in the debates had implicated them as part of the problem, rather than the solution. The Minister's scathing condemnation of members of his own coalition government and their interest group allies only reinforced what the SPD had been saying all along about the failure of corporatist groups to safeguard the public interest. These ideas undermined the subsidiarity principle, and drew attention to the need for more forceful government intervention. Accordingly, opportunities for future more penetrating contestation of the dominant policy paradigm were created by the challenging policy discourse that accompanied the GRG.

The *Gesundheitsstrukturgesetz* 1992: Challenging the Dominant Paradigm

Following the debacle of the GRG, the new minister of health, Horst Seehofer, altered the policy network to minimise the role of corporatist groups in negotiating a new set of health reforms. The open challenge to subsidiarity articulated by his predecessor, and supported by the opposition SPD, made possible this rather significant change in the policy process. Excluding corporatist groups, and even Land governments, early in the process narrowed the range of opposition and facilitated a negotiated compromise both within the coalition and with the opposition SPD. Bringing the SPD into the process gave it greater legitimacy, opportunity and leverage in promoting an alternative approach to reform.

The nascent challenging discourse articulated by the SPD during the GRG debates was also given impetus by a number of other factors which exacerbated the problem of health care costs. These factors, which are discussed in the next section, allowed the SPD to reframe the problem as a crisis that demanded major restructuring of the GKV. The SPD further developed the challenging discourse by drawing on 'facts' which demonstrated the failure of the usual policy instruments and the corporatist actors in the system to address pressing needs. Rather than questioning the core principles of the GKV system (solidarity and subsidiarity), the SPD put forward an alternative policy frame that built on these principles. Finally, it promoted pragmatic alternatives to the government's policies that were consistent with the normative elements of the dominant paradigm but also entailed significant structural changes.

Moving Toward Crisis: 1990-1992

Following the federal election in late 1990, in which the CDU/CSU renewed their coalition with the FDP, Chancellor Kohl lauded the stabilising effect of the GRG in his opening address to the Bundestag, pointing to the 0.7% reduction in the average premium contribution, and committed his government to its continued implementation. He pledged to build on the success of the GRG with a "reform of the organisational and financing structures of the GKV" (Kohl, in Deutscher Bundestag 1991a: 76). The opposition party disagreed with the government's characterisation of the success of the GRG and berated it for past failures. Marshalling key facts that challenged the government's instrumental discourse, the SPD suggested that Blüm's years in the health portfolio could be characterised "as the years of benefit cuts, the years of cashing out, the years of de-solidarisation." (Dreßler, in Deutscher Bundestag 1991b: 201). The SPD health critic questioned the credibility and ability of the coalition to actually formulate an effective reform plan, suggesting that "...the CDU/CSU and FDP are, on this issue, like fire and water: when the two come together, we all know they only produce steam." He vowed that the SPD would fight

for structural reforms in the GKV, and reiterated his party's reform alternatives (Deutscher Bundestag 1991b:201; Forster 1991).

By early 1991, it was apparent that the GRG's impact on rising premiums and overall health care costs was going to be short-lived, undermining the government's instrumental discourse. Premiums rose from 12.2% of wage costs in 1991 to over 13% by the end of 1992. The GKV were projecting a combined deficit of DM 15 billion (Giaimo 2002; Spiegel 1992a). The KAiG expert advisory committee warned of a looming financial crisis in the GKV, focusing on the cost of integrating and upgrading health services in the new eastern Länder and the need to restructure and harmonise risk profiles among the different GKV plans (Süddeustche Zeitung 1991a). However, in his remarks to a physicians' meeting in May 1991, Chancellor Kohl explicitly ruled out such reforms. He declared that "the principle of structured membership will be consciously adhered to in the development of statutory health insurance in the new Bundesländern. Classification by different insurance fund types remains indispensable to organisational reform" (Kohl 1991: 404).

Following the 1991 federal election, the government created a separate Ministry of Health, bringing together various regulatory functions that had been divided between different ministries. Nevertheless, the health minister, Gerda Hasselfeldt, appeared to make little headway in the ongoing implementation of the GRG, many elements of which had quickly faltered in the lead-up to the 1990 federal election. Instead, the minister antagonised corporatist groups, particularly physicians' associations, by accusing them of failing to live up to their part of the bargain under the terms of the GRG (Windschild 1992). Other groups, such as the peak associations of the GKV funds, also criticised the government's lack of commitment to full implementation of the GRG, and accused it of overstating the stabilising effects of the 1989 reform package (DOK 1992a).

Meanwhile, the SPD continued taking the government to task for failing to take action on the rising levels of health insurance premiums. The opposition charged the government with playing politics to avoid difficult decisions during the upcoming Land elections, in which all three major parties had substantial stakes. The SPD's Dreßler described the government's failure to address premium differentials and structural reform as a "socially destructive zero-sum game" (SZ 1992a). The SPD and other critics succeeded in keeping the issue of health care reform in the popular media, with increasingly negative headlines about the government's inaction.

Disagreements about the direction of health reforms within the CDU/CSU-FDP coalition resurfaced, instigated in part by the pronouncements of CDU politician Paul Hoffacker. Hoffacker's controversial proposal for health reform included a substantial increase in the amount of patient charges in the system. Individuals would pay a total

of one percent of their gross incomes toward copayments for insured services, and would be refunded any unspent funds at the end of the year as an incentive to be more responsible in their use of services. Hoffacker also proposed allowing greater competition between statutory insurance funds by permitting all patients to shop around – in effect, by rescinding the *Gliederungsprinzip* – and instituting an industry-funded rebate system for over-priced prescription medications (FAZ 1992b). Hoffacker's proposal polarised an already fractious coalition. The FDP and other members of the CDU were generally supportive, particularly of the increased patient charges. The SPD was predictably opposed, as were the Minister herself and some of her colleagues, on the grounds that it placed an unequal burden for the reforms onto patients.

Hasselfeldt became the lightening rod for growing discontent with health politics. She was generally perceived, both within government and by the public, to be a hapless and ineffective minister, who was "not particularly engaged and also not an influential politician" (Eichhorn 1992). Her appointment seemed to reflect a lack of priority to health reform on part of the Chancellor and his government. Moreover, she was able neither to mollify health lobby groups nor bridge the chasm within the coalition on the direction health reform should take (Eichhorn 1992; FAZ 1992c). In late April, Hasselfeldt resigned as health minister. Within hours she was replaced by Horst Seehofer, who unlike Hasselfeldt, brought a wealth of experience to the post, having served as parliamentary secretary to Norbert Blüm during the GRG reforms. Seehofer was perceived to be tougher than Hasselfeldt (FAZ 1992d), and quickly promised "rigorous belt-tightening in the statutory insurance funds" (Seehofer, in Ziller 1992: 8). Thus began the government's 'second stage' of health care reform.

Challenging Subsidiarity: Altering the Policy Network

In a press interview within hours of his appointment, Seehofer hinted at a shift from the government's previous policymaking approach. Like his predecessors, he made clear that the burden of future reforms would be shared equitably between all parties, including providers (Seehofer, in Donaukurier 1992). Unlike his predecessors, he accompanied his words with action. Seehofer began by fundamentally changing the normal pattern of policy making and the shape of the actor network involved. This change early in the policy formulation process was important for two reasons. First, it significantly altered the actor constellation in the health policy network by marginalising corporatist groups, which later facilitated consideration of a broader range of policy alternatives. Second, it revealed the weakening of the subsidiarity principle, and opened the door for government to take a more interventionist approach to reform.

During the earlier GRG reforms, there had been an implicit objective to protect physicians and other powerful constituents of the governing parties from being adversely affected by new policies, notwithstanding the *Solidargemeinschaft* rhetoric (Webber 1989). Moreover, the normal pattern of health policy making usually involved key interest groups in the initial phases of formulating policy goals and alternatives in conjunction with Ministry bureaucrats, before the political brokering with party and Land representatives occurred (Manow 1994). In contrast, Seehofer's first initiative was to immediately call together health and social policy experts in the governing coalition to form a working group on health reform (the *Koalitionsarbeitsgruppe* – KAG). Over the course of a three-week retreat, this group of politicians would draft a reform plan for endorsement by the members of the governing coalition, which would then be made public for vetting by other groups. During the retreat, working group members were prohibited from communicating or consulting with the press or other interested parties – a strategy that Seehofer later claimed greatly facilitated the ability of the coalition to reach consensus. The retreat allowed the working group members to avoid having to confront the "Trommelfeuer der Lobby" (Seehofer, in SZ 1992b).

This exclusion of interest groups and other interested parties (notably, representatives of Land governments) in the early stages was the most significant difference in the process of policy formulation between the earlier GRG and the proposed GSG. In the formulation of the GRG, and virtually all of the earlier reforms, interest group representation and collaboration were an integral and expected part of policy development, as were consultations with party representatives at the Land level and within the Bundesrat. This type of involvement was strikingly absent in the early stages of the GSG reforms (Bandelow 1994; Manow 1994; Perschke-Hartmann 1994).

As Manow (1994: 21) has described, changing the normal patterns of the policy making process by excluding provider groups in the early stages "had the consequence of extraordinarily broadening the range of policy options..." available to the political leadership. Insofar as the claims and vetoes of interest groups could be excluded from the early internal negotiations, the range of possible compromises was widened, rendering a coalition agreement more likely. Indeed, the coalition working group charged with planning for the GRG in 1987 was able to agree only on a set of broad 'principles' for reform. In contrast, the 1992 coalition working group emerged with a very specific package of proposals, despite divisions between FDP and CDU/CSU members. Once an agreement was reached within the coalition, it was much more difficult for one party to withdraw its support for any specific element of the package without compromising the entire proposal – a risk few political actors were willing to take, given the perceived magnitude of the health care cost problems (Ärzte-Zeitung 1992).

By excluding corporatist actors from policy deliberations, Seehofer implied that blame for failed reforms in the past, most recently the 1989 GRG, lay with them –in both their self-serving attempts to block necessary reforms, and in their failure to implement cost containment strategies – rather than in the efficacy of the strategies themselves. Indeed, he pointed a finger directly at these groups, noting that providers had hindered the achievement of the savings targets outlined in the 1989 GRG, and that he was determined to ensure they would do their share in the current reform (Der Spiegel 1992b). Shifting the blame and undermining subsidiarity created the room for a challenging discourse in a number of ways.

First, blaming corporatist actors for past policy failures was politically expedient for a government whose plans for health reform were coming under increasingly negative public scrutiny. The publicity tactics of physicians' groups in opposing the Blüm reforms, their personal campaign against the ill-fated Hasselfeldt, and the vitriolic and divisive battle they launched against Seehofer, undermined their public credibility and made them an easy target. Furthermore, shifting the blame facilitated the neutralisation of a powerful and vocal group of opponents to Seehofer's planned reforms. Indeed, throughout the GSG debates, Seehofer often referred to his experience with the Blüm reforms. He seemed to take to heart his former minister's characterisation of health politics as being akin to doing "water gymnastics in a shark tank" (Blüm, as cited in Ziller 1992). He was determined to keep at least some of the sharks at bay during the early part of the decision making process.

By excluding powerful actors, Seehofer was also sending a clear and strong message – this time his government was serious about reform and would be willing to take whatever actions were necessary to see them through, including going over the heads of powerful interest groups. This deliberate shift in the power dynamic suggests an element of policy learning and a change in the understanding of problem ownership among government actors. Given the failure of corporatist groups to effectively deal with the problems of the ailing insurance system and the perception that the problems had reached crisis proportions, the government was determined to take a much more active, indeed *étatiste*, approach to health reforms than it had in the past. Excluding corporatist actors from the policy process also undermined the SPD's allegations that the coalition government was too friendly with these groups and would not enact a reform in the best interests of the public.

Second, shifting the blame was a particularly useful tactic within the coalition because it also made it more difficult for rogue elements in the FDP to align themselves with provider groups when the internal battle heated up. The FDP's strongly liberal position on the direction that health reforms should take was politically untenable with many CDU/CSU members, as well as with the SPD and large segments of the population. By sidelining corporatist groups, Seehofer strategically undermined the

FDP's core basis of support, and weakened yet another strident opponent in the reform debate.

Finally, the change in the normal process of health policy making was both justified by and, in turn, reinforced the notion of crisis. Although the idea of a 'cost explosion' in the health insurance system had been around for some time (Braun, Kühn, Reiners 1998), it was further compounded in the early 1990s by the costs of German re-unification and the pressures of international competitiveness. Keeler (1993: 441) notes that

> a crisis can create a sense of urgency predicated on the assumption that already serious problems will be exacerbated by inaction. A sense of urgency may serve to override the caution and/or concern for procedure manifested by officials of both the executive and legislature...during more tranquil times and allows for unusually rapid and uncritical acceptance of reform proposals intended to resolve the crisis.

To justify a shift in the normal pattern of decision making, the government used the crisis metaphor. The SPD capitalised further on this crisis metaphor later to transform the substance of the reforms proposed by coalition. It redefined the problem from a cost control issue that could be dealt with using incremental adjustments to a deeper, more fundamental problem of weakened solidarity that required structural adjustments.

Framing the Problem

The crucial change in the framing of the problem involved the gradual invocation of the concept of a crisis in the health care system. The labelling of an event as a crisis is a part of a framing process that draws attention to particular aspects of the problem while drawing it away from others (Edelman 1977). 'Crisis' implies a unique and unfamiliar situation, arising from accidental or inadvertent causes not in the control of political leaders, and requiring "sacrifices in order to surmount it" (Edelman 1977: 44). A crisis event or situation can open a window for policy change in a number of ways. In addition to Keeler's (1993) observation that the sense of urgency may result in unusually rapid and uncritical adoption of reform proposals, Birkland (1998: 55) suggests that crises (or 'focusing events') may facilitate the mobilisation of groups who will use the situation to push their concerns onto the policy agenda, and may expand the issue to include problems that might otherwise have remained dormant.

Following the approval of the working group's proposals by the FDP and CDU/CSU membership and the Chancellor, the health minister made them public in early June 1992. In his introduction of the plan, Seehofer remarked on the unique historical juncture facing the nation as a result of German re-unification and the planned

European internal market: "In this exceptional situation, we can not allow social insurance contributions to rise unchecked." (Seehofer 1992). These contextual factors in the broader political and economic environment facilitated the significant policy shift that was about to occur in the health arena.

The costs of both the rapid reunification of Germany and the anticipated formation of the European Union drove home the need to contain health costs more broadly and insurance premiums more specifically. Reunification demanded large transfers of money and resources from west to east, and the federal government was in the midst of thorny negotiations for a Solidarity Pact with Land governments to achieve the goal of fiscal equalisation between the old and new Länder (Renzch 1998).[4] In the health arena, Germans in the west substantially subsidised the premiums and other health expenditures of Germans in the east, many more of whom were unemployed, sick or poor than their western counterparts. At the same time, however, the prospects of greater European integration, including monetary union, demanded ever-greater fiscal and economic prudence.

Together, these two factors served to magnify the perceptions of the policy problems associated with rising health insurance costs and premiums, and created a sense of urgency that was lacking in previous reforms. Although he was reluctant to label the situation within the health insurance system as a 'crisis', Seehofer nevertheless referred to the "cost explosion" in the system as "alarming", which if allowed to continue unchecked would threaten Germany's competitiveness, as well as other social programs. He used an emergency metaphor when he declared, "I want to pursue preventative measures in a timely manner, before the entire system is in flames, not rush to the fire when there is nothing left to rescue" (as cited in Forster and Graupner 1992: 11). Therefore, in announcing the reform plan, Seehofer called upon all parties and groups in the health system to make sacrifices: providers through budgetary caps, and patients through higher user charges. The *Solidargemeinschaft* of the Blüm reforms was re-invoked in order to justify significant but ostensibly temporary measures to deal with cost problems in the health care system (AOK-Bundesverband 1992:412-13).

Notwithstanding the rhetoric about the seriousness of the problems, the government's discourse was mainly instrumental, oriented toward fine-tuning existing policy instruments and correcting obvious cost-containment failures of the past. Like his predecessor Norbert Blüm, Seehofer attributed spiralling health care costs to over-capacity, waste and misuse on part of providers and patients, rather than to the failure of the government's past policies (Seehofer 1992a). He argued that solidarity

[4] In 1992, about DM170 billion was transferred to the new Länder, amounting to approximately 6% of the GNP of West Germany and about 60% of the East German GNP (Renzsch 1998: 127).

demanded an increase in the personal responsibility of individuals for paying for their care. However, unlike Blüm's focus on eliminating luxury and non-necessary benefits and services, Seehofer implied an even more restrictive scope of benefits, arguing that personal responsibility required a reorientation of insurance toward catastrophic risks:

> We must redraw the dividing line between solidarity and personal responsibility. My philosophy is: the largest risks for each must be insured unconditionally through collective health insurance. I would hope that beneficiaries like Minister Seehofer could partake of the blessings of transplantation medicine if he needed to. But we can only offer that in the long term if we are not forced to pay for every Band-Aid, every aspirin, or every bandage through mandatory insurance plans (Seehofer 1992b).

With this justification, the Minister introduced new charges for hospital services and significantly increased charges for other medically necessary services and prescription drugs. These charges were expected to amount to a savings of about DM 3.2 million. On the issue of structural reform of the GKV, particularly the large premium differentials between plans, the Minister appeared to favour free choice of insurance fund for all workers, but opposed risk equalisation between insurance plans:

> In contrast to white-collar workers, blue-collar workers today have no right to choose between insurance funds. This is, in my opinion, unconstitutional... However, I do not wish an across-the-board financial equalisation [across funds]. That would only serve to reward inefficiency (Seehofer in Donaukurier 1992).

Instead, any discussion of free choice and equalisation was deferred indefinitely, until after the appropriate and necessary data collection systems were in place. In the meantime, the new legislation would mandate that the health expenditures of insurance funds not exceed their annual incomes. To "socially balance" the reforms, sacrifices would be demanded of providers as well. The government proposed mandatory global caps for medical and dental services, as well as hospital services and prescription medications. These caps were set at 1991 expenditure levels. As a result, DM 8.2 billion would be "torn from the teeth of the 'sharks'": physicians, dentists, the pharmaceutical industry, and this time even hospitals. (Der Spiegel 1992a).

In contrast to the Minister, the SPD wholeheartedly embraced the crisis metaphor to convey the message that the existing system was beyond fixing, and needed to be overhauled. It used the political and economic situation of the early 1990s to expand the issue of health reform from the government's narrowly defined cost containment problem to a broader and deeper problem of structural inequities and failures. The SPD challenged the facts the government presented about the success of its previous reforms. It argued that the cost problem, particularly as measured in terms of high premium differentials among German workers, was so large that the usual means of

addressing them were no longer valid. The substantially lower incomes and higher unemployment rates of Germans in the new eastern Länder raised the spectre of even larger premium differentials between insurance plans and deeper deficits. Perhaps more importantly, the SPD was able to recast the problem as an issue of solidarity, not only between all German workers, but also between Germans in the affluent west and their fellow citizens in the new eastern Länder. This latter argument was particularly emotive and persuasive, given the concurrent constitutional negotiations for full unification of the two Germanys and financial equalisation across all Länder.

Rudolf Dreßler, the SPD's social policy critic, criticised the inability of the coalition to effectively address the problems, noting that "...the coalition parties are significantly at odds with one another about the way out of the crisis in our statutory health insurance system" (Dreßler 1992b: 51). While the government's discourse also had a sense of urgency about it and focused primarily on the short-term, the SPD pushed for a long-term, rational restructuring of the system. Dreßler argued repeatedly that

> the failure of three cost containment laws makes clear that through [cost containment] means, the problems of the health care system cannot be solved. Excessive expenditure growth is simply a symptom of deeper structural deficiencies in the health care system. Instead of trying to cure the symptoms with new cost containment laws, ultimately [we must] eliminate the structural faults (Dreßler 1992b: 48).

By focusing on the problem of the large disparities in insurance rates, the SPD engaged in a challenging discourse that shifted the debate to an issue on which few political actors could disagree. It capitalised on the notion of crisis in the system to demand and justify major structural reforms of the GKV, which had until that time never been seriously considered.

Constructing a Challenging Discourse: Redefining Solidarity

Policy discourses are characterised by the process used in their construction, and the elements of the policy frame that are their subjects. The discourse that challenged the government's definition of solidarity and its role in health reform was distinct in that it was constructed by actors representing a broader range of interests and views than the closed corporatist network that normally dominated the health arena. Furthermore, the discourse did not challenge the underlying principles of the policy paradigm guiding health care. Instead, it sought to strengthen those principles, particularly solidarity, by proposing different policy instruments for more effectively achieving the goals of the system.

Anticipating the opposition of the SPD and its veto in the Bundesrat, Seehofer strategically split the proposed reforms into two separate pieces of legislation. One

bill, which would require Bundesrat approval because it included changes to the hospital sector over which the Länder had shared jurisdiction, contained provisions for new hospital financing arrangements and other structural reforms, including changes to the GKV. This first bill would eventually become the *Gesundheitsstrukturgesetz* (GSG). A second bill, which would not require Bundesrat approval, included the controversial provisions for new and higher patient charges which were made through amendments to the *Sozialgesetzbuch*.[5] In dividing its proposals in this way, the government outlined the aspects of its reform plans on which it was willing to negotiate with the opposition, and those on which it would not concede. Seehofer indicated that he would actively seek the input and co-operation of the SPD for constructive improvements to the GSG bill, noting that "[i]n this difficult situation, collaboration is a dictate of reason." (Seehofer 1992a). At the same time, however, he declared that removing "even one stone from this edifice would inevitably cause it to collapse" (SZ 1992d).

A successful challenging discourse typically builds upon the existing core norms of the dominant policy frame, rather than questioning them. Instead, it challenges the cognitive elements of that dominant frame by marshalling new facts or alternative interpretations of facts to argue for substantive policy change to better meet the norms. In this process, the challenging discourse may also reinterpret or redefine the norms in light of changes in the policy context and/or broader society. The SPD responded to the government's reform bills by expanding upon its challenging discourse in these ways.

Normative Basis of the Challenging Discourse

1992 Leg.

The two reform bills were not given first reading in the Bundestag until mid-September, 1992. In the period between the Minister's announcement of the reform plans in June and the bills' first reading, the SPD worked intensively with its sister parties at the Land level to flesh out an alternative reform plan.[6] Marshalling the support of the majority of representatives in the Bundesrat, including those from the CDU/CSU-governed Länder, the SPD pushed for a regionalised GKV system organised at the Land level. New regional 'conferences' of representatives would be established to manage the system on a day-to-day basis, and would include balanced representation from providers (including hospitals, physicians, and others), insurance funds, and Land/local governments.

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[5] If the Bundesrat did not approve this bill, it would be sent to the *Vermittlungsauschuss* for adjudication. If the *Vermittlungsauschuss* were to rule in favour of the Bundesrat position, the Bundestag could still approve the original bill if it had the support of two-thirds of the members.

[6] In fact, a number of Land governments had, as early as 1991, expressed their wish for a structural reform of the GKV at the Land level, to give the insurance funds greater control over the system (Reiners 1991).

The conferences would be given a number of competencies. They would have the authority to undertake planning for human resources and health service needs of the population. This would inform both the number of physicians required in a particular region and the volume and types of services negotiated between providers (physicians, dentists, and hospitals) and the GKV. In the pharmaceutical sector, the reference pricing system would be strengthened. The KAiG would develop a "positive list" of necessary drugs for which the GKV would pay. In the statutory health insurance system, the GKV would be restructured to allow for risk-adjusted financial equalisation between funds within each Land, and free choice of funds for all workers, blue-collar and white-collar. To ensure some equity across richer and poorer Länder, insurance funds would be required to maintain their premiums within 5% of the national average (Deutscher Bundestag 1992a; FAZ 1992f). This latter proposal was a compromise between the federal SPD and Land governments. The federal party had originally wanted centralisation and financial equalisation at the national level but was opposed by Land governments. Given the substantial differences in the economies and employment rates between Länder, the pattern of premium differentials also manifested itself along regional lines. The more wealthy and powerful Land governments were reluctant to undertake equalisation that might disadvantage their citizens or their economies. Land governments had the support of organised labour's peak association, the *Deutscher Gewerkschaftsbund* (DGB), for a decentralised system of financial equalisation (Handelsblatt 1992c).

The SPD and its allies proposed this plan as an alternative to the cost containment strategies that the government had proposed – primarily, higher copayments and more benefit reductions. They "challenged the government to bring forward a dramatic restructuring of health care...," arguing that "further delay of this restructuring is not acceptable" (Deutscher Bundestag 1992a: 2). They argued that the government's proposals:

- undermined the solidarity principle – that the GKV should be financed by premiums based on income not health risks – because the ill would be paying much more;
- were one-sided in that they benefited the healthy at the cost of the ill, and employers at the cost of employees;
- were problematic because they attempted to alter demand for health services on the basis of economic incentives rather than clinical criteria;
- would not reduce overall health care costs but only shift a greater proportion of them out of the insurance system and into the private expenditures of the insured;
- would be ineffective because they did not alter the structural sources of the system's problems (Deutscher Bundestag 1992a: 1-2).

In this discourse, the SPD made the norm of solidarity the centre of the debate, moving it away from issues of cost containment. Rather than challenging the legitimacy of solidarity as the principled basis of the social insurance system, the opposition attempted to redefine and reinforce it. Furthermore, the SPD also claimed to support the principle of subsidiarity, and called for a re-balancing of the authority and competencies of providers and payers, particularly insurers, to more effectively manage the system. By questioning the government's own commitments to solidarity, and the effectiveness of its plans in actually addressing the "real problems" of the system, the SPD focused the debate on the cognitive elements of the policy discourse – the information and social facts the government was using to promote its plans.

The SPD was joined by a number of societal groups in arguing for the centrality of solidarity in the social health insurance system, including organised labour and representatives of some (but not all) GKV. These groups, like the SPD, claimed that the government's plans would dismantle solidarity. Union groups representing both blue and white-collar workers suggested that the government's plans were "short-sighted" and "socially unbalanced" (Handelsblatt 1992a). They felt the reforms would diminish the social insurance system, and create a system of "second class medicine." Similarly, numerous organisations representing the chronically ill and disabled maintained that:

> the planned reforms are the introduction of long-term dismantling of the social state: increasing individual contributions to the social security system are being instituted in place of the principle of solidarity which has been in effect until now... The broadening of user charges for pharmaceuticals and medical items represent a further step in the dissolution of the collective solidarity of the statutory health insurance system (FR 1992b).

Members of the CDU and CSU were among the most important allies the SPD had in championing solidarity. Although the government's concept of solidarity was focused primarily on narrowing the range of benefits to ensure the system was sustainable, some members of the governing coalition invoked a concept of solidarity that was similar to the SPD's, focusing on the idea of equity between insured. For example, the CDU's social policy committee (the CDA) spoke out against the government's reform plans, saying that it was concerned that patients, particularly those in the eastern Länder, would be excessively burdened by increases in patient charges (SZ 1992bi). Furthermore, a prominent CSU politician at the Land level also expressed his reservations about the planned reforms, suggesting that structural reform of the GKV, including risk equalisation, was needed (General Anzeiger 1992).

Cognitive Elements of the Challenging Discourse

The challenging discourse of the SPD and its allies built upon 'facts' – the unrelenting increase in premiums, the growing disparity between insurance plans, the deficits accumulated by a number of insurers, the larger portion of user charges and patient copayments being imposed – which patently illustrated that past policy initiatives had failed to alter the downward spiral of the GKV system. Dreßler pointed out that the savings target of the Blüm reform had not been reached: instead of the DM14 billion target, the actual savings in the GKV had been about DM6 billion, all of which had come from shifting costs onto patients through higher copayments and charges (Dreßler 1992b). Furthermore, patient charges had not been effective in reducing costs. For example, although patient charges had doubled for dental services, overall expenditures in the sector had risen by over 15% since the GRG was enacted. Similarly in the pharmaceutical sector, despite higher copayments, overall expenditures on prescription medications had risen by 11.5% in just over two years (Dreßler 1992b). Therefore, there was little reason to believe that similar strategies this time around would be any more effective.

The SPD also accused the government of having given in to the powerful interest lobby of corporatist actors, at the expense of the payers – workers and to a lesser degree, employers. The priority that government continued to give to particular provider groups in defence of the principle of subsidiarity was criticised for excluding other important groups, who might more effectively keep the system in check. The SPD's proposed regional conferences would rebalance the authority of insurers and governments vis à vis providers in planning for the health needs of the population. Further, they argued, regulated competition between insurance funds would provide more effective incentives for efficiency on the part of providers than anything the government had proposed. The SPD felt its plan was a radical, more equitable and efficient restructuring of the GKV, and would demand more accountability from corporatist players, both by consumers and by the state (Dreßler 1992a).

The DGB also warned that the government's planned reforms would be the ruin of the GKV system. Organised labour viewed the lobbying of dentists, doctors and other providers as excessive and exaggerated, but they had nevertheless brought the minister to his knees, just as they had his predecessor Blüm. The real danger, the DGB argued, was the increasing burden on workers and employers of high health care costs, which were fundamentally not being addressed (SZ 1992c). After a brief hiatus, health expenditures had once again begun to rise, demonstrating clearly that the earlier reforms had failed. Ursula Engelen-Kefer, the vice-chair of the DGB, pleaded for longer-term reform strategies that would stabilise contribution rates but at the same time ensure quality and effectiveness. She argued that "demand-side instruments," such as copayments and benefits reductions, had been demonstrated to have little

impact on overall expenditures. What was needed instead were changes on the supply side, such as greater authority for the GKV vis à vis providers, risk equalisation between funds at the Land level, and equality in extending free choice of insurance plans for all workers, regardless of income (DGB 1992; Engelen-Kefer 1992).

The government countered these accusations about the failed GRG reforms with the rather feeble argument that insurance premiums and overall health expenditures would have risen faster had the GRG not been implemented. However, its credibility was further eroded by announcements of operating deficits and premium increases in the GKV in virtually all Länder throughout 1991 and 1992. The health minister, rather than tackling the facts and information of the SPD, finally acknowledged that the "GKV are facing the most serious financial crisis since their creation." He noted that GKV deficits had almost doubled within the previous year, and that the average premium contribution rate had reached a record high at over 13% (Seehofer 1992a).

Seehofer's discourse suggested a shift in the government's strategy on the reform package. He appeared to be adopting the policy frame the SPD had employed, particularly when he talked about the impact of the higher premiums on particular groups. He agreed that high premiums were inequitable because they burdened certain segments of the population – namely, blue collar workers and retired citizens – the most. Although he had made references to equity in the past, they had usually been in the context of sharing the burden of reform between providers and the insured. Seehofer used language that implied further movement toward the idea of crisis, referring to the seriousness of the situation with words such as "dramatic" and "catastrophic" to describe the consequences of inaction (Die Zeit 1992). He went further and acknowledged that the strategies of the past, particularly the GRG, had failed: "...today I am of the opinion that copayments alone cannot reduce [excessive service] volumes" in the system. Citing the same facts used by the SPD, he pointed out that patient charges had not reduced expenditures in a number of sectors, and in fact seemed to have had the opposite effect (Seehofer, as cited in Die Zeit 1992).

The widening of the policy window that resulted from the growing consensus on the existence of a crisis in the GKV facilitated more rapid movement toward significant policy changes. Conceding that the reform could not pass in the Bundesrat without the co-operation of the SPD, the government offered to work with the opposition to address the "great challenge" of securing the health care system for the future. Chancellor Kohl personally approached the leadership of the SPD to promise real talks, and Seehofer did the same with SPD social policy experts (Der Spiegel 1992c). Seehofer's tone with the opposition was conciliatory and accommodating: "Together with the SPD, we will seek a way out of the crisis; for example, with an organisational reform of insurance funds... There will be further competition between funds, but we must look seriously into risk equalisation..." (Die Zeit 1992).

The SPD enthusiastically took up the government's offer to collaborate. In a classic case of political bargaining, the party's lead negotiator, Rudolf Dreßler, made clear that any collaboration would come with conditions. His party would not support a reform package that did not include structural reforms to the GKV, nor would the SPD approve increases in patient charges. He also demanded his party have a weight in the final decision-making that was proportional to its representation in Parliament: i.e., that the SPD, which had 35% of seats in the Bundesrat be given greater say in the negotiations than the FDP, which had only 10% (Handelsblatt 1992f). Finally, the SPD would not tolerate any interference by provider groups during the tripartite negotiations. For his part, the Minister resolved to retain the overall savings target of DM11.4 billion, while the FDP declared it would not support risk equalisation between insurance plans (SZ 1992e; FAZ 1992j).

Seehofer strategically played the SPD and FDP off one another, making it apparent that he would consider forming an alliance with one party if the other was unwilling to co-operate. However, his earlier defence of the solidarity principle, contrary to the position of the FDP, made clear where his allegiance lay if negotiations did not reach a three-way consensus. Well before the official tripartite retreat to hammer out a deal, the Minister demonstrated the extent of his willingness to compromise. He signalled a reversal in his government's position on free choice of funds and, implicitly, on risk-adjusted financial equalisation:

> We are united with the SPD in the goal of preserving social health insurance... Differential rights to choose between funds for white and blue-collar workers no longer fit with our present-day societal reality. We cannot withhold this right from blue-collar workers into the unforeseeable future... Therefore, in principle I am for a structural reform of insurance funds *and their financing* (Seehofer 1992d, italics added).

At the end of a four-day retreat in early October, the parties emerged with an agreement in which the broad concept of solidarity promoted by the SPD appeared to have prevailed. The three parties announced a consensus package that was described by the SPD as "the biggest reform in German health insurance," and "a historical compromise" (Dreßler, as cited in Sanches 1992). Seehofer called it "the most dramatic reorganisation of the health insurance system since 1945" (Seehofer, as cited in FAZ 1992k). Even the FDP lauded the outcome as a justifiable compromise (Cronenberg, as cited in Handelsblatt 1992g).

The agreement was proposed in a single bill called the *Gesundheitsstrukturgesetz* (GSG), and replaced the two bills the coalition government had proposed in mid-summer. The key elements of the agreement, which bore the unmistakable imprint of the SPD, included:

- lower copayments for hospital services and prescriptions than in the original bills;

- broadening of the reference pricing system to include all prescription medications, which would be accompanied by a solidarity contribution from the pharmaceutical industry in the form of 5% reduction in the price of all prescription drugs;
- changes in the financing mechanism of hospitals from open-ended per diem reimbursements toward case- and volume-adjusted capped budgets, which would be negotiated with insurance funds;
- market-oriented competition between insurance funds, accompanied by risk-adjusted financial equalisation across and within different types of fund; and,
- free choice of funds for all of the insured, blue collar and white collar workers alike, beginning in 1996.

The provisions for budgetary caps on physician services and prescription drugs remained unchanged from the original coalition agreement. The caps were temporary and would stay in place for two years, after which corporatist actors would once again negotiate their budgets with the GKV.

The agreement reflected the focus on enhancing solidarity in a number of ways. By targeting mainly provider groups, who would bear the brunt of the financial and regulatory burden of the reforms, the government signalled that the reforms were indeed "socially balanced" between providers and the insured. Providers would be expected to realise almost DM10 billion of the anticipated DM11.4 billion in savings from the reforms. In recognition of the much greater financial burden borne by patients with the GRG, the current reform would limit the costs to patients, through moderately higher copayments, to less than DM2 billion. Most significant for solidarity were the structural changes to the GKV and the free choice of funds. With risk-adjusted financial equalisation between funds, wide premium and benefit differentials would be eliminated. Funds with healthier and wealthier members would subsidise those with sicker and poorer members, and premium contributions would continue to be based on incomes rather than on the risk status of individuals. Thus, with this agreement, the *Solidargemeinschaft* was broadened enormously,

The GSG was widely interpreted as a victory for the SPD and a personal triumph of the Minister, with the FDP having been sidelined (Ärzte Zeitung 1992c; Handelsblatt 1992h; Manow 1994). The Minister in particular was lauded for having stood up to the "health care lobby," and for his cleverness and determination in directing such a major transformation to save the system (Der Spiegel 1992c). The unlikely 'grand coalition' between the governing parties and the opposition had finally achieved a "real reform" of the health insurance system (SZ 1992g). The GSG was passed easily and with little debate by large majorities in the Bundestag and Bundesrat, coming into effect on January 1, 1993.

Policy Outcomes of the Challenging Discourse

The GSG was an exceptional case of policy change in German health politics. It represented a breakthrough in the institutionalised 'reform blockades' that had almost immobilised policy making in the health care system for decades. Furthermore, it heralded significant changes to the policy paradigm that had governed German health policy for a century. These changes were made possible by the challenging discourse promoted by the SPD and its supporters, which redefined the problems in the health care system from cost containment issues to the need to protect and enhance the core principle of solidarity.

This challenging discourse reinforced the fundamental principles of the statutory health insurance system, particularly solidarity, which were widely accepted and supported by key groups of interests, as well as the general public. Rather, the discourse suggested that the cost explosion in the system was compromising solidarity by causing a steep rise in premiums and resulting in larger premium differentials between blue and white-collar workers. Furthermore, the discourse challenged the government's reform strategies by arguing that the usual policy instruments for cost containment, such as user charges and reductions in benefits, were compounding rather than solving the problems.

Promoted by the SPD and its allies, the challenging discourse was centred around facts regarding the growing intensity and severity of problems in the system. The facts included the costs of reunification, the continued growth in overall health expenditures, the rising deficits in the GKV, and larger premiums for the insured. These facts facilitated a shift in the framing of the issues from difficulties with the system that could be addressed in the usual way to a problem of crisis proportions that demanded much more radical structural changes. The SPD confronted the government's past record on health reforms, pointing to the failure of corporatist groups to honour their commitments and responsibilities. The challenging discourse presented an alternative set of feasible strategies to achieve the newly broadened principle of solidarity in the statutory health insurance system.

The success of the challenging discourse in facilitating significant policy change rests on a number of factors. First, the SPD capitalised on the perception of crisis, which was shared by government actors, and communicated to the public. It was able to redefine and reframe the problem from the need for cost containment to maintain the current system to the need for structural reform to sustain and improve the system for the future. The crisis metaphor also gave the government ample justification for altering the usual policy process by excluding corporatist actors from the deliberations, and thus eliminate one significant institutional barrier to reform. The crisis allowed the government to take a much more interventionist approach to health reform than

it had in the past, to rationalise the need for quick and decisive action, and to demand sacrifices from all groups in the polity, including its own constituents.

Second, the challenging discourse focused on enhancing rather than undermining the normative elements of the statutory health insurance system. It also gave precedence to solidarity over subsidiarity, when the two principles appeared to collide. This re-prioritisation of the two principles justified a significant change in the policy making process, which in turn facilitated agreement on far-reaching reforms. The belief in solidarity was shared by most Germans, and perhaps more importantly, by members of the CDU/CSU and SPD. It formed the basis of the alliance between the CDU/CSU and SPD in a 'grand coalition', and allowed them to overcome the institutional barriers to reform posed by federalism, political partisanship, and the opposition of the FDP. Once it became an 'insider' in the policy network, the SPD was in a pivotal position to further its challenging discourse. The focus on solidarity as the most important of the core principles also facilitated the government's ability to exclude corporatist groups from reform negotiations, thereby eliminating another institutionalised source of resistance and opposition. The government's and opposition's portrayal of these groups as being more concerned with private gain than the public good justified their exclusion.

Third, the challenging discourse provided a set of reasonable policy alternatives that were consistent with the values of solidarity and subsidiarity. Eliminating structured membership was consistent with the norm of societal solidarity; it acknowledged the equality of all Germans, irrespective of age, job class, health status or income. Risk equalisation between GKV funds was also considered politically feasible, since it would reduce incentives for cream-skimming by insurers and facilitate the transfer of resources from wealthy funds in the western and richer Länder to the struggling funds in the eastern and poorer Länder. Furthermore, giving people free choice of funds would introduce market-like incentives for efficiency and require limited state intervention, protecting the principle of subsidiarity in the day-to-day governance of the system.

Finally, the challenging discourse was promulgated by an influential and credible source – the SPD. The party's deep-rooted social democratic philosophy was entirely consistent with the challenging discourse it promoted, particularly on the issue of solidarity. Furthermore, the usual policy participants – corporatist groups and the FDP – had been discredited by both the CDU/CSU and SPD, and had garnered little public support for their positions on health reform. The SPD's political legitimacy a social democratic party allowed it promote structural reforms in the health care system with less public suspicion or opposition than might have been elicited had the proposal come from the governing parties of the centre-right.

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Chapter 5:

Institutional Structures and Health System Dynamics in Canada

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> *The support shown by Canadians for a universal, one-tier, single-payer health care system depends on their belief that it will provide to everyone, regardless of income, access to health care of the highest possible quality when that care is needed... After all, for Canadians, health care is not simply another government program. It has become tantamount to a right of citizenship. It reflects and it embodies some of the most fundamental values and principles of being a Canadian. If we as governments, as providers, fail to fix health care, we will have failed the country itself.* (Federal Health Minister Alan Rock, 1997).
>
> *Medicare is a worthy national achievement, a defining aspect of our citizenship and an expression of social cohesion.* (Commission on the Future of Health Care in Canada 2002: xxi)

The dominant policy paradigm in Canadian health politics is premised on the understanding of health care as a right of social citizenship – a right that can and should be freely exercised by any Canadian, in any part of the country, regardless of health or wealth. The power of this paradigm, as expressed in the above quotations, lies in its underlying norms of equality and accessibility, which are deeply embedded not only in the social psyche of the nation but also in its political institutional structures.

However, in the policy literature, the durability of the health policy paradigm in Canada is more often attributed to the rules governing the exercise of political authority – primarily federalism, parliamentary governance, and state-society relations – than it is to the embeddedness of the paradigm itself. In these arguments, policy stasis is the result of the inability of political actors to overcome institutionalised decision rules necessary for policy change. On the contrary, as this chapter will demonstrate, institutional arrangements governing Canadian health policy should actually facilitate policy change rather than inhibit it. The Westminster parliamentary system of government and the particularities of Canada's electoral and party systems concentrate an inordinate amount of authority in the political executive – to the point where some analysts describe Canadian governments as 'friendly dictatorships'. The only real veto on executive power in Canadian politics is the electorate. Secondly, although federal-provincial wrangling has dominated the health policy agenda for decades, health policy decision-making authority lies exclusively with provincial

governments. The provinces have constitutional jurisdiction over health care, whereas the federal government exercises its influence through its spending power. The federal spending power is no minor policy instrument; in some provinces, Medicare would cease to exist without federal funds. However, in the period under study, the federal spending power declined almost to the point of obsolescence, and the political legitimacy of the federal spending power was arguably the weakest it had been since Confederation. In such a situation, it would be reasonable to assume that a relatively wealthy and determined provincial government would face few tangible intergovernmental barriers to implementing health policy change.

Finally, the technical expertise of provider groups – mainly physicians – in the health care system is indeed influential in shaping policy. However, given degree of authority centralised in the political executive, interest groups generally have had limited access to and influence on government actors. Therefore, the political power of these groups to effectively prevent or alter policy decisions is relatively limited. As the past decade of health system restructuring in Canada has demonstrated, these groups have had limited success in challenging the autonomy or capacity of determined provincial governments to take decisive action.

In this and the next chapter, an alternative explanation for the longevity of Canada's health policy paradigm will be elaborated – one that explores the role of deeply ingrained ideas, in the form of norms and values, that govern the system. This chapter will make the argument that institutionalist explanations about policy immobility in Canadian health care do not adequately explain why challenges to the dominant policy paradigm have failed to take hold. Nor do these explanations capture or give sufficient credit to the power of policy ideas – as expressed in the dominant policy frame governing the system – in shaping and limiting the scope for policy change. Before turning to an examination of the institutionalist explanations, the next section will briefly describe the dominant policy paradigm and the case of the challenge to that paradigm put forth by the province of Alberta.

Canada's Dominant Policy Paradigm and the Institutional Legacies of National Health Insurance

Canada's national health insurance system is actually a collection of ten provincial and three territorial systems that are governed by broad national principles. These principles ensure that the vast majority of Canadians receive all necessary medical and hospital services, with no charges at the point of service. The system was established in two stages. First, in 1957, the federal government enacted the Hospital Insurance and Diagnostic Services Act (HIDSA), which initiated a publicly financed insurance program for medically necessary hospital and diagnostic services. Second, coverage for physicians' services was introduced in 1966 with the Medical Care Act (MCA). The

federal government consolidated the HIDSA and the MCA in the Canada Health Act (CHA) in 1984.

Implicit in the federal legislation are two organizing principles of the system – public payment and private practice – which have been in place, virtually unchanged, since its inception (Naylor 1986). The *public payment* principle requires provincial governments to ensure that all medically necessary physician, hospital and diagnostic services are available on 'uniform terms and conditions' to all legal residents. The system is financed primarily through general taxation revenues, and in a few provinces, supplemented by insurance premiums and/or designated payroll taxes. All medically necessary hospital and physician services must be provided to patients without charge and irrespective of a person's ability to pay, including payment of premiums. Third-party private insurance for government-insured hospital, medical and diagnostic services provided within Canada is prohibited. In addition to the services covered by the Canada Health Act, all jurisdictions also offer a range of home care services, pharmacare and dental plans for certain portions of their populations, and financial subsidies for assistive devices. The scope and breadth of coverage for these services and benefits vary significantly across jurisdictions, and all are subject to user charges and/or patient copayments.

The *private practice* principle reflects the fact that the provision of hospital and medical services occurs almost entirely within the private sector. That is, most physicians are not employees of government, but rather are private entrepreneurs who negotiate fees-for-service with government, and bill government insurance plans for payment. A small proportion of physicians is paid through alternative payment arrangements, such as patient per capita fees or salaries. Hospitals are also private corporations, although the vast majority is non-profit institutions owned and operated by voluntary organizations, community boards of trustees or municipalities. In principle, hospitals are accountable to their local communities rather than to the provincial government, but they also negotiate with government or government agencies for their annual operating budgets, and to a lesser degree, for capital and infrastructure funding.

This division of health care financing and delivery between the public and private sectors, respectively, suggests that the primary role of government is to 'purchase' services for its citizens. Provincial governments exercise monopsony power in negotiating fees with provincial medical associations, which act on behalf of all physicians billing provincial insurance plans for their fees, and with individual

hospitals.[1] Day-to-day operation and management, as well as clinical and service delivery decisions are left to managers and providers within the system. Consumers of health care services – insured patients – exercise free choice of primary care physicians, while most other services require medical referrals.

The core principle underlying these organizational arrangements is equity. Equity is manifest in the five program criteria or conditions of the Canada Health Act – universality, accessibility, comprehensiveness, portability and public administration. *Public administration* requires that provincial plans be "administered and operated on a non-profit basis by a public authority" (Canada Health Act, R.S. 1985, c. C-6) that reports directly to the provincial government. *Comprehensiveness* requires that "all insured health services provided by hospitals, medical practitioners or dentists..." be covered by provincial plans. *Universality* requires that 100% of eligible residents be covered by provincial plans "on uniform terms and conditions." The *portability* provision prohibits provincial residency requirements for eligibility that exceed a three month period, and also requires provincial plans to provide coverage for provincial residents when temporarily outside their home province, either in or out of Canada. Finally, the *accessibility* requirement, which is most explicitly tied to equity, deals directly with the issue of patient charges. It states that a provincial plan "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons."

As the quotes at the beginning of this chapter illustrate, the principles of the Canada Health Act and health policy paradigm they establish, have become well grounded in the political culture and identity of the nation. Since the early discussions about a national system of health insurance by the federal Liberal Party in 1918, the idea of universally accessible health care for all Canadians has become firmly entrenched in political discourses about national identity and unity, social citizenship, and the role of the state. Central to this health care paradigm are publicly financed services because access to high quality health care without financial barriers is a collective responsibility (Canada, National Health and Welfare 1983; Mendelsohn 2001). However, in the 1980s and extending well into the 1990s, the government of the province of Alberta actively contested the principles of equity and public payment. Alberta defied the Canada Health Act, specifically the accessibility provision, by allowing patient charges for a number of medically necessary services that were covered by the provincial health insurance plan, and proposing new charges for other services.

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[1] In a number of provinces, regional health authorities are delegated the responsibility and budgets to negotiate 'purchasing agreements' with local hospitals and other service provider organisations (not including physicians). In some instances, hospital boards were amalgamated and replaced by the regional authority.

The challenging discourse put forward by the Alberta government had two facets. First, it questioned the constitutional and moral legitimacy of the federal government's role in areas of provincial jurisdiction, of which health care was one. Second, the Alberta government disputed the merits of the accessibility provision itself – that is, whether the prohibition on user charges was actually necessary to ensure equitable access. Despite frequent and regular confrontations with the federal government, Alberta's challenging discourse failed to persuade key stakeholders to adopt a new Medicare paradigm. On the contrary, the discourse mobilized many interests and citizen groups, as well as the federal and other provincial governments, in opposition. This opposition was unified around augmentative discourses – both rhetorical and instrumental – which reaffirmed the equity and public payment principles, and successfully maintained the status quo of the system.

Before turning to the particular case of Alberta's challenges in the next chapter, the remainder of this chapter will explore the evolution of institutional arrangements for health care in Canada. It will present the institutional arguments for health policy immobility and demonstrate their inability to fully explain the power and persistence of the dominant paradigm in the face of determined challenges.

Institutional Dynamics and Policy Immobility

The public payment, private practice organizational principles, and the underlying core principle of equity, as articulated in the five conditions of the Canada Health Act, form the policy paradigm governing Canada's health care system. The stability of this paradigm is attributed to a combination of factors, including the institutional structures of the system, as well as the power of particular interest groups – mainly physicians (Boase 1996; Hacker 1998; Maioni 1998; Taylor 1987; Tuohy 1989, 1999). The Canadian policy literature suggests that health politics in Canada are primarily influenced by:

1) The combination of Canada's Westminster parliamentary system of government and its electoral system, which concentrate both power and accountability in the executive, and inhibit policy innovation and change;
2) The decentralized federal system, dominated by inter-state executive relations, which has led to a competitive and confrontational dynamic on health issues and policy stasis;
3) Clientele pluralistic relations between key health system interest groups and the state, particularly physicians and provincial governments.

The combination of Westminster parliamentary government with an unusually decentralized form of federalism has led to a highly politicized regionalism in Canada, rooted in "the drive of provincial political, bureaucratic, and economic elites to mold provincial societies and undertake responsibility for managing provincial economic development" (Simeon 2002:17). This 'province building', accompanied and challenged by the 'nation-building' efforts of the federal government, particularly in the politics of the welfare state, has often resulted in an intergovernmental stalemate on the issue of health care – perhaps the most popular and politically salient program of any government in Canada. However, this stalemate, it will be argued, is an ideational/discursive rather than an institutional or structural barrier to policy change.

Westminster Parliamentary Government and Political Parties

Strong states – that is, governments that are autonomous from societal groups in formulating policy objectives and that have the capacity to act on these objectives and see them implemented – are a function of institutional structures and rules (Coleman and Skogstad 1990). In particular, state strength is influenced by constitutional provisions, such as the fused executive and legislative branches of government in Westminster parliamentary systems, rules of convention, such as strong party discipline, and electoral rules, such as the first-past-the-post system that favours single-party majority governments (Immergut 1992; Weaver and Rockman 1993). Each of these factors influences the number of discrete decision points at different institutional locations – the greater the number of decision points, the larger the number of potential vetoes or "points of strategic uncertainty" (Immergut 1992: 66).

In Canada, the executives of both the federal Parliament and of provincial legislatures are selected from members of the governing party. The executive is governed by a strong tradition of solidarity: regardless of internal debates and disagreements, all members of cabinet are expected to reflect a publicly united front on all issues. Power is further concentrated within cabinet in the Premier or Prime Minister, who is often described as *primus inter pares* – first among equals – since s/he wields the authority to appoint members from the governing party to cabinet (Bakvis and MacDonald 1993; Dunn 1996; Kornberg, Mishler and Clarke 1982). With this privilege, the First Minister can exercise considerable personal influence over cabinet appointments and therefore cabinet decisions.

The convention of tight party discipline virtually ensures that cabinet will receive the support of members of the governing party. Members of the parliamentary party are required to vote with cabinet, and only rarely are 'free votes' on particular issues tolerated. Canada's single-member plurality electoral system favours stable single-party parliamentary majorities and thus ensures that the government will have the support of the legislature (Bakvis and MacDonald 1993; see Table 4.1). Finally,

provincial parliaments have no second chamber to challenge their decisions, and although the federal parliament still retains a second chamber – the Senate – it has very limited impact on the policy process and only very rarely exercises its constitutional veto.

This paucity of legislative veto points in the Canadian parliamentary system means that the executive is the "effective point of decision" in provincial and federal parliaments (Immergut 1992: 65). As a result of these institutional structures and rules, "legislative politics in [Canada] are almost entirely party politics, marked by a primal and relentlessly adversarial division between the government and the opposition. Government and opposition, of course, are defined essentially in terms of parties" (White 1996: 207). And political parties in Canada have evolved over time into "an extension of the leader, a personalized machine to build and sustain a coalition of support for the leader's policies." (Carty 1991: 136).

Therefore, the only likely condition for a *parliamentary* veto in Canada is minority government in which political parties actively exercise their influence. Although minorities are less frequent in Canada than Germany, they do occur and have the potential for significant influence in policy decisions. For example, in 1966 the minority Liberal government passed the federal Medical Care Act in part due to the New Democratic Party's (NDP) threat of defection from their informal parliamentary coalition (Maioni 1998). In general, however, the relative infrequency of minority governments and the strength of party discipline at both levels of government in Canada concentrate accountability within the governing party, making *electoral* vetoes more significant than parliamentary vetoes (Immergut 1992). As a result, political parties and their leaders have come to have influential roles in shaping electoral politics, and in turn, public policy.

In order to gain office, political parties in Canada tend to cultivate broad coalitions of support, rather than focusing on narrowly defined ideological or class issues. They are often referred to as 'brokerage parties' because they "are essentially similar organizations opportunistically appealing to a variety of interests; ideology distinguishes neither the party activists nor the positions adopted by the parties" (Brodie and Jenson 1996: 59). Brokerage parties have only a small contingent of loyal voters; instead they rely on recreating coalitions at each election and tend to compete with one another for the same policy space and the same voters. They also tend to "organize around leaders rather than around political principles and ideologies..." (Clarke et al. 1996: 16).

Canada's two main brokerage parties, the Liberal Party and the Progressive Conservative Party, have long been criticized for their lack of policy innovation and their virtually indistinguishable platforms. Clarke et al. (1996) suggest that the role of innovation in the Canadian system is often played by smaller 'third' parties that emerge in difficult social or economic environments to protest and/or mobilize against the status quo. For instance, the Cooperative Commonwealth Federation (CCF),[2] which was originally a protest party from western Canada, played the role of innovator in the development of Medicare, although the national programs were introduced under the aegis of Liberal governments.

Provincial party systems are much more varied than the federal system. Although most provinces have two fairly competitive major parties, the identity of the parties themselves varies considerably. In some provinces, the Liberal and Conservative parties have historically constituted the 'major parties' (i.e., they each consistently receive about 30% or more of the popular vote); in others, the major parties have also included the CCF/NDP, the Social Credit (SC), the Union Nationale, and/or the Parti Québécois (McCormick 1996)[3]. Alberta stands out from this provincial pattern of two- or three-party competition, having "functioned for decades with only a single major party..." (McCormick 1996: 351). This is less a reflection of homogeneity among the voting population and its policy preferences than of the distortions created by the electoral system and electoral boundaries (Archer, Gibbins and Drabek 1990; Dyck 1996; Smith 2001). Leadership also appears to have a particularly important role in the fortunes of Alberta's political parties – party leaders have dominated Alberta politics and actively reshaped the province's political culture to meet new circumstances (Pal 1992: 3-4; Bell 1993). As a result, "politics in Alberta is characterized by a single party consistently receiving support at the major-party level, with sporadic challenges from a shifting variety of opposition groups" (McCormick 1996: 368).

The differences in the party systems of Alberta and the federal government suggest that the Westminster system at the federal level might create more obstacles to policy change than the provincial level. Although power is concentrated in the executive in both cases, the potential for an electoral veto is greater at the federal level than in Alberta because of the nature of different party systems. Whereas one or more viable opposition parties in an election may challenge the federal executive and governing party, the dominant political party in Alberta very rarely faces an effective opposition. The evolution of Medicare can, in part, be explained by the dynamics of the federal party system.

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[2] The CCF became the New Democratic Party (NDP) in 1961.

[3] It is important to note that provincial parties – with the exception perhaps of the NDP – are completely independent entities, both organisationally and sometimes even ideologically, from their federal counterparts.

The Federal Party System and the Genesis of Medicare

The federal Liberal party has long been associated with the idea of Medicare in Canada. Following the end of World War I, the Liberal Party of Canada under the leadership of MacKenzie King adopted an ideology of 'positive liberalism'. This approach embraced the idea of state-sponsored welfare liberalism to maximise individual initiative and opportunity (Campbell and Christian 1996). The party resolved, "in so far as may be practicable, having regard for Canada's financial position, an adequate system of insurance against unemployment, sickness, dependence in old age, and other disability, which would include old age pensions, widows' pensions, and maternity benefits, should be instituted by the Federal Government." (As cited in Campbell and Christian 1996: 78).

Following World War II, the party advanced a Keynesian worldview that would include a revamped tax system and a host of new social programs. The discourse that accompanied federal proposals was truth-seeking in that it sought to build consensus about the purpose and scope of government in a post-war society. These proposals were put forth in a federal-provincial conference following the end of the war. Although the Green Book proposals (as the federal plans became known) were delayed by federal-provincial disagreement on fiscal issues (a harbinger of similar future disputes), they established a normative policy frame that became impossible for lukewarm Liberals and other federal and provincial parties to disregard in the long run (Taylor 1987). The delay in implementing the Green Book proposals allowed the Liberal party to retreat to a non-committal approach toward national health insurance in the 1949 election campaign. However, political pressure for social reforms from the increasingly popular CCF made some form of a national program almost inevitable (Maioni 1995; Taylor 1987). In 1956, the Prime Minister announced a shared-cost national insurance program for hospital and diagnostic services. The Hospital Insurance and Diagnostic Services Act (HIDSA) was passed unanimously in the House on April 4, 1957 – two days before Parliament was dissolved and a federal election was called (Maioni 1998).

The 1957 election ushered in a turbulent period in Canadian electoral politics. The Liberal government was defeated by a small margin, and the Conservative Party formed a minority government that lasted only one year. In 1958, the Conservatives won by a landslide – the largest majority in Canadian history (see Table 4.1). However, four years later, they were reduced to minority status, and defeated the following year by a minority Liberal government. The Liberals went on to govern virtually uninterrupted for the next two decades. They presided over the introduction

of a national medical care program in 1966 (the Medical Care Act), and later firmly enshrined the principles of Canadian Medicare in the Canada Health Act in 1984.

Table 5.1: Election Results, Canada 1935 – 2000 (Selected Parties)

Year	Prime Minister	Conservative		Liberal		CCF/NDP		Social Credit	
		% Seats	% Vote	% Seats	% Vote	% Seats	% Vote	% Seats	% Vote
1935	King (Lib)	16	30	71	45	3	9	7	4
1940	King (Lib)	16	31	74	51	3	8	4	3
1945	King (Lib)	27	27	51	41	11	16	5	4
1949	St. Laurent (Lib)	16	30	74	49	5	13	4	4
1953	St. Laurent (Lib)	19	31	65	49	9	11	6	5
1957	Diefenbaker (Con)	42	39	40	41	9	11	7	7
1958	Diefenbaker (Con)	78	54	18	34	3	9	0	2
1962	Diefenbaker (Con)	44	37	38	37	7	14	11	12
1963	Pearson (Lib)	36	33	49	42	6	13	9	12
1965	Pearson (Lib)	37	32	49	40	8	18	2	4
1968	Trudeau (Lib)	27	31	59	45	8	17	0	1
1972	Trudeau (Lib)	41	35	41	38	12	18	6	8
1974	Trudeau (Lib)	36	35	53	43	6	15	4	5
1979	Clark (Con)	48	36	40	40	9	18	2	5
1980	Trudeau (Lib)	37	33	52	44	11	20	0	1
1984	Mulroney (Con)	75	50	14	28	11	19		
1988	Mulroney (Con)	57	43	28	32	15	20	Reform Party[4]	
1993	Chrétien (Lib)	1	16	60	41	3	7	18	19
1997	Chrétien (Lib)	7	11	51	38	7	19	20	19
2000	Chrétien (Lib)	4	12	57	41	4	9	22	26

Sources: Thorburn 1991; Clarke et al. 1996; Elections Canada Online 2003a and 2003b

The other main political party in Canada at the time, the Conservative Party, promoted a blend of toryism and economic liberalism leading up to and following World War I. While it too favoured some form of social policy and welfare state, it did so for different reasons – social policy was a means to maintaining social order rather than a necessary condition for individual freedom (Campbell and Christian 1996). However, burdened by the difficulties of governing during times of war and economic depression, the party faced a great deal of internal turmoil and conflict, and experienced the wrath of voters in the 1935 election, when it was thrown from office (see Table 5.1). Prime Minister R. B. Bennett's version of America's New Deal had tried to embrace the discourse of welfare liberalism but was rejected both at the polls and by some members of his own party. Following Bennett, the party had numerous leaders and "struggled to find its way ideologically." (Bickerton, Gagnon and Smith 1999: 32; Campbell and Christian 1996). It remained a fractured and largely

[4] The Reform Party became the Canadian Reform Conservative Alliance in 2000, which in turn joined with the Progressive Conservative Party of Canada to form the Conservative Party of Canada in 2003.

ineffective opposition party during more than two decades of Liberal rule, which ended with the 1957 election.

The election of John Diefenbaker to lead the Conservatives (now known as the Progressive Conservative Party, or PCs) and, shortly afterward the country, rather paradoxically only magnified the lack of ideological direction within the party. Diefenbaker's leadership rested less on his ideology, which more often than not was inconsistent with the conservative tradition of business liberalism, than on his populism (Campbell and Christian 1996). For instance, he supported social reform and his government implemented hospital and diagnostic services insurance programs that were legislated by the Liberal government, but he seemed reluctant to expand the program to include medical care insurance. Instead in June 1961, under pressure from the Canadian Medical Association, the Prime Minister appointed the Royal Commission on Health Services (RCHS) to investigate the issues. Taylor (1987: 335) notes: "By his decision [to appoint the RCHS], the prime minister may well have assumed that he had removed the issue of health insurance from his active agenda for the next three years." However, by the time the Commission reported, the Conservatives had been elected out of office and replaced once again by the Liberals. It was not until Brian Mulroney entered the scene as party leader in the early 1980s that the Conservatives were able to regroup and pose an effective challenge to Liberal dominance.

Under Mulroney, the Conservative Party advocated a neo-conservatism in the style of its contemporaries led by Reagan in the U.S. and Thatcher in Britain. But, typical of Canadian brokerage style politics, the party did not wish to alienate voters by adhering to a narrow ideological path. Instead, Mulroney and his party engaged in an instrumental discourse regarding health care, describing it as part of a 'social trust', while at the same time advocating fiscal conservatism to protect that trust (O'Neill 1996). In two terms in office, notwithstanding attempts to reduce overall government expenditures, the Conservatives did little to actively challenge the dominant health policy paradigm (O'Neill 1996).

The electoral dynamic between the Liberals and Conservatives, particularly in the immediate post-war era, was profoundly influenced by the CCF, which has been Canada's most successful and enduring social democratic party. It was created in 1933 as an alliance of trade unions, small socialist parties, agrarian protest movements, women's groups, and the Social Gospel (Bickerton, Gagnon and Smith 1999). As a federation of disparate groups, it embraced a number of often competing ideologies and policy objectives including, among other things, social insurance and socialized health services. It was not until the prosperous post-war era that the CCF gained a

more defined purpose and greater electoral success. Its emphasis shifted from the overthrow of capitalism to "a new kind of reformism which proposed to modify capitalism only as much as was necessary to achieve welfare goals for the population. The essential tool for implementation of these reforms was the state" (Brodie and Jenson 1991: 202).

This more moderated vision for society, along with the formal endorsement of organized labour, helped the CCF make substantial gains in popular opinion polls. In 1943, the CCF marginally surpassed both the Liberal and Conservative parties in popular support. By the mid-1940s, the CCF had succeeded in winning provincial elections in Saskatchewan, where it was led by the legendary Tommy Douglas, and in gaining official opposition status in British Columbia and Ontario. Although it failed to translate this popularity into gaining federal office, the party's robust showing the polls posed a tangible electoral threat to the governing Liberals.

Canadian labour organizations had long been advocating for a publicly funded health insurance program and decided to formally endorse and collaborate with the CCF. As a result, the federal CCF was reborn and renamed the New Democratic Party (NDP) in 1961, with Tommy Douglas as its leader. The NDP continued to have more electoral success provincially than federally, especially in the west where it has formed governments at various points in Manitoba, Saskatchewan and British Columbia. Nevertheless, Maioni (1998: 158) argues that "the CCF-NDP's presence forced the major parties, at both the provincial and federal levels, to recognize the potential of the labor vote, and it gave Canadian labor significant leverage on the political agenda for health reform." Maioni (1998: 161) concludes that "the conflict around the control of the health agenda was profoundly affected by the existence of a third party of the Left. At every stage in the health insurance debate in Canada, reform initiatives by both federal and provincial leaders were influenced by this social-democratic force."

Alberta: Medicare in a One-Party State

Single party dominance has characterized Alberta politics for much of the province's history (See Table 5.2). What makes Alberta unique in Canadian politics is not the enduring tenure of a particular party but rather the relative weakness of opposition parties in the provincial legislature. In eighteen general elections between 1935 and 2001, only twice has a party other than the winning party won more than 30% of the total number of seats in the legislature. In almost all cases, the winning party has won with a sizable majority (i.e., well over 60% of seats). In addition to the distortions created by the electoral system, a heavy rural bias in the allocation of legislative seats has favoured parties in power – Social Credit and Conservative governments received their strongest support from rural constituencies, in contrast with the opposition

Liberals and CCF/NDP, who drew their support from large urban centres (Dyck 1996; Smith 2001).[5]

Table 5.2: Election Results, Alberta 1935 – 2001 (Selected Parties)

Year	Premier	Conservative		Liberal		CCF/NDP		Social Credit	
		% Seats	% Vote	% Seats	% Vote	% Seats	% Vote	% Seats	% Vote
1935	Aberhart (SC)	3	7	8	23	---	---	89	54
1940	Aberhart (SC)	---	---	2	1	0	11	63	43
1944	Manning (SC)	---	---	---	---	3	25	85	52
1948	Manning (SC)	---	---	4	18	4	19	89	56
1952	Manning (SC)	3	4	7	22	3	14	85	56
1955	Manning (SC)	5	9	25	31	3	8	61	46
1959	Manning (SC)	2	24	2	14	0	4	94	56
1963	Manning (SC)	0	13	3	20	0	10	95	55
1967	Manning (SC)	9	26	5	11	0	16	85	45
1971	Lougheed (PC)	65	47	0	1	1	11	33	41
1975	Lougheed (PC)	92	63	0	5	1	13	5	18
1979	Lougheed (PC)	94	57	0	6	1	16	5	20
1982	Lougheed (PC)	95	62	0	2	3	19	0	1
1986	Getty (PC)	73	51	5	12	19	29	---	---
1989	Getty (PC)	71	44	10	29	19	27	0	0
1993	Klein (PC)	61	44	39	40	0	11	0	2
1997	Klein (PC)	76	51	22	33	2	9	0	7
2001	Klein (PC)	89	61	8	27	2	8	0	0

Sources: From Caldarola 1979; Elections Alberta 2003; '---' indicates that no candidates were nominated for this election

Alberta's Social Credit party was founded by William ("Bible Bill") Aberhart, and within months went on to resoundingly defeat the United Farmers of Alberta (UFA) government in the 1935 provincial election. Social Credit was a "confederation of loosely connected study groups, largely composed of workers, farmers, and not especially successful small businessmen, united only by a common disillusionment with existing political organization and support for the basic Aberhart proposals" (Finkel 1989: 39). Aberhart, who was a fundamentalist lay preacher with a very popular bible hour radio program, also preached a populist 'secular gospel' promising to reform the monetary and financial systems of the province which, coming in the throes of the Depression, had great popular appeal. Although he was largely thwarted in his economic reform efforts by a string of unfavourable court decisions about the constitutionality of his plans (these decisions were a significant source of federal-provincial tensions that have since grown), Aberhart's government did make progress

[5] Smith (2001: 285) notes that "in 1955 Calgary and Edmonton had an average of 17,768 and 18,153 electors per MLA respectively, versus 7,411 electors per MLA in the rest of the province...a bias that has since been attenuated but not eliminated."

on a number of social policy issues, including health care. The number of hospital beds was increased and programs were established to provide free medical care for pensioners, and for tuberculosis, cancer, polio and maternity patients. The government also subsidized a number of municipal health insurance schemes that included hospital care, dental benefits and pharmaceuticals (Caldarola 1979; Finkel 1989).

Social Credit after Aberhart became much less radical and populist. Under the leadership of Ernest Manning, who succeeded Aberhart in 1943, "Social Credit quickly abandoned its populist roots, and became the most purely business liberal government ever to govern a Canadian province" (Campbell and Christian 1996:201). The Manning government resisted implementing the federal government's compulsory health insurance programs, arguing that they discriminated "'against a system designed to minimize the abuse of hospital services and reduce the aggregate cost to the two levels of government.'" (Premier Ernest Manning, as cited by Finkel 1989: 149-50). Manning instead promoted discourse that gave primacy to market principles such as free choice and individual responsibility:

> Mr. Manning stated that in his view the principles of universal compulsory application are unsound in a free society. He maintained that an individual should have the right to decide the manner in which he received medical care and he considered compulsory universal application as a violation of this principle... He believed that society collectively should be responsible for bringing the costs within reach of the individual but the state's responsibility should be limited to this... (Minutes of federal-provincial conference, July 1965, as cited by Finkel 1989: 150).

With the support of the medical and health insurance lobbies, Alberta implemented a system dominated by private insurance plans, with government subsidies only for certain low-income groups within the population. This system – dubbed "Manningcare" – was widely criticized since only a minority of those eligible for subsidies were actually subsidized, while wealthy farmers were able to qualify for subsidies by taking advantage of favourable tax loopholes (Taylor 1987). The national medical care insurance program was implemented despite the protests of the Alberta government, including the minister of health, who resigned in protest against the federal proposals. The province acceded to the federal Medical Care Act only after Manning's resignation, and only because of the federal government's "political blackmail" in offering a program that was popular with Albertans but so ideologically distasteful to their government.

Subsequent governments in Alberta, both Social Credit and Conservative (the latter took office in 1971), did very little to change Medicare or other social programs. Throughout the 1970s, oil and gas revenues ensured the province's prosperity and

overall social spending continued to rise, with Alberta topping the list of Canadian provinces both with respect to lowest taxes and highest overall per capita public spending (McMillan 1996; Smith 2001). By the mid 1980s, however, provincial fortunes took a sharp dive as the petroleum and agricultural industries on which the economy depended were struggling and unemployment rates rose sharply. The government initiated a series of reductions in social program spending, with the result that it had the lowest rate of growth in public spending of all provinces between 1986 and 1992 (Smith 2001: 290). As the economic situation worsened, so did the political fortunes of the government. Plagued by labour unrest and a population disgruntled by rising taxes and high unemployment, the Conservative government was only able to capture 44% of the popular vote in the 1989 election. The Liberals and NDP each garnered almost 30%, but the Conservatives returned again with a majority government. It was in this political and economic climate that Ralph Klein became premier and a significant shift in the political environment of the province occurred.

From the beginning, Klein established a strongly ideological and populist discourse to distance himself from the profligacy and unpopularity of the previous government. The "Klein Revolution" emphasized economic conservatism, openly challenged the role of government in society and initiated a massive withdrawal of the state from the everyday lives of its citizens. This withdrawal is most apparent in large reductions in government spending on various social programs, including health, education and welfare. Between 1993 and 1997, real per capita government expenditures in Alberta were reduced by one third (Bruce, Kneebone and McKenzie 1997). In health care alone, per capita spending in real dollars fell by 27%. This remarkable achievement "demonstrates that few if any other systems in the Western industrialized world can match the cost-controlling abilities of a Canadian province operating within the confines of the national Medicare Act once the province has developed the political intestinal fortitude required to reduce health care costs markedly" (Plain 1997: 291). Despite such demonstrable fortitude and ideological commitment, not to mention institutional capacity, in virtually all other aspects of its agenda, the Klein government rather surprisingly backed away from its challenge of the principles of the Canada Health Act. This failure will be explored in more detail in the next chapter.

Political Institutions and the Concentration of Power

This review of parliamentary and party politics in Canada and Alberta suggests that these institutional arrangements not only were not an obstacle to significant policy change, but that they also left considerable scope for such change. The provincial political executive has a considerable degree of autonomy and capacity to act in the health arena since the concentration of authority in the executive is virtually

unchecked in the parliamentary system, except in rare instances of minority government. As a result, electoral politics and political parties are the primary sources of challenge to the power of the governing party.

In federal politics, the three-party system that dominated the post-war era was a crucial factor in the implementation of a national Medicare program. The CCF-NDP actively promoted the idea of national health insurance and garnered the support of key groups, including organized labour. With this support, the CCF-NDP was able to pose a credible electoral threat to the governing Liberal Party, forcing the Liberals to act on their earlier promises of a national system of health insurance.

The Social Credit and Progressive Conservative parties have dominated Alberta's single-party system for more than 65 years. Both of these parties have promoted a conservative economic agenda that favoured trickle-down economics and a residual role for the state in social provision. Although the government acceded to national Medicare programs, it was with great reluctance and resentment that the federal government had politically blackmailed Alberta. In contrast to the federal situation, opposition parties had virtually no effect on the decisions of the Alberta government since they posed no credible electoral threat. The consequence of Alberta's single-party system, which remains in place to this day, is that the power of the executive is effectively uncontested.

Canadian Federalism and the Division of Powers

Since its formation in the nineteenth century, Canada's federal system has evolved from a highly centralized to one of the most decentralized federations in the world today. The Constitution Act 1867 created two orders of government, federal and provincial, granting the federal government the powers of reservation and disallowance as the 'senior' government. The more significant powers at the time, such as taxation, international trade and defense, were also given to the federal government, with provincial governments having jurisdiction over what were considered smaller and more local spheres, such as natural resources, health and social policy. However, over time the balance of power has shifted from the federal to provincial governments. Federal powers of disallowance and reservation have fallen into disuse, and the so-called 'local' issues, such as natural resource royalties, property and civil rights and social matters have demanded an increasing proportion of the attention and finances of government.

The interaction of two sets of relatively autonomous political actors creates a number of different policy dynamics that have profoundly affected health policy development over time. In the immediate post-war era, intergovernmental relations were generally cooperative. Policy dynamics were characterized by independent policy innovations

within the provinces with diffusion across all provinces facilitated by the spending power of the federal government. However, in the late 1960s, the dynamic became more competitive, characterized by competitive state building and policy preemption in different policy spheres (Pierson 1995: 459; Weaver 1986). Students of federalism argue that the dilemmas of shared decision making, particularly with two relatively autonomous orders of government, tend to result in satisficing rather than optimal policy outcomes; a preoccupation with institutional and jurisdictional protections more than actual policy content; and to opting-out or unilateral action rather than collaboration (Pierson 1995: 462; Richards 1998; Scharpf 1988). Thus, at the intergovernmental interface, jurisdictional dilemmas "in general...produce policy outputs such as might have been expected from a large coalition government." (Tuohy 1989:143).

In the health sector, the policy dynamics of federalism since the late 1960s have indeed appeared to constrain the capacity for coordinated policy change (G. Gray 1991; Maioni 1998; Tuohy 1999). The division of powers in Canadian federalism has resulted in

> a system of parallel rather than interlocking governments, with each government asserting the right of unilateral action in its separate jurisdiction...The wide scope for unilateral action arising from the way powers are divided in the constitution provides the conditions for the aggressive unilateralism and 'thrust and riposte' that characterizes much of the recent history of Canadian intergovernmental relations. In these conflicts, the rules themselves have been high on the political agenda (Painter, as cited in Pierson 1995:464).

However, despite their demonstrated institutional capacity and constitutional authority for unilateral action in Medicare, provincial governments have been reluctant to directly challenge or violate the principles of the Canada Health Act. This is surprising because the Act "does not purport to legally bind provincial governments. Rather, it binds the federal government by defining the conditions that must be met for federal payments to the provinces to be legal" (Choudhry 2001:41). In fact, Supreme Court jurisprudence suggests that, given the division of powers, direct federal regulation of health insurance would be unconstitutional. Instead, federal intervention in health care can only come about through the use of its spending power – that is, by spending "monies in areas of provincial jurisdiction by making transfer payments to provinces, and by attaching conditions to those funds." (Choudhry 2001:41).

The federal spending power was a critical factor in the diffusion of Medicare across the provinces but less of a factor in establishing the parameters for such a program in

the first place, as will be demonstrated in the next section. Rather, it was provincial governments that provided the innovation and the impetus for universal health insurance. Since intergovernmental relations during this period were co-operative and consensual, the pursuit of a national system of health insurance was facilitated with federal financial support. However, as a subsequent section of this chapter will demonstrate, the reverse is not necessarily true: the federal spending power is not and need not be a brake on the retrenchment of those same programs in more recent times. In the late 1970s, intergovernmental relations became much more competitive and confrontational, particularly in the health arena. In this climate, unilateral action by both orders of government, but particularly the federal government, was the norm. The federal government initiated a succession of freezes and reductions in transfers to the provinces for health and other social programs, opening the door for some provinces to threaten to break away from the federal conditions articulated in the Canada Health Act.

The following sections will explore these developments in Canadian federalism and health policy, with a particular focus on the relationship between Alberta and the federal government.

Cooperative Federalism and the Genesis of Canadian Medicare

An era of cooperative federalism following the immediate post-war period gave birth to Medicare through conditional, shared cost programs for hospital construction, hospital and diagnostic care, and finally, medical care. Although relations between the two orders of government were typically acrimonious, they nevertheless reflected a problem solving decision style based on trust, shared interests and broadly common goals (Dupré 1985). The motivations for entering into negotiations for a national program were different for each government, but they shared a truth-seeking discourse in which their common objectives were to address inequities in the burden of illness both between individuals as well as provinces, and smooth Canada's transition to an industrial economy (Banting 1987; Simeon 2002). Both orders of government were also subject to political pressure from their respective constituencies and political opponents, many of whom expected and advocated for a stronger role for government in social provision (Banting 1987; Maioni 1995; Taylor 1987). "In effect, pan-Canadian social policy seemed to rest on a pan-Canadian consensus on the social role of the state" (Banting 1998: 59).

After World War II, the federal government established a system of National Health Grants – conditional grants for a range of health services, research, training and hospital construction (Taylor 1987). The grants were welcomed by provincial governments and generally viewed as the first stage of a broader national program of health insurance, and cemented the *de facto* interdependence between two orders of

government. Following this initial burst of activity, the federal government's commitment to a national health insurance program wavered with the retirement of Prime Minister King. His successor, Louis St. Laurent, preferred a 'free enterprise' approach. Instead, it was provincial governments, notably Saskatchewan, which made substantial progress toward public health insurance.

In 1947, Saskatchewan's CCF government introduced publicly funded hospital insurance for all its residents, which later served as a model for governments across the country. As Premier Douglas observed, "We had to demonstrate the feasibility of the Plan before the Dominion-Provincial Conference if we were ever going to get federal participation" (as cited in Taylor 1987:80). Saskatchewan's innovation was followed in 1948 by a similar program in British Columbia. Alberta's Social Credit government phased in subsidies for municipal hospital plans, beginning in 1949, which covered about 75% of its population. Newfoundland also had a publicly financed cottage hospital system covering about half its population. Finally, under strong pressure from a number of provincial governments, particularly Ontario, and following extensive intergovernmental negotiation, the federal government introduced the national Hospital Insurance and Diagnostic Services Act (HIDSA) in 1957, which provided conditional grants for the program to be implemented across the country.

In 1962, Saskatchewan was again the policy innovator in establishing publicly financed medical care insurance for physicians' services. By 1966, under pressure from the NDP in opposition and a number of provincial governments, the federal government legislated the Medical Care Act (MCA). The Act facilitated the diffusion of Saskatchewan's program across the country with an offer of shared-cost financing to any province that had a publicly administered, portable, comprehensive and universal medical insurance program. Unlike the HIDSA, however, the MCA was legislated over the strong protests of a number of groups, including three key provincial governments – Quebec, Ontario and Alberta. Taylor (1987: 355) notes there was "growing opposition to 'shared-cost' programs... [I]t was the imposed conditions that, it was claimed, eroded provincial autonomy and distorted priorities, that had become increasingly repugnant to the provinces." Alberta's long-standing Minister of Health resigned in protest against the new national program, and Ontario's premier, John Robarts, characterized Medicare as "a glowing example of a Machiavellian scheme that is in my humble opinion one of the greatest political frauds that has been perpetrated on the people of this country" (Robarts, as quoted in Taylor 1987: 375). Thus, the second phase of Medicare came at the price of cordial intergovernmental relations, and marked an important shift toward a more competitive, distrustful dynamic between the two orders of government.

Competitive Federalism: Provincial Priorities versus National Principles

As Keith Banting (1995:270) notes, "the welfare state has long been recognized as an instrument of social integration, capable of mediating conflict and preserving stability in divided societies." The federal government used social policy, especially health care programs, to create a pan-Canadian identity and constituency that transcended territorially circumscribed economic, cultural and linguistic cleavages of Canadian society. "[T]he core of the citizenship regime was a strong and active federal government, providing and protecting the social rights of individuals and the culture of Canada" (Jensen 1997:636). This regime was premised on the idea that "Canadian citizens should have similar social rights and obligations regardless of the province in which they live." (Lazar and McIntosh 1998:7; Banting 1998; Mhatre and Deber 1992; Redden 2002).

In the late 1960s, provincial governments began to challenge the legitimacy of both the notion of a pan-Canadian identity and the federal government's role in the federation. Chafing against what they perceived as federal interference, a number of governments, particularly Quebec and Alberta, argued in favour of the 'federal principle'.[6] Since confederation, successive Alberta governments had periodically clashed with Ottawa on a range of issues, including economic policy, natural resource ownership and royalties, and the federal spending power (Gibbins 1992; Meekison 1992; Russell 1990). Moreover, weak intrastate mechanisms for federal-provincial accommodation, including the fact that historically Alberta elected very few members of parliament from the governing party, gave credence to the feelings of Albertans that they were marginalised members of the federation. As a result, "federal-provincial conflict and regional conflict between Alberta and the national community have both dominated and distorted political life within the province" (Gibbins 1985:128).

In 1971, a new 'economic provincialism', fueled by the prosperity of the energy boom, emerged under the leadership of a revitalized Conservative Party in Alberta. Upon taking office, the new premier vowed to strengthen the province's position and role in the federation. Gibbins (1992: 72) argues that "Alberta's constitutional objectives in the 1970s were primarily defensive in character," aimed at expanding provincial control over and reducing federal intrusion into provincial jurisdiction. Alberta led the provincial charge in subsequent constitutional negotiations to ensure greater provincial autonomy in key policy areas, including natural resources and economic policy.

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[6] The federal principle is defined as "'the method of dividing powers so that the general and regional governments are each, within a sphere, co-ordinate and independent.'" Thus "federalism represents a system of government 'under which the ordinary powers of sovereignty are elaborately divided between the common or national government and the separate states.'"(A.V. Dicey, as cited in Telford 1999:6)

Alberta's and Quebec's challenges to the nature of the federal political community and 'national' policy goals shifted federal-provincial relations toward a more competitive and discordant dynamic, which played out in a number of policy areas, including health care. The 1970s and 1980s brought rapidly rising health care costs coupled with fiscal constraints, placing pressure on both orders of government to contain their expenditures. In 1977, the provinces and federal government agreed to renegotiate the federal shared cost commitment to health and social programs. In place of the original cost-sharing arrangement in which the federal government contributed 50 cents for every dollar spent on health care by provincial governments, the new Established Programs Financing (EPF) system transferred tax points and block grants to the provinces for health programs. Initially, the EPF appeared to ease some of the intergovernmental tensions. It

> removed Ottawa's intervention [into provincial jurisdiction] and the distortion of provincial priorities that the provinces saw as an aggravating property of earlier arrangements. From Ottawa's perspective, the main advantage of EPF was that a large federal spending program was no longer tied to provincial decisions and therefore beyond the control of the federal government (Malsove and Rubashewsky 1986:104).

In fact, Taylor (1987: 435) argues that the "EPF...represented the most massive transfer of revenues (and therefore the substance of power) from the federal to the provincial governments in Canadian history."

The satisfaction with the new arrangements was short-lived, particularly on the part of the federal government. In addition to fiscal considerations (namely, that the provinces were receiving more money than they would have under the old arrangements; see Brown 1986), the federal government was dissatisfied with its reduced visibility to most Canadians. Ottawa "felt that it was not receiving any political credit or recognition for the very large level of funding it was providing." (Maslove and Rubashewsky 1986:108). Moreover, it accused provincial governments of reneging on the agreement by diverting funds to non-health care programs and eroding Medicare by tacitly allowing user charges. As health costs increased and fiscal pressures on governments mounted, provincial governments accused the federal government of underfunding the system, thereby necessitating extra-billing and patient charges. They charged that Ottawa no longer had the moral authority to enforce national standards or program conditions (Taylor 1986:19).

The federal government commissioned two high-profile federal review exercises to investigate these allegations. Both found that provinces were not diverting health care

monies, but also that increasingly prevalent extra-billing and patient charges were contrary to the principles of the national programs. One report concluded that "the proper role for the federal government, in consultation with provincial governments, is the formulation, monitoring and enforcement of conditions on its financial support of provincial programs..." (Canada, Task Force on Federal Provincial Fiscal Relations 1981: 115). Ottawa responded to these findings by introducing the Canada Health Act, despite the opposition of virtually every provincial government in the country. The Act enshrined the principles of Medicare and gave the federal government the financial leverage to impose them on the provinces. Adams (2001:76-77) observes that "the passage of the Canada Health Act could be described more as a political flag-raising event than a unique moment in Canadian health history...," because it "allow[ed] the federal government to claim a trusteeship role of the health system on behalf of Canadians at no financial cost to itself. But there was nonetheless a price – a political one. This arrogant act did provoke much intergovernmental conflict that has lasted for a generation."

Apart from fracturing effects of regionalism and nationalism, the post-war citizenship regime was also challenged by a shift in the ideological consensus about the role of the state. Banting (1997: 52) argues that "throughout the postwar era, the federal government played a critical role in forging an ideological compromise among provincial governments on the main directions of social policy." However, the 1980s ushered in a decisive political shift to the right in governments around the world and move towards monetarist macro-economic orthodoxy. Canada was no exception. At the federal level, the Progressive Conservative Party came back into power after almost two decades in opposition, and a number of provinces also turned to conservative governments, marking the end of the postwar ideological compromise. Maioni and Smith (2004: 299) suggest that "the popularity of some programs, particularly health care, initially placed electoral limits on the open advocacy of social policy retrenchment. Nonetheless, successive federal governments found less visible ways to carry out social policy retrenchment in what has been called the 'politics of stealth'." Relying primarily on reductions in transfers to the provinces, successive federal governments reduced their financial commitments to Medicare and other social programs. By the early 1990s, it was projected that the cash transfers for Medicare would fall to zero within the decade and the federal government would have no spending power left to enforce the conditions of the Canada Health Act. Rather than mollifying provincial governments with additional funds or agreeing to relax the conditions, the federal government further inflamed intergovernmental tensions by declaring it would continue to have a presence in Medicare, regardless of the size of the transfers.

This 'politics of fragmentation' was intensified during this period as a result of protracted, bitter, and ultimately failed debates about constitutional reform. Calls for

decentralization and greater provincial autonomy came from each region of the country, and coupled with the fiscal problems of deep recession, seemed to leave virtually no aspect of governance in the federation uncontested. The mid-1990s marked the nadir of Canada's political and economic crises, creating a climate of uncertainty and upheaval in which a challenge to a weakened federal government's commitment to and authority over Medicare might be expected to meet little or no resistance.

Instead, a change in federal political leadership shifted the political discourse about Medicare back to a focus on the equity and public payment principles. Since it had no jurisdictional authority and dwindling spending power, the federal government relied heavily on rhetorical arguments to resist Alberta's challenging discourse. As the next chapter will demonstrate, it successfully drew upon the deep well of antagonism that other provincial governments and the public had towards what they perceived to be threats to the very foundations of "Medicare as we know it." One set of groups that was not opposed to Alberta's challenge was physicians' associations. However, as the next sections will demonstrate, despite their relative influence in the health sector, physicians' professional associations have been largely unable to effectively shift the Canadian political discourse on health care from its original, dominant paradigm.

Corporatist Relations and Medical Dominance

The prominence of the medical profession in health policy debates is not a phenomenon unique to Canada. The profession has traditionally had a monopoly on the requisite technical expertise and scientific knowledge necessary to govern and manage health care. Over time, this has allowed physicians to become one of the most highly organized and well-resourced interest groups in health politics. However, this monopoly has gradually been attenuated by the development of the state's institutional and bureaucratic capacity to govern and operate the vast medical-industrial complex that constitutes the health care system in most industrialized nations. Moreover, experiences with health reform in recent years have clearly demonstrated that in most countries, including both Canada and Germany, the political power of physicians has been circumscribed as governments struggle to contain health care costs.

"Canadian medicare...rested from its inception in the 1960s on a fundamental accommodation between the medical profession and the state..." (Tuohy 1999: 30). This accommodation may be described as a form of corporatism, in which governments delegated broad discretionary authority to the medical profession to police its own ranks by regulating the scope of practice of licensees, establishing codes

of ethics for practitioners, and setting fee structures for its members. In exchange, governments limited (but did not eliminate) the entrepreneurial discretion of physicians by demanding negotiated provincial fee structures and, perhaps more significantly, excluded physicians from setting the terms of health insurance programs. Individual physicians continued to have the freedom to work in their choice of location, select their own patients and types of practice, as well as to bill patients over and above the established fees (Tuohy 1976a). This accommodation between the medical profession and government was premised on two grounds: the dominance of the biomedical model of health and illness, and the need for a political compromise to implement a publicly funded system.

The biomedical model that dominates western medicine assigns to the medical profession the role of purveyor of scientific information and arbiter of technical authority about health and illness. "As science has risen to a privileged status in the hierarchy of persuasive belief, its institutionally validated interpreters – notably physicians, who are its emissaries in the most personal matters of physical and mental health – have developed stronger claims to authority, not only in scientific and clinical matters but also over the social and political relations surrounding them." (Starr and Immergut 1987:224). Moreover, at the level of individual patients, physicians "serve as intermediaries between science and private experience, interpreting personal troubles in the abstract language of scientific knowledge"(Paul Starr, as quoted by Moran 1999:100).

The biomedical model confers not only professional legitimacy and authority, but also the political power to influence health policy making, which is "strengthened by the legally supported monopoly over practice that it has enjoyed for most of [the last] century" (Lewis 1999: 158). Professional autonomy of physicians is premised on their technical authority over the science and practice of medicine. However, Naylor (1986) makes the point that technical autonomy can, and has been, checked by indirect constraints related to economic incentives and resource availability:

> These links between technical and socio-economic matters not only heighten professional concern over third party mediation in the medical services marketplace; they also provide organized medicine with an important weapon in political battles to ensure that intervention by the state or other agencies occurs in patterns salutary to professional status, incomes and working conditions. Disputes over remuneration can, for instance, be turned into crusades for better-quality care... (Naylor 1986:13).

Medical associations have often appealed to these arguments in attempting to broaden public support for their opposition to greater state intervention in medical billing and remuneration policies. They have also lobbied government officials, although such the effects of lobbying have had only limited success in Canada's Westminster system

(Naylor 1986). They have withdrawn services and engaged in public relations campaigns in an effort to pressure governments. Strikes by physicians in Saskatchewan, Ontario and Quebec, and the vocal opposition of physicians to the Canada Health Act are some instances in which the profession launched very public campaigns against government policies (Heiber and Deber 1987; Stevenson et al. 1988; Tuohy 1988). Finally, the profession has also frequently formed strategic alliances with other groups – business representative associations, the insurance industry and others to further its entrepreneurial efforts (Naylor 1986; Taylor 1987).

Despite their capacity for strong legislative action, governments in the 1950s and 1960s had neither the technical expertise nor bureaucratic capacity to manage a state-run system without the cooperation of the medical profession. Physicians, in contrast, had well-established private practices scattered throughout each community across the country. Furthermore, a legacy of the early failures to implement a national insurance program was the widespread proliferation of private insurance plans, many of which were owned and administered by physicians. The success of these private plans and practices created a path dependency effect, and served to limit the scope of organizational alternatives for financing and service delivery. In the end, governments chose to use the insurance model and simply underwrite the costs of medical and hospital care, but leave the private delivery system virtually untouched (Hacker 1998; Tuohy 1992).

The 'private practice, public payment' compromise underpins the structure of the Canadian health care system even today. It has had profound impact on relations between the profession, government and other health provider groups. Firstly, the compromise ensured that most other groups were implicitly excluded from the policy network governing health – third-party payers were effectively shut out, and the scopes of practice of other provider groups remained subject to the control of the medical profession (Coburn 1993; Tuohy 1999). For example, 'medically necessary' services that must be publicly insured under federal legislation are simply defined as any services that *physicians* provide. Secondly, the compromise placed physicians in a position of strength vis à vis government by encouraging them to negotiate the terms and conditions of their work *en masse*. This monopoly power of medical associations to negotiate contracts with government has since become both legalized and institutionalized, ensuring that the profession has significant sway in the structure and management of the health care system.

Coleman and Skogstad (1990:21) propose that in order to become an effective policy participant, an association must be able to "order and coordinate a range of complex information and activity so as to arrive at positions on relatively sophisticated policy

questions. Second...the group must be sufficiently autonomous from members to be able to transcend their short term interests and to take a longer term perspective on policy while still guaranteeing members' compliance." The capacity of medical associations to coordinate activities and information was enhanced substantially with the advent of Medicare, particularly once the provincial associations banded together under the umbrella of the Canadian Medical Association. The ability of the associations' leadership to remain autonomous from their membership has also been gradually strengthened over the years, so that now in most provinces the provincial association has legal authority to negotiate fees on behalf of all its members, and the provincial regulatory college licenses, monitors and regulates the professional practice of all its members. Although there have often been pockets of discontent and even groups that have broken off from the provincial or national association, "common interests welded the overwhelming majority of doctors into a strongly united group." (Naylor 1986:251).

Over time, as health systems expanded in scope and complexity, government bureaucracies also grew in size and expertise. The relationship between the profession and the state began to change as governments became more interventionist than they had in the first decade of Medicare. In part this was motivated by the rapidly rising costs of health care, particularly during the climate of fiscal constraint in the late 1980s and 1990s. Physician services, which comprised about 22% of provincial expenditures on health in 1989, were a natural target for controlling overall health spending (Katz et al. 1997). To contain their expenditures, governments contemplated intervening in areas that had traditionally been left to the discretion of the profession. Instead of directly regulating the types and volumes of services that physicians provided (which would been strongly opposed on grounds of professional autonomy), governments demanded more stringent control of the overall price of medical services. In most provinces, this control came in the controversial form of global caps on physician budgets, leaving associations to determine the manner of the allocation of those budgets amongst their members (Hurley and Card 1996; Katz et al. 1997).

Needless to say that this shift in fortunes soured the generally collegial relationships between the profession and most provincial governments. Katz et al. (1997: 1424-5) note that the profession had "few alternatives [to accepting the budgetary caps imposed by government], since medical associations are politically weaker than provincial governments." Moreover, provincial governments had the support of their publics, who showed "little sympathy for physician income disputes." The relationship between individual provincial governments and the profession in these negotiations varied from "Gallic statism" in Quebec to adversarial collective bargaining in British Columbia, Ontario, Alberta and Manitoba, and in between, "mutual accommodation" in Saskatchewan and the Atlantic provinces (Tuohy 1999).

Until the late 1980s in Alberta, the accommodative relationship between the profession and government had changed little from the days of Premier Manning and his support of the medical association's proposals for limited subsidized private insurance and free enterprise. The profession's right to extra bill patients beyond the provincial fee schedule was defended vigorously by the Alberta government during the Canada Health Act debates. At that time, extra billing was more prevalent in Alberta than any other province and the practice was not restricted to patients who could easily afford to pay, as was required by the professional association. By 1986 Alberta doctors had the highest average income of among all Canadian doctors (Taylor 1987). However, once the Canada Health Act came into effect and the province faced looming deficits, the prospect of an avoidable $36 million penalty from Ottawa was difficult to defend. The province negotiated with the Alberta Medical Association to exchange an increase in fees for an end to extra billing – what Taylor observes was "a quiet and surprising ending to a long and firmly held policy position" (Taylor 1987: 462). As the state of provincial finances continued to deteriorate, the Alberta government imposed deeper cuts on health care budgets and further alienated the profession by bypassing negotiations and breaking prior fee agreements (Katz et al. 1997).

Gradually, however, relationships between the medical profession and provincial governments seemed to converge in the 1990s as governments sought to both "assert their roles more forcefully and also to elaborate the terms of their accommodations with the profession. In this process, both the informal mechanisms of the 'mutual accommodation' model and the more formalized but more narrowly focused mechanisms of the adversarial collective bargaining model began to change." (Tuohy 1999:210). Tuohy contends that the new relationships facilitated greater collaboration between government and the profession, and resulted in the development of formalized 'co-management' structures – bipartite or tripartite joint management committees – in most provinces. These structures enabled a number of important cost control measures to be implemented, such as global budgets for physician services, reductions in the supply of physicians, delisting and privatization of some services, and alternative payment mechanisms.

The experiences of the 1990s demonstrate, according to Tuohy (1999: 230), that governments are not unwilling to exercise their legislative power in the face of professional opposition when necessary, but prefer to "establish a 'shadow' within which their negotiations with the profession [will] proceed." In other words, they prefer the quiet accommodation of clientele relations to the adversarial relationships associated with pluralist politics. Moreover, governments tended to rely on blunt

policy instruments (such as budgetary caps) to make adjustments within their health systems, further reinforcing the arms-length relationship between the state and the members of the profession.

Over time, the threat of government's legislative power has attenuated the power and influence of the medical profession. "The profession, fearful of exclusively top-down policy decisions, has remained rhetorically aggressive while becoming progressively more conciliatory in negotiation. It has grudgingly yielded the centre of the policy community to government bureaucracy, and its reluctant acquiescence to its more circumscribed role has encouraged governments to pursue ever more top-down policy directions" (Boase 1996: 298). The Canadian experience does not differ substantially from that in other countries, where similar fiscal imperatives have given governments the necessary leverage to push for health care reform and system restructuring, even over effectively mobilized powerful interests. As Immergut (1992: 41) observes in her comparative study of the political influence of the profession,

> contrary to what is often believed, medical monopoly [based on technical or professional authority] is not a key element in influencing legislative decisions. The exclusive right of doctors to treat patients was off-limits in these debates – and in that sense, professional autonomy was entirely successful ... – but this professional autonomy did not translate into political influence concerning economic aspects of national health insurance.

Summary

This chapter has explored different factors that may account for the lack of policy change in Canadian health policy since the late 1960s. Both institutional and interest-based arguments seem to offer a less than convincing explanations for the inability of the province of Alberta to effectively pursue its challenge to the principles of Medicare in the mid-1990s. The concentration of authority and accountability in Canada's Westminster system of government give the political executive virtually uncontested power to make policy decisions. This concentration was particularly true in Alberta, where the pattern of single-party rule over the past century has weakened the mitigating effects of an electoral veto as a check on executive power.

Similarly, the argument that federalism makes substantive policy change difficult due to intergovernmental interdependence is also contestable. First, the legal constitutional jurisdiction for health care belongs indisputably to the provinces, with the federal role limited to its spending power. Second, unilateral actions by both orders of government have epitomized Canadian Medicare from its very beginnings in Saskatchewan, right through to the passing of the Canada Health Act and subsequent changes in intergovernmental fiscal relations. Although federalism has made collaborative action and intergovernmental consensus difficult, if not impossible, it

has done little to prevent unilateral decisions on the part of a determined government – federal or provincial. Third, as the federal spending power has become more and more circumscribed by virtue of declining transfer payments, the material gains to be obtained through compliance with the conditions of the Canada Health Act have dwindled for a number of provincial governments, including Alberta's. In fact, many political observers have periodically predicted the imminent demise of the national system based on this decline. Finally, the early 1990s were a time of considerable political and economic upheaval in Canada. At that time, faced with constitutional disarray, the threat of Quebec's secession, and of massive deficits and debt, the federal government was arguably at its weakest and most vulnerable state vis à vis the provinces in Canadian history. Alberta, in contrast, had a government that was intensely committed to its own political and fiscal agenda, as well as to a decentralized federation with enhanced provincial autonomy. In this climate, the jurisdictional challenge raised by the privatization of health care might have been expected to pass virtually unnoticed given the larger, more divisive constitutional and economic issues that preoccupied the nation at the time. It did not. Alberta's challenging discourse seemed, on the contrary, to unite governments, interest groups and the populace in opposition to the privatization of Medicare and to incite a renewed emphasis on the need for a federal role in Canada's health policy arena.

Lastly, during the period of retrenchment from the mid 1980s to the 1990s, governments of all political stripes in all provinces managed to undertake health care reforms and substantial expenditure reductions despite the very vocal and public opposition of physicians. Although it may be true that physicians suffered less than their other counterparts in the health care system, governments nevertheless did not shy away from confronting, and when necessary, excluding medical associations in their health policy deliberations.

Given the propitious political and economic climate of the period under study, these institutional and interest explanations do not clearly demonstrate why a challenging discourse posed by government of Alberta failed to have purchase. In the next chapter, we will turn to an alternative set of explanations that explore the policy discourses in which policy actors were engaged. In examining the processes and events leading to Alberta's failed challenge, it will be demonstrated that the privatization discourse lacked certain key elements necessary for a successful shift in Canada's health policy paradigm.

Chapter 6

Reforming Canadian Medicare: Universality versus Residualism

From the birth of Canadian Medicare into the late 1980s, the dominant discourse in Canadian health policy was rhetorical. As outlined in the previous chapter, this discourse focused almost exclusively on the merit of the normative principles of universality and accessibility, and how to better protect and enforce them. Although the institutional arrangements and constellations of interests outlined in Chapter 5 suggest a high likelihood for success of a challenging discourse promoted by a determined provincial government, little change in Canada's dominant health policy paradigm has occurred. In this chapter, an alternative explanation for the stability of the Medicare paradigm will be explored, using the case of the province of Alberta. In this approach, ideas and discourse are the central focus of the analysis.

Perceptions of a deep fiscal crisis in health care hit Canada in the early 1990s. As in Germany, talk of health reform was largely focused on cost-containment initiatives on the supply side: reorganization of system structures to enhance efficiency and effectiveness, and across-the-board reductions in health spending. Although the principles of universality and accessibility in Medicare were not openly questioned, key political and health system actors, particularly in Alberta, made an attempt to shift the policy discourse toward a privatization paradigm. Privatization would involve a greater role for private financing, through patient charges or a parallel private system of health insurance.[1] It would deal with the increasing burden of Medicare on already over-committed government coffers by allowing those who could afford it to seek and pay for health services in the private sector.

This challenging privatization discourse failed to take hold for a number of reasons. First, as we saw in the German case study, a successful challenging discourse must be mounted in a way that does not challenge the core norms or principles of the dominant paradigm, but rather builds on them or offers a better way for realizing them. In contrast to the dominant universalist paradigm in which Canadians have a

[1] In the context of this paper, the term 'privatization' will refer exclusively to the privatization of *financing* for health care through various forms, such as private insurance or direct charges, for services that would otherwise be completely covered by a provincial plan. Also, although the proportion of private expenditure has been increasing relative to public, the vast majority of that increase is for services not covered under the conditions of the CHA. There are various other aspects of the system that can be discussed in the context of privatization, but are not included in this paper. For a full discussion of these issues, see Greg Stoddart and Roberta Labelle, *Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology and Options*. (Ottawa: Health and Welfare Canada, 1985).

right to health care, and health care provision is viewed as a societal responsibility, Alberta's challenging discourse had residulist overtones, based on the normative idea of individual responsibility for health and health care, and a residual role for the state in social provision. The timing of this challenge was also significant. Since it came during a period of intense debate over national unity, the challenge became doubly threatening because Medicare had become a firmly entrenched element of Canadian national identity. Second, in the absence of a broad consensus for change among policy elites, as was the case in Germany, challenging discourses are unlikely to succeed. The Alberta government was censured by other provincial governments and the federal government, as well as health care lobby groups, including providers, for trying to privatize Medicare. Many of these groups were suspicious of the Alberta government's commitment to Medicare, and feared that its privatization proposals were the beginning of the dismantling of the public system. Finally, the proponents of a successful challenging discourse must present a case based on 'facts' that shows their alternative approach will avoid the presumed failures of the dominant paradigm. The Alberta government was unable to demonstrate that overall health expenditures, both public and private, would be better controlled with greater privatization, especially in light of the American evidence. Nor was it able to persuasively argue that the quality of publicly funded services would not decline, or that equal access would not jeopardized.

This chapter will develop this argument in more detail. The next section will describe the dominant Medicare paradigm and analyze the augmentative discourses, both rhetorical and instrumental, that were used to reinforce and justify it throughout the 1980s. It will further demonstrate the broad elite consensus in favour of Medicare and its underlying principles of universality and accessibility. The subsequent section will describe and analyze the development and deployment of Alberta's challenging discourse, examining the particular problem definition espoused by the government and the normative and cognitive elements of the discourse used to make the case for greater privatization in Medicare. In the final section, the reasons for the failure of Alberta's challenging discourse will be discussed.

The Dominant Medicare Paradigm and Federal Augmentative Discourses

In the first two decades of national hospital and medical insurance, provincial health programs grew in size and scope. As the proportion of the population covered by the plans approached 100%, the number of hospitals and providers grew to meet the demand. Furthermore, a number of other related services were added to basic coverage. As a result, health expenditures rose steadily from about 7.1% of GDP in 1970 to 8.7% of GDP in 1985. A significant portion of this increase occurred between 1980 and 1985, during a period of economic recession (Tholl 1994). Although public health insurance programs were not targeted directly for cost savings, provincial

governments accused the federal government of eroding Medicare by capping its health and social transfers to the provinces. A number of provinces had begun tacitly to allow user charges and extra-billing of patients as sources of additional income and means to curb frivolous demand. Ever at the forefront of health care controversies in Canada, the province of Alberta announced in 1983 that it was planning to raise health care premiums, increase existing user fees for patients and levy a new $20 per day charge for hospital care. In addition, the Alberta government did little to rein in extra-billing by physicians, who, contrary to the policies and claims of their professional association, had been charging both low and high-income earners alike for insured services.

The Canada Health Act as Rhetorical Discourse: Medicare and Social Citizenship

In response to the increasing prevalence of patient charges across the country and growing public concern about Medicare, the federal government adopted an aggressively rhetorical discourse to bring provinces in line with the intended principles of the program. The federal discourse successfully shifted the problem definition from one of underfunding within the health care system to one of protecting the very foundations of the system: the normative principles of Medicare, particularly universality. Ottawa denied the existence of an underfunding problem. Instead, it implied that the provinces had simply failed to manage the system effectively and efficiently. Federal Minister of Health Monique Bégin stated that the "current malaise in the health care system is due neither to the overall level of funding nor the size of federal contributions." The more significant issue for the Minister was the economic barrier to care posed by user charges. She noted that

> the small direct charges of the past are now growing and spreading. Medicare as we know it is gradually eroding. Through a cumulation of direct charges on the sick – each one possibly not a big increase in itself – the goal of complete insurance, fully prepaid, is being abandoned (Canada 1983: 31).

Emphasizing the normative principles of Medicare, she declared:

> The Government of Canada believes that a civilised and wealthy nation, such as ours, should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that comes with having prepaid insurance. The misfortune of illness which at some time touches each one of us is burden enough: the costs of care should be borne by society as a whole (Canada 1983: 6).

Although the extent of extra-billing and user charges was rather marginal relative to overall health care expenditures, the issue was taken up as a symbolic one by the federal government. Buoyed by the recommendations of two high-level federal advisory commissions on the issue, Minister Bégin noted that "existing legislation is

not adequate to deal with the problem because it does not clearly tell the provinces, health care providers and the public that direct charges for health services will not be supported" (Canada 1983: 33). She therefore announced that under the terms of new legislation, the Canada Health Act, the government would withhold cash transfers to Alberta and other provinces that permitted practices that violated the principles of Medicare.

In taking the moral high ground as a defender of Medicare, and thus legitimizing its extra-jurisdictional role in health policy, the federal government engaged in an intensive public relations exercise. However, it made no attempt to coordinate or collaborate with provincial governments or the medical profession in formulating the legislation – two of the most influential and antagonistic actors to the Act (Tuohy 1988). Instead, within a period of six months, the Canada Health Act was drafted and passed, most notably with all-party approval in Parliament. The CHA succeeded in further institutionalizing the dominant policy frame and legitimizing the federal government's role in enforcing Medicare's principles.

Provincial governments threatened to challenge the constitutionality of the legislation in the courts and complained bitterly about their relationship with the federal government. Alberta's health minister David Russell suggested that "the erosion of Medicare is a myth... The real threat to Medicare lies in Health Minister Bégin's attempts to pass a punitive and damaging health act that reflects the move away from cooperative federalism to an arbitrary unilateralism that is not in the interests of Canadians" (as quoted in Taylor 1987: 461). Reflecting on provincial dealings with Ottawa, Russell commented that "any small bit of consultation or cooperation (with the provinces) is going to be a gigantic improvement" (Canadian Press 1984). Under the terms of the Act, seven provinces were levied penalties but were given a grace period within which to comply with the federal terms without losing funds.

Alberta vowed to defy the Act and refused to comply. Justifying his opposition, Alberta's premier argued that "the $14 to $20 million the province faces in penalties will be offset 'by about five times that amount' because user fees and extra billing control overutilisation of the system"[2] (as quoted in Rich 1984:1). Alberta's health minister defended the free enterprise rights of physicians, suggesting that "the ability of doctors to set their own fees is a price we as citizens are paying to maintain high quality health care" (as quoted in Rich 1984:1). However, the Premier acknowledged that public support for his government's opposition to the Canada Health Act was weak. He likened introducing Medicare user fees to "an income tax increase. People aren't happy about it..." (Lougheed, quoted in Nelson 1984). In the end, despite their

[2] Taylor (1987) suggests that extra-billing by Alberta physicians had generated an addition $14.5 million to their incomes in 1983. This does not include additional user charges that were levied by hospitals and other clinics.

public posturing, all provinces, including Alberta, complied with the federal deadline for implementing the Canada Health Act.

In the years after it was legislated, provincial governments seemed to resign themselves to the existence of the Canada Health Act. They continued to administer their health insurance plans and expand their health systems with few direct federal intrusions. Public satisfaction with the health system in each province was so high that no government seemed willing to challenge the dominant paradigm that had been so firmly entrenched by the CHA. Intergovernmental tensions continued to build, however, as successive federal administrations unilaterally reduced health and social program transfers to the provinces. Facing mounting deficits and debts, each order of government blamed the other for difficult retrenchment decisions – the provinces blamed the federal government for downloading its problems to them by continuing to reduce transfers, while the federal government accused the provinces of trying to blame their own fiscal and mismanagement problems on Ottawa (Taras and Tupper 1994). Medicare once again rose to prominence on the national political agenda, but this time against the backdrop of constitutional politics.

Medicare and Constitutional Politics as Instrumental Discourse

The 1980s and early 1990s were a period of intense constitutional debate in Canada, dominated by the issue of national unity. Following the repatriation of Canada's Constitution from the United Kingdom in 1982, the increasing momentum of Quebec nationalism and Western regionalism dominated the intergovernmental political agenda. This era of 'megaconstitutional politics' was marked by two failed rounds of intergovernmental negotiations and a national referendum about the nature of the Canadian federation. Among the central and most contentious issues in the negotiations were the division of powers between the federal and provincial governments, and the federal spending powers. There was, however, little consensus among policy elites on the nature of a renewed Canadian federation. On one hand, the government of Quebec demanded full sovereignty over a range of policy areas, including health care. On the other, the federal government and a number of provincial governments seemed reluctant to remove Ottawa's role entirely from the social aspect of the federal union. Some provinces, such as Alberta, seemed to fall somewhere in between, arguing for a renewed federation but leaving out the specifics of what that federation would look like. As will be illustrated in the next section, this lack of consensus spilled over into health politics.

The Conservative federal government, led by Brian Mulroney, used an instrumental discourse to justify a reduced role for the federal government in a number of policy areas, including health. Staking out a middle ground between the separatist and federalist extremes, the government defended the principles of Medicare, but argued

that they could be more effectively achieved by allowing more flexibility at the provincial level. This position was also consistent with the government's election platform, which promised to get Canada's fiscal house back in order by fighting the debt and deficit, lowering taxes and creating jobs. The party had promised to deregulate political life, declaring that Canadians were "overgoverned," and to heal the rift between Ottawa and the provinces by promoting greater flexibility in the federation. When questioned during the election campaign about the role of social programs in this economic platform, Mulroney echoed the dominant rhetorical discourse of social rights and social citizenship, declaring that universal social programs, including Medicare, were a "sacred trust" not to be tampered with. He affirmed "the total and sustained support of the Progressive Conservative Party to this dimension of universality" (Mulroney, as quoted in Ruimy 1984).

However, once in office, the new Conservative government shifted to an instrumental discourse on health and social policies. It attempted to redefine the concept of universality to better accommodate the nation's fiscal situation and the government's economic and political agenda. Prime Minister Mulroney remarked "that universality in Canadian social programs is relative," and that in the context of scarcity, for "a government as close to the poor house as you can get," the objective was to get resources to those most in need. However, he qualified this by saying for some programs, particularly Medicare, "universality, at all times and in every circumstance" was non-negotiable (Mulroney, as quoted in Radwanski 1984). The federal finance minister was more direct in his statements, suggesting that universality was no longer appropriate or affordable. This position was consistent with the government's discourse of economic prosperity as the solution to the problems that plagued the nation. This discourse dominated the government's agenda over the next eight years, and was most evident in its pursuit of free trade arrangements with the United States, interprovincial trade agreements within Canada, and in constitutional negotiations with the provinces.

Beginning with the 1985 federal budget, the government drew on this instrumental discourse to announce a series of adjustments to its policy instruments in the health and social policy areas – that is, the conditional financial transfers to the provinces. The size of the transfers would be capped, and eventually this cap would reduce the cash value of the grants to each province; in some cases, the cash value would be virtually zero. The government's instrumental discourse justified these changes by arguing that the best way to secure social programs for the future was to immediately reduce government spending and tackle the national debt. By 1991, the government declared that taxpayers could no longer afford to continue paying more for health care. Federal Finance Minister Michael Wilson said that "there are going to have to be some changes made [in the Medicare system] because we cannot continue to have a

program grow year in year out at 10 to 12 per cent per annum when the economy is only growing at seven or eight per cent..." (as cited in Canadian Press, 1991a).

However, as is typical of an instrumental discourse, the government did not wish to appear to be challenging or abandoning the normative principles of Medicare. Acknowledging that with the planned reductions in health and social transfer payments to the provinces, the government would eventually lose the fiscal leverage to enforce Canada Health Act standards, Ottawa promised to introduce legislation to protect national standards and universality. In the end, the issue became caught up in constitutional politics and the promised legislation was never introduced. Instead, reacting to broader constitutional matters, the federal health minister put forward the idea of greater flexibility in Medicare and the CHA by permitting different rules from province to province. Although he later backed down from this position, the federal government appeared to have opened the door to renegotiating the Canada Health Act as part of the constitutional debate (Pole 1991).

This issue of flexibility in the federation was critical in constitutional negotiations that were in full swing between 1988 and 1992. The federal government continued with its discourse of economic prosperity and greater flexibility as the means to ensure political stability and social well-being:

> The Constitutional proposals put forward by the government of Canada... focused primarily on those priorities that are necessary to maintain our economic prosperity and genuine economic and personal opportunity for all our people. Our approach to sustaining that prosperity is, first of all, an inherent flexibility in our Canadian federation that allows us to live together and celebrate our differences... (Prime Minister Mulroney 1991b:2).

Therefore, the position of the Mulroney government was that any new constitutional arrangements would have to ensure a stronger economy and smaller government:

> First, any change should lead to a more prosperous Canada. This has been the benchmark of federal economic policy... If it can be demonstrated that a transfer of some federal jurisdictions to the provinces will enhance the prosperity of Canadians, the federal government will not hesitate to agree to it. Second...the federal government will promote constitutional changes that lead to a more efficient federation and a more competitive nation. There are far too many overlapping jurisdictions in this country. Canadians are overgoverned. (Mulroney 1991a:4-5)

The Prime Minister added that certain national standards would need to be maintained, which meant, for example, "that health care must be accessible for all Canadians" (Mulroney 1991a:5). The final text of the 1992 constitutional accord incorporated a social and economic union clause that specified the objectives of such a

union would include "providing throughout Canada a health care system that is comprehensive, universal, portable, publicly administered and accessible." Although at first this seemed to be a rather surprising statement given the intergovernmental rancor over the Canada Health Act, the agreement made explicit that nothing in the social and economic union clause would be justiciable. That is, less stringent and virtually unenforceable 'standards' for Medicare would replace the binding legal 'conditions' for federal funding under the Canada Health Act.

The constitutional accord failed the test of public scrutiny in a national referendum in late 1992. It was criticized and ultimately rejected for many different and often conflicting reasons, and created rather unexpected alliances between disparate groups. On the social policy front, women's groups, health and social service provider groups, social activists and federalists argued that the agreement ceded too much federal authority and power to provincial governments, many of whom had little interest in protecting Canada's social safety net. They further argued that the accord's opt-out clause, which would allow provinces to opt out of new programs but still receive federal funds, would virtually ensure that no new national social programs, such as childcare, would be created (Alberts 1992a). The recently negotiated Canada-US Free Trade Agreement compounded the concerns of health system activists since the trade agreement made policy reversals on private financing and provision of health care services much more difficult, if not impossible. More generally, the negative response to the constitutional proposals was attributed to the lack of trust that Canadians had in their leaders (Clarke and Kornberg 1994). In particular, the Mulroney administration was perceived to be rife with corruption, with a long list of broken promises. The prime minister himself was singled out in public opinion polls, and has since had the ignominious label as the most unpopular leader in Canadian history (B. Jeffrey 1992).

Canada in Crisis: Disunity and Dissension

Against this backdrop of failed constitutional negotiations with the provinces and a discredited federal government, the level of disagreement and dissension about the Canadian social and political union seemed to swell. Health policy became inextricably bound to constitutional politics, as many groups reframed the freeze on transfer payments for Medicare as a betrayal of national unity rather than simply an economic decision. Federal opposition party leaders accused the government of engaging in constitutionalism by stealth – in effect, decentralizing powers to the provinces via fiscal means when political negotiations seemed doomed to fail. The Liberals accused the government of having "killed Medicare,"(Liberal MP Sheila Copps, as quoted in Fraser 1991a), declaring that the "budget dismantles Canada as we know it... Medicare is dead, dead, dead, finished, dead and gone." (Liberal MP Brian Tobin, as quoted in Fraser 1991a). Appealing to the centrality of Medicare in

Canadian national identity, Tobin went on to say that "one of the definitions of being a Canadian, one of the values of Canadian citizenship is the ability to be sick and get first-class medical services no matter where you live in this country...That principle is not only violated...it is destroyed in this budget." (as quoted in Fraser 1991b). Similarly, federal NDP leader Audrey McLaughlin pointedly asked, "[h]ow can the Prime Minister seriously talk of national unity when this budget helps to destroy medicare?" (cited in Fraser 1991b).

In Quebec, the budget and Ottawa's plans to continue enforcement of the CHA were viewed as symptomatic of the larger problems with Canadian federalism. Quebec's Health and Social Services Minister warned that Ottawa was "definitely feeding arguments to those who have separatist ambitions... [The budget] is a clear demonstration that a major constitutional reform is needed..." (Côté, as cited in Séguin & Mickleburgh 1991). The Quebec government protested that not only did Ottawa have no constitutional jurisdiction to enforce the national standards of the CHA, but also that it had failed to honour its commitment to assist the provinces in adequately financing the system. Quebec had already announced a pilot proposal to allow hospitals to charge some patients a $5 fee for visits to hospital emergency rooms as a means to control health care costs. When federal health officials protested, Quebec's intergovernmental affairs minister, Gil Rémilliard, advised Ottawa to "mind its own business" and not interfere with provincial plans (Séguin 1990).

Reaction from most provincial governments was more muted, particularly on the national unity front. Most, however, acknowledged the link between Medicare and the national unity file, as expressed by Alberta's minister of health: "I look at the health system as a Canada value, something that sets us apart in many ways and links into a whole bunch of other things, including the Constitution and the national unity discussions that are under way" (Alberta Health Minister Nancy Betkowski, as quoted in Canadian Press 1992a). Some governments, including Alberta's, interpreted the transfer reductions as evidence that the federal government was "moving closer to our position," which involved giving "the responsibility and the funding to the province, and let the province do the job" (Alberta Treasurer Dick Johnston, as quoted in Geddes 1991a). Others were more critical, denouncing the federal government for downloading its fiscal and economic burdens onto provincial coffers and suggesting that the reductions in transfers would make it difficult for them to maintain national standards for health and social programs (Allen & Seguin 1991). For example, New Brunswick finance minister Allan Mahar said that "we've started down the road to the end of Medicare in Canada as we know it, unless the federal government is prepared to sit down and talk with the provinces and find a way to resolve the problem" (as cited in Canadian Press, 1991a).

Societal groups expressed the concern that reductions in transfer payments to the provinces would effectively abolish any role for the federal government in enforcing the principles of Medicare, and lead to an erosion of those principles across the country. This view was put forward by the Health Action Lobby, or HEAL, which represented the key national umbrella organisations of provider groups, including the Canadian Medical Association, the Canadian Nurses Association, the Canadian Hospital Association, the Canadian Public Health Association, the Canadian Long Term Care Association, as well as the Consumers' Association of Canada (Thompson 1991). The director of the Canadian Health Coalition, another umbrella group including representatives from labour, seniors, women, students, consumers and health care providers, said the Conservatives "are going to kill [Medicare] off even quicker than we thought" (as cited in Séguin & Mickleburgh 1991). The National Council of Welfare echoed these concerns to the federal government (National Council of Welfare 1991). The presidents of the Canadian Medical Association and the Canadian Hospitals Association both suggested that the reductions in transfers were "strangling medicare" (as cited in Séguin & Mickleburgh 1991), forcing the question, "'Can we afford universal access?'"(as cited in Ramsey 1991).

The failure of intergovernmental negotiations to resolve issues related to the constitution and the federal social and economic union created a sense of political crisis, both in terms of national unity as well as the future of Medicare. The degree of dissension amongst political elites rose in public debate and spawned two new national political entities. First, it gave rise to the nationalist Bloc Québécois Party (BQ), which had Quebec statehood as its mandate. The BQ won two-thirds of the seats from Quebec in the 1993 federal election, and gave political voice to the separatist movement at the federal level. The BQ, along with its provincial counterpart, the Parti Québécois, fanned the fires of Quebec nationalism, culminating in an extraordinarily narrow defeat for the 'yes' forces in the 1995 Quebec referendum on secession. Short of separation, the goals of the BQ included pressing the federal government to devolve more power and fiscal capacity to the province and limit its role in provincial policy issues, including health. Second, the failure of constitutional reform also provoked a deepening of western discontent, which was manifest in the rapid growth of support for the new Reform Party of Canada. The Reform Party had deep roots in its birthplace of Alberta, where it picked up 22 of 26 the province's seats in the 1993 federal election. Like the BQ, Reform also campaigned on a promise of greater provincial autonomy and a smaller role for the federal government in a number of policy areas, including health.

The future of Medicare also seemed to be in doubt outside of constitutional politics. Public opinion appeared to support the view that some privatization of financing was inevitable to maintain the system. The majority of Canadians believed that the best way to deal with the rising costs of health care was to charge fees to use the system –

in direct contravention of the accessibility principle of the CHA (Little 1991).[3] The federal Conservative Party had formally endorsed a resolution supporting user fees in health care (York 1991), as had Alberta's Conservative Party (Canadian Press 1993) and the Manitoba wing of the federal party (Russell 1991). Moreover, there was dissension among the ranks of the federal government as various senior ministers expressed contradictory positions on the issue (although the Minster of Health repeatedly pledged his support to the principles) (Pole 1991). The Reform Party vowed to leave Medicare to the provinces and condoned the introduction of private elements for financing health care. Individual provinces were publicly toying with the idea of implementing user charges to raise funds (Canadian Press 1991b; Moulton-Barrett 1991; Séguin 1990). The Canadian Medical Association also endorsed 'creative' means of financing health care, not explicitly ruling out user charges or a parallel private insurance system (Mickleburgh 1992b). Finally, during the 1993 leadership race of the federal Conservative Party, a number of candidates endorsed the idea of making changes to the Canada Health Act to allow user charges, including the winning candidate, Prime Minister Kim Campbell (Delacourt 1993a). However, the new Prime Minister recanted her statements during the subsequent federal election campaign and Liberal party leader Jean Chrétien promised that Medicare would remain unchanged (Delacourt 1993b).

In this climate of the impending demise of Medicare and the country, one might expect a challenging discourse centred on private financing in health care to find fertile ground. The perceived magnitude of the problems created a compelling momentum for policy change, opening a window for a challenging discourse with alternative policy solutions to be brought forward. The Mulroney government helped pave the way to a private financing alternative by shifting from a rhetorical defense of Medicare and its principles to an instrumental discourse of reform. This discourse justified a reduction in health transfers to the provinces and a weaker interpretation of universality in national social programs. The government also turned a blind eye to provincial infractions of the CHA in order to maintain a modicum of intergovernmental harmony[4] (Boase 2001).

One of the most significant developments of this selective enforcement of the Act was the growth of private health care clinics across the country. The Mulroney government overlooked Alberta's sanctioning of these private clinics which charged patients for "medical and surgical appliances and supplies." Under the terms of the

[3] The Canada Health Act defines two types of fees: the first is extra-billing (section 18), which is the additional charge levied by physicians on patients for insured medical services, to top-up their Medicare fees; the second are user charges (section 19), which are any other fees charged by providers (hospitals, physicians) for insured services, such as facilities fees.

[4] In fact, the Auditor General of Canada in his 1987 report lambasted the government for failing to adequately monitor compliance with the Act (Canada 1987).

Canada Health Act, these supplies would normally be included in hospital overhead and thus the charges would not be allowable (Canada 1989). These clinics became the catalyst for Alberta's challenge to the dominant health policy paradigm. Shortly after the 1993 federal election in which the Liberal party came to power under Jean Chrétien, the government of Alberta once again forced the issue to the forefront, and compelled governments across the nation into action.

Health Reform in Alberta: Establishing the Groundwork for a Challenging Discourse

Two important political shifts helped bring the issue of the proliferation of private clinics onto the political agenda, both federally and provincially. The first shift occurred in Alberta politics, with the arrival of a new premier, former Calgary mayor-turned-MLA Ralph Klein. Klein took over the leadership of the struggling Conservative Party in late 1992, and led it to victory in the 1993 provincial election. The populist and sometimes controversial premier ran his leadership and electoral campaigns using an instrumental discourse about the need to reign in government spending. His party's platform focused on greater transparency and accountability in government and more fiscal responsibility, which included reductions in both government size and spending. He pledged to get rid of the large provincial deficit within four years, and introduce legislation to prohibit governments from passing deficit budgets in the future (Calgary Herald 1992a). Slaying the deficit was to be achieved by cutting overall government spending by 20%. Health care was to be protected from the full force of these cuts, with only a $127 million reduction in spending in the first year (about 3% of the health budget), and about $600 million over the four year period. After the election, however, these figures quickly climbed to a 25% reduction in public health care spending over four years – almost $1 billion.

The second shift occurred federally with the election of a new Liberal government. Early in his tenure, Klein dealt with a Conservative federal government that had been content to take no action on monitoring provinces' compliance with the CHA. The new Liberal majority government, led by Jean Chrétien, was adamantly opposed to health care user fees but promised to allow greater "flexibility" in the health care system (Séguin 1993). However, unlike the previous administration, the new government was also firmly committed to a strong central government – the antithesis of Alberta's long-standing constitutional goals. Complicating this stance was the federal fiscal situation – an operating deficit of over $44 billion and debt financing payments that amounted to almost one-third of federal revenues (Feehan 1995). The new federal government's determined deficit reduction strategies, which included reduced provincial transfers, combined with its insistence on a strong and continued role in health policy made for volatile intergovernmental relations, and provided the

Alberta premier with an ideal opening for his challenging discourse regarding Medicare.

The following sections will describe the process leading up to Alberta's challenging discourse. First, the government put in place the tools it would need to build the case that Medicare spending in Alberta was unsustainable. Using systemic retrenchment strategies, the Klein administration reduced the size of the public purse and altered decision-making rules to make spending increases on any programs, including health, much more difficult. It attempted to recast the problems in the health care system as being caused by indiscriminate spending by 'special interests' (i.e., providers and others who worked in and managed the system) and irresponsible users. It created a causal story in which blame was attributed to some of the most well-organized, well-informed and well-resourced defenders of the health care system. The causal story undermined their legitimacy as participants in the health policy process and directed attention to policies for changing their behaviours. Finally, and perhaps inadvertently, the Premier drew attention to the normative elements underlying the Medicare paradigm by discussing the possibility of a 'two-tier' system.

Systemic Retrenchment in Alberta: "Selling the Cadillac, Keeping the Oldsmobile"[5]

Once in government, Klein set about challenging the Medicare paradigm by laying the ground work. Health reform strategies in the late 1980s in Alberta had been accompanied by an instrumental discourse that focused on cost containment and supply-side strategies. The Klein government instead promoted a challenging discourse that questioned the role of government and objectives of Medicare in society. It undertook extensive restructuring and retrenchment early in its mandate by using systemic strategies, similar to those outlined by Paul Pierson in his study of welfare state retrenchment under Ronald Reagan and Margaret Thatcher. Pierson (1993) suggests that changes in social programs' rules and structures can often be politically unpalatable because these programs are often very popular amongst the public. Instead, governments may make more subtle systemic changes to alter the political and economic context in which policies are made. Pierson identifies a number of strategies governments may use to foster systemic retrenchment: constrain the flow of revenues to future administrations; change the way in which decisions are made by changing the institutional rules and structures in which they are made; and attempt to change public attitudes toward social programs. The Klein government used strategies very similar to those described by Pierson in establishing the groundwork for its challenging discourse in the health arena.

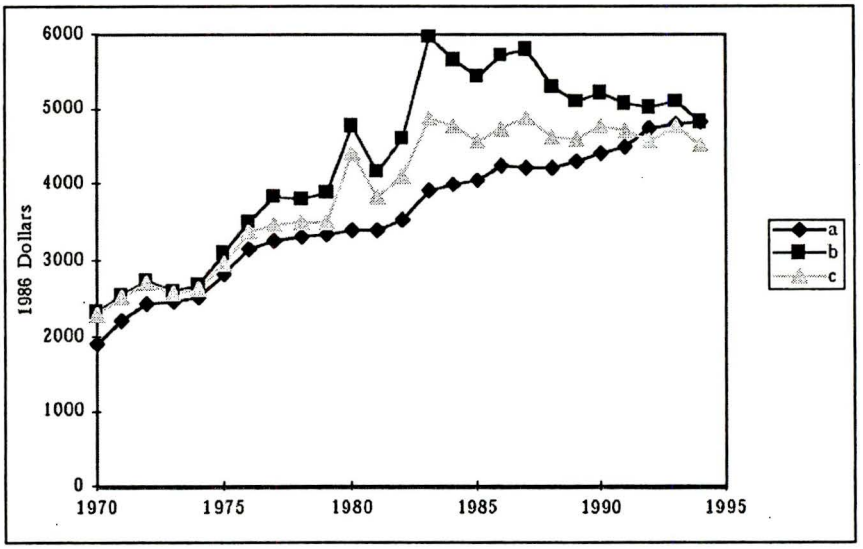
[5] This phrase is taken from a newspaper column by Don Braid (Braid 1993a).

Changing Public Attitudes and the Discourse of Fiscal Crisis

The Klein government began its tenure with a tough message for Albertans: a freeze on all government spending, and a reduction in salaries for MLAs. This, the Premier suggested, was to "signal to Albertans the new reality. And that is that we can no longer live beyond our means" (Klein, as quoted in Geddes 1993a). The provincial treasurer had a more pithy message for Albertans – the province could no longer afford "Cadillac services," and so Albertans should settle instead for "Oldsmobile services" (Treasurer Jim Dinning, as quoted in Braid 1993a). The May 1993 budget specified what the downsizing from Cadillac to Oldsmobile would involve: a rethinking of "not just what government does, but what government is" (Alberta 1993a:8). As part of this rethinking, "a fundamental restructuring" of the health care system was necessary.

The notion of a fiscal crisis in Alberta was actively promoted and used to justify significant expenditure reductions in all aspects of government operations and programs. Albertans were implored to do their share and make sacrifices. Government officials frequently compared Alberta's situation to the experience of New Zealand, which had in the mid 1980s "hit the wall" when its credit rating was downgraded and the government had difficulty securing international loans to help finance its debt and deficits (Schwartz 1997). Alberta's credit rating had been downgraded in May 1992, and a Treasury official suggested that the province could also very soon "hit the wall": "Without action it is the case that sometime in the next year of two the treasurer could walk into cabinet and announce Alberta's credit has run out. Governments do run out of money." (Paul Taylor, as quoted in Crockatt 1993a). Government officials repeatedly referred to the fiscal and economic crisis faced by Alberta as largely a function of spending on public programs – spending that was 'out of control', 'skyrocketing', or 'soaring', even though total spending on health and other social services had been relatively stable as a percent of provincial GDP (Taft 1997; See Figure 6.1). Little or no mention was made of issues on the revenue side of the equation – Alberta's low tax rates and weak natural resource revenues – and raising taxes was categorically ruled out (Kneebone and McKenzie 1997).

Figure 6.1: Alberta Real Per Capita Expenditures (1969-70 to 1993-94)



a. **Canada**

b. **Alberta Total**

c. **Alberta, Total Human Services Expenditures (excluding business subsidies and economic development expenditures)**

Source: McMillan 1996:3

Even though Alberta was not facing an imminent 'debt wall' crisis (Mansell 1997), this discourse was very successful in convincing the public that deficit and debt reduction were the most important priorities of government. During the 1993 provincial election, all three political parties, including the social democratic NDP, campaigned on an economic restructuring platform, and public opinion polls indicated that Albertans believed the economy to be the most significant issue facing the government. A more telling finding is reported by Keith Archer and Roger Gibbins (1997) who surveyed Albertans in 1995, when the effects of budgetary cutbacks were most acutely being felt. In their survey, Archer and Gibbins found an overwhelming degree of support for the government's goal of eliminating the deficit (81%) and almost universal agreement that the best way to do this was through spending cuts (see Table 6.1). However, in keeping with Pierson's observation that programmatic cuts are politically much less popular, Archer and Gibbins found that cuts to health and education programs were seen as being "too big" by a majority of the population (see Table 6.2).

Table 6.1: Deficit Elimination Strategies

"The government could balance the budget in a number of ways. I am going to read several options, and for each one please tell me whether the government should or should not do this to balance the budget."

	Should (%)	Should not (%)
Cut spending	89.8	8.6
Increase personal tax	19.4	78.3
Increase corporate tax	66.9	28.3
Increase user fees	46.5	49.0
Have a sales tax in Alberta	16.2	81.9

Source: Archer and Gibbins 1997:464

Table 6.2: Reactions to Specific Budget Cuts

"Now I'd like to ask you a few questions about some specific budget cuts. As you may know, spending on programs is being cut by varying amounts. For each of the following programs, do you think the cuts have been too big, too small or just about right?"

	Too big (%)	Too Small (%)	Just Right (%)
Primary and Secondary Education	56.6	3.8	37.3
Universities and Colleges	57.0	4.2	31.8
Health	64.5	6.2	26.4
Social Services and Welfare	34.3	18.5	39.0

Source: Archer and Gibbins 1997:467

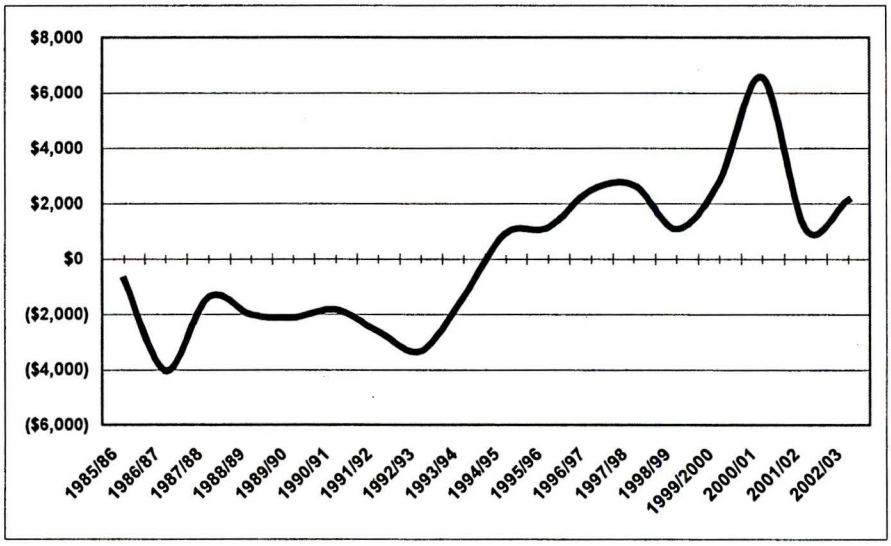
Constraining Government Revenues: Proscribing Deficits

The economic and institutional restructuring that was undertaken in New Zealand was used as a model in Alberta, focusing on structural changes that would limit government spending in a permanent way (Schwartz 1997). These changes included legislated fiscal discipline through the Deficit Elimination Act (DEA), which required a zero deficit by 1996-97, and zero deficits thereafter; the Taxpayer Protection Act, which required the government to hold a binding referendum on the question of a provincial sales tax before such a tax could be introduced; and the Balanced Budget and Debt Retirement Act (BBDRA), which laid out a schedule for eliminating the provincial debt, and required that at least $100 million and all budgetary surpluses each year be applied to debt retirement (Mansell 1997). As Schwartz (1997: 414) concludes, "all of this makes any departure from budget-cutting routines highly visible, exposing politicians who propose spending increases or try to shift the burden of taxation to public censure."

The outcomes of this legislated fiscal discipline are illustrated in Figures 6.2 and 6.3. Alberta achieved its first balanced budget under this regime in 1994-95, one year earlier than expected. These budgetary surpluses, the result of expenditure reductions

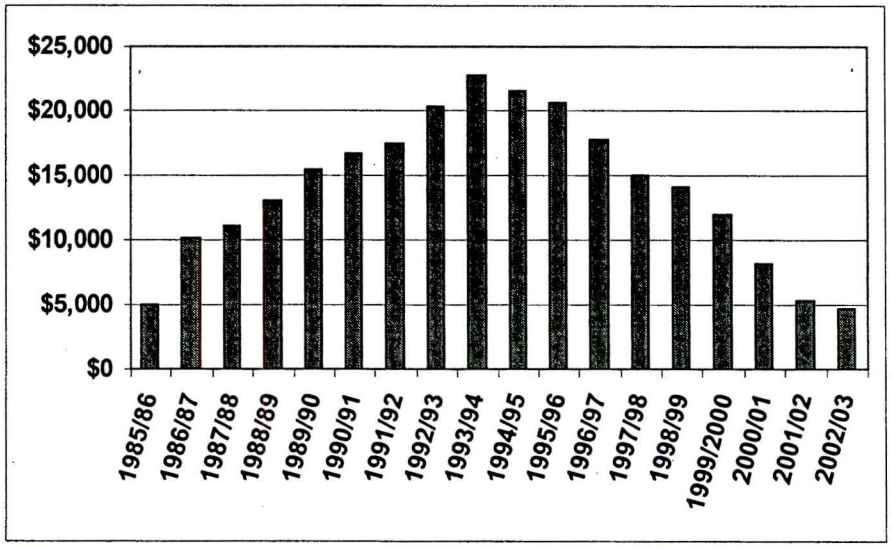
and more favourable international commodity prices, have enabled the government to retire the provincial debt decades earlier than planned. In the summer of 2004, Klein announced that the province would be debt free by the 2005-06 fiscal year.

Figure 6.2: Alberta, Net Revenues (Expenditures), 1985 to 2003 ($millions)



Source: CIHI 2003

Figure 6.3: Alberta, Total Provincial Debt, 1985 to 2003 ($millions)



Source: CIHI 2003

Shifting the Institutional Landscape: Reinventing Government

Finally, the Klein government changed the way government did business by altering internal operating procedures related to budgeting and business planning, as well as moving to devolved policy and decision-making. These changes were based on the popular book by business gurus David Osborne and Ted Gaebler, *Reinventing Government*, which entreated governments to focus on steering rather than rowing – that is, to delegate authority, to use market incentives and competition in the delivery of services, and to use performance monitoring and incentives (McKenzie 1997; Schwartz 1997). Alberta's budgeting process was radically reformed to reflect this philosophy. Public consultations (or roundtables) and expert panels were used widely to ostensibly delegate authority for difficult fiscal decisions (these will be discussed in more detail in the next section). As Boothe (1997) describes in detail, a business planning approach was introduced within government, necessitating each government department or agency develop a three-year plan based on projected budgetary constraints and include a list of performance targets against which the plan would be periodically assessed. Finally, the political decision-making process was also changed to increase the power and influence of backbench MLAs and strengthen the role of the government's standing committees vis à vis government ministers (Boothe 1997; Schwartz 1997).

> In effect, Klein isolated ministers as spenders, converted backbenchers from individuals all seeking a share of the pie to a group with a common interest in disciplining spenders, and reinserted ministers as watchdogs on other ministers through their participation in the SPCs [Standing Policy Committees] that did not monitor their own particular department. The SPC system significantly enhances the power of the finance minister as only Treasury has the right to vet the fiscal implications of business plans... (Schwartz 1997: 414).

In addition to altering the budget process, the government ostensibly decentralized and devolved authority to local units and authorities to make decisions about how to implement the reforms and budget cuts in health, education and social services. In part these changes were intended to facilitate better decision-making tailored to local needs, as well as to introduce greater competition between agencies. However, at the same time, the government introduced tight constraints around decision-making and competition, narrowing the scope of opportunities for and reducing the probability of innovation by local authorities. As a result, critics argued that the agencies were political scapegoats, designed primarily to take the blame for the government's predetermined retrenchment decisions (Archer and Gibbins 1997; Pierson 1993; Weaver 1986).

The changes in the political and bureaucratic institutional landscape in Alberta were justified by the government as a means to broaden policy decision making by including popular representation, both in the form of backbench MLAs and members

of the public. The actual effects of the changes on decision making, however, were rather different. The new internal operating procedures and the devolution of authority to local authorities were tightly circumscribed by rules and regulations made almost exclusively by the political executive. As a result, rather than broadening the range of actors involved in decision making, as is pivotal for a successful challenging discourse, authority was further concentrated in an already powerful small group of political actors. Similarly, as will be discussed in the next section, the government's public consultations or roundtables were perceived to be more of a public relations exercise than meaningful dialogue between citizens and their government.

The Spending Crisis in Health Care: Causal Elements of a Challenging Discourse

Against this backdrop of systemic retrenchment, health programs soon became targets for expenditure reduction. The focus of the political discourse on health reform was similar to the problem definition promulgated by the Klein government about the state of Alberta's finances: deficits were equated with overspending, with virtually no discussion of other factors that might have led to deficits. In health care, this overspending was attributed to abuse and misuse by patients, over-paid and self-interested providers, and lobbying by 'special interests' to protect their piece of the pie. Stone (1989) suggests that a causal story that articulates a relatively simple problem definition, and that can attribute the source or cause of the problem to an identifiable group or groups, may serve a number of political purposes. A causal story can challenge the existing social order by calling into question the abilities and intentions of those groups and marginalise them by de-legitimizing their involvement. It can focus blame and responsibility on particular groups and thus simplify a problem that likely has much more complex roots. And it can identify other groups as the 'fixers' – those who can and should solve the problem.

To deal with the expenditure problems in health care, the government indicated that spending had to be reduced in certain areas. The original budgetary target for government health expenditures, set just prior to the 1993 provincial election, was a reduction of $127 million (3.1%) for the 1993-94 fiscal year (Alberta 1993a). In his May budget speech, the Treasurer told Albertans that "the costs of the health care system are growing at a rate we can no longer afford." (Dinning as quoted in Alberts 1993a). Shortly after the June election, the newly reelected government concluded that health spending was growing faster than anticipated in the May budget. As a result, the Premier announced in July that an additional $67.5 million would have to be 'squeezed out' of administration in the 1993-94 fiscal year, with the original $127 million to be saved based on recommendations from provincial roundtable meetings (Alberts & Walker 1993).

Taras and Tupper (1994:77) argue that the Klein government deliberately fostered "a 'politics of resentment' whose target [was] well-educated, public sector workers...[who were] not merely overpaid shirkers but also authority figures whose status must be reduced." This targeting is evident in the government's announcements as to how the savings were to be achieved. First, the extra $67.5 million in reductions would be made through wage rollbacks in the health workforce, freezes or reductions of salaries and fees for physicians, and reductions in the number of administrators and bureaucrats in the system. Second, the $127 million in savings was to be based on advice the government was given in roundtable consultations, which were to be held across the province over the next few months. These roundtables, the government argued, would take back power from the bureaucrats and 'special interests' and return decision-making back to 'average citizens'. As will be shortly illustrated, these roundtables were to become a formative component of the challenging political discourse in the reforms to come. Finally, the regional health authorities that were established to manage health services explicitly excluded representation from provider groups in their governance (Philippon and Wasylyshyn 1996).

This announcement of the additional $67.5 million in cuts was met with furious opposition. Groups of protesters regularly came out to Government House to rally against the government's plans. Nurses, ancillary workers and even physicians protested and threatened strike action against the imposed 5% wage rollback; consumers' groups, seniors, women's organizations and average Albertans were anxious about proposed hospital closures and angry about higher premiums and user fees for a whole range of services from home care and nursing homes to physiotherapy and assistive devices. The groups raised concerns that the government's latest announcements pre-empted the roundtables process and undermined the credibility of the consultations. Nevertheless, in keeping with the portrayal of providers as part of the problem rather than the solution, the Premier vowed that he would not succumb to their pressure or retreat from the government's long-range fiscal plan. "They can stand out there and they can yell and they can scream...and they can call me every rotten, stinking name under the sun... I'm...not going to blink" (Premier Klein, as quoted in Calgary Herald 1993).

The roundtable process was meant to be an inclusive forum in which the legitimate partners in the system could debate and arrive at decisions. It also provided a venue for the government's particular causal story and established the agenda for the reform debates. The first delayed health roundtable was held in August of 1993, and included 160 invited participants from business, provider groups and the public. A government-prepared discussion paper for participants laid out a causal story that was consistent with the fiscal crisis that informed the broader political agenda, suggesting that Alberta wasn't a "financial goner. Not yet. But if we continue the course we're on, with no correction, we certainly will be." Without a reduction in health spending, it

was suggested, there would be "very little left to pay for schools, for universities, for police, for roads, parks and for protecting the environment." However, simply cutting costs was not going to be sufficient to save the system. An efficiency argument was made to open the door for fundamental restructuring, although no mention was made of changing the Canada Health Act. "To put it bluntly, we spend a lot of money without a clear indication that we are spending it in the best way" (Alberta, as quoted in Struzik 1993b). The goal for health reform was an overall reduction in the province's health budget of about $1 billion – 25% of the government's health expenditures – over the next four years.

The roundtable process met with mixed success, and on balance the public response to the consultations seemed negative. Some suggested that the sessions were important in finally getting the real issues into public debate. One moderator at the first roundtable argued that "We have a ticking time bomb of a deficit. And if we don't take action today, that time bomb is going to get bigger and more dangerous" (John Brosseau, as quoted in Walker 1993a). Others questioned the legitimacy of the roundtables as true consultations, accusing the government of using the process to manipulate the public agenda. For example, the Alberta Federation of Labor (AFL) leader argued that "the government has already announced they're taking millions of dollars out of the health care system. Now they're bringing people in trying to lead the public to believe that now this is consultation...It's just nothing more than public grandstanding" (Karpowich, as quoted in Toneguzzi 1993). Similarly, the opposition party's health critic, Howard Sapers, asked, "with a set agenda and admission restricted to a select group, how can the upcoming provincial roundtable on health consider itself to be a true public consultation?" (Sapers, as quoted in Toneguzzi 1993). Senior citizens' and consumers' groups were also critical of the roundtables process; suggesting that it was simply a cover for decisions that had already been made. The Freedom of Information and Privacy Association of Alberta also criticized the process for its lack of openness and selective list of invitees. A representative of the association, lawyer Michael Greene, claimed that "there is no requirement for the government to open the books. The whole approach to deficit reduction is very difficult for the general public and specific interest groups because the information is fed to them" (as quoted in Marshall 1993). Bringing home the issue of the closed nature of the process were accusations in the media that the chairman of the health roundtables was in a conflict of interest and had bypassed government tendering rules by awarding contracts to his friends and relatives. Thus the roundtables in many ways reinforced the perception that the policy making process in Alberta had become more centralized and closed under the new government.

Private Clinics and User Charges: Normative Elements of a Challenging Discourse

While the health roundtables were taking place, the issue of private clinics began to filter up onto the political agenda. The clinics had begun to proliferate in the early 1990s in a number of provinces, including Alberta. These clinics not only billed provincial plans for their services, they also billed individual patients for use of their facilities and medical supplies ('facility fees') – a practice in clear contravention of the CHA. The most prominent among them were in Alberta: seven eye surgery clinics, two private abortion clinics and two MRI (magnetic resonance imaging) centres. The eye surgery clinics had been in operation since the first one opened in 1984 by Dr. Howard Gimbel, and had been expanding. In 1990, the eye clinics billed the Alberta government $1.6 million in medical fees and billed patients over $5 million in facility fees and enhanced services (Walker & Heinrich 1991). However, it wasn't until two private MRI clinics were approved and slated to open in the spring of 1993 that the issue of private clinics was pushed onto the public agenda.

The two MRI clinics were particularly controversial because, unlike the eye clinics, they were financed entirely by private sources – mainly individual patients or third party insurers such as workers' compensation. As such, they seemed to be much more unambiguously in contravention of the Canada Health Act's accessibility principle, and were blatant examples of queue jumping by people who could afford to pay for their own tests. In some cases, hospitals could also refer urgent patients to the clinics, as long as the tests were paid for from the hospital's operating budget. The clinics also raised conflict of interest concerns since they were operated by private consortiums that included physicians who also practiced in the public system. For example, one of the private clinics was headed by the acting director of radiology from a large Calgary hospital. Critics of the practice were concerned that some of these physicians could inappropriately steer patients toward the private clinics by offering more prompt or more 'comprehensive' testing (e.g., such as the use of newer, more up-to-date technology). However, in a confidential memo to hospital administrators, government health officials indicated that physicians who worked at the private clinics would not be required to opt out of Medicare "at this time" – another contravention of the Canada Health Act (Cernetig 1993a).

The opening of the MRI clinics revived the debate about user charges in the health care system, both in Alberta and at the federal level, where a national election campaign was under way. In Alberta, the government responded to the concerns raised about the clinics by denying that the clinics would jeopardize accessibility or universality. Instead, officials argued that the clinics would provide services more efficiently than the public sector. Furthermore, by taking patients who were willing to pay for their services out of the public system, the clinics would ease some cost and service burdens in the public system, and as a result, enhance overall accessibility. For

example, the health minister, Shirley McClellan, suggested the clinics were a non-issue: "There's nothing wrong with [the clinics] as long as nobody is disadvantaged by not being able to pay and as long as they have the same access to health services." And in her view, Albertans did have that access through the public system, if they wanted it (McClellan, as quoted in Helm 1993a).

The Premier's views on user charges and the private clinics were at times incoherent and shifting, creating confusion and fueling concerns about the future of Medicare in Alberta. Klein first expressed his views on the Canada Health Act in January 1993, when he proposed a meeting with the federal government to discuss changes to the Act to allow provincial governments to charge user fees. He said he sensed "the political will out there is [that] steps have to be taken to cut down on abuse and perhaps a small user fee for those who can afford it might be a way to do this" (Klein, as quoted in Canadian Press 1993a). However, in his election campaigning, he had pledged to protect the principles of the Canada Health Act in Alberta's health care system, saying "Our government is committed to maintaining universal access to quality health care. We will work to prevent a two-tiered health care system ..." (Klein, as quoted in Edmonton Journal 1993b). When challenged on his earlier position on the Canada Health Act and user fees, the Premier explained his statements by saying that he had "only been thinking out loud. I'll talk about it, but that's not to say it will happen." (Klein, as quoted in Aikenhead 1993a).

The Premier appeared to reverse his views yet again later that year, after the election, when he predicted that the result of long-term restructuring in the health system would be that hospitals would charge patients for more of their services to remain competitive. "People say that we are moving toward a two-tiered health care system in Alberta. But that's not all bad. Some health services have to carry charges or there will be abuse" (Klein, as quoted in Western Report 1993). In response to the private clinics issue, he suggested that "certainly there is a place for these machines in the private sector and those who want to have a private analysis will simply have to pay for it" (Klein, as quoted in Panzeri 1993a). Despite his earlier election pledges, Klein seemed relatively unconcerned about conflicts between private clinics with their patient charges and Canada Health Act principles. He focused on cognitive elements in the government's challenging discourse, arguing that user fees were not incompatible with the Canada Health Act since they would deter only unnecessary services, and at the same time enhance efficiency.

By framing privatization policy alternatives using the 'two tiers' metaphor, however, the Premier shifted the debate from a focus on cost-containment within the existing parameters of the system to one that questioned the normative values of universality and accessibility underlying Medicare. Cost containment strategies, such as budget cuts and premium increases, could be portrayed as consistent with the dominant

health policy paradigm since they were simply adjustments to existing policy instruments. In contrast, the 'two tiers' metaphor shifted the discourse to one that manifestly challenged the core principles of the dominant policy frame. "Two tiered" implied a different level service for the wealthy and another for the less advantaged – unmistakably the antithesis of universality and accessibility.

This shift in the challenging discourse opened the government up to accusations of allowing two-tier medicine to flourish in Alberta. Friends of Medicare, a public interest group comprised of individual members, service organizations, social justice groups, unions, and churches, suggested that the system was moving toward an "if you can afford it, you can get it" philosophy (Irene Gouin, Treasurer, Friends of Medicare, as quoted in Struzik 1993a). Former Conservative health minister and leadership contender Nancy Betkowski suggested the clinics blurred the line between private and public, and were "starting to strike at the heart of medicare." (Betkowski, as quoted in Edmonton Journal 1993a). She was echoing the criticisms of the provincial opposition parties, nursing unions, other labour unions and the Consumers' Association of Canada (CAC). In September 1993, the CAC submitted a letter to Health Canada asking for a formal investigation into Alberta's private clinics to determine whether they contravened the Canada Health Act by charging patients 'facility fees' (Crockatt 1993b).

Consolidating the Challenging Discourse

Before the federal government could become involved, one more factor helped push the user fee/privatization issue in Alberta more forcefully onto the provincial and national political agendas. The final report from the health care roundtables, called *Starting Points*, was made public in late 1993. The report emphasized the dire fiscal situation of the province, the high and growing costs of health care, "waste, inefficiency, duplication and overexpenditure in the system," as well as an "acute lack of accountability," which "allowed the preservation of bureaucracy to take priority over the true needs of health consumers" (Alberta 1993b:4-5). Consistent with a challenging discourse, it called into question the capacity of existing system structures to provide high quality services at a reasonable cost. Instead, it recommended a number of major structural reforms in the health care system to 'put the consumer first', including the creation of 17 regional health authorities. Similar to the Thatcher health reforms in Britain, which had established an 'internal market' for health care, Alberta's, new regional authorities would be encouraged to solicit competitive service contracts from the private and public sector to meet the needs of their populations.

The report further recommended that health services be divided into 'core' or essential services, which would continue to be insured by the provincial plan, and non-essential services which would be de-listed from the provincial plan and be made available

privately. The issue of de-insuring non-essential services had been raised by a number of other provincial governments besides Alberta, largely in the context of cutting health care costs. Since the Canada Health Act offered no clear definition of 'medically necessary', provincial governments had tended to define "services as 'medically required' by regulation, without reference to any substantive or policy-based definition of that term... While this procedure is flexible, it is also arguably susceptible to political and economic winds..." (Canadian Bar Association 1994: 37). Concerned about the implications of de-insuring health services for the comprehensiveness principle of the Canada Health Act, the Health Action Lobby (HEAL) commissioned a report to examine the issue. The authors of that report suggested that attempts to de-list services from their provincial health plans had been done in an ad hoc and opportunistic manner, "driven by the need to save money" (Deber, Ross & Catz 1994: 27). Thus the recommendations of *Starting Points* seemed to reinforce the fear among the government's opponents that large components of Medicare would be privatized – both through the proliferation of private fee-charging clinics and through the growth of a parallel private insurance system. The report buttressed the opinion that the Alberta government was actively dismantling Medicare (Crockatt 1993c; Walker & Alberts 1993a, 1993b).

By the time *Starting Points* was released, a new federal government had been elected. The new Liberal administration seemed to take a greater interest in the user fee issue than had the Mulroney government. The federal Minister of Health, Diane Marleau, very explicitly laid out her government's opposition to user charges and private clinics, and vowed to uphold the Canada Health Act. The stage was thus set for a confrontation between the dominant health policy paradigm, as defined by the Canada Health Act, and a challenging discourse promoting private financing alternatives.

The Failure of the Privatization Challenge

Despite its formidable resources and commitment, the Alberta government failed to provide a persuasive challenging discourse to overcome the resistance to the privatization elements of its proposed reforms. As alluded to earlier, this failure can be attributed to three main factors. First, cognitive elements of the challenging discourse were inconsistent with the widely accepted and deeply valued norms of collective social responsibility, universality and accessibility that underpinned the dominant Medicare paradigm. Instead, the challenging discourse implicitly undermined those norms and values, and even, at times, openly questioned them. As a result, the government's opponents were able to rally around a fiercely rhetorical and long-entrenched discourse to defend Medicare. Second, the Klein government lacked credibility when it professed to protect Medicare yet simultaneously radically reduced health care spending and promoted the most conservative political agenda of any

government in the country. Finally, and perhaps most critically, the government failed to provide a convincing set of facts and arguments that its proposed reforms, including the private clinics, would actually solve the problems of the health care system but not compromise Medicare principles. Each of these arguments will be developed in more detail in the following sections.

Challenging Universality and Accessibility

Alberta's challenging discourse was articulated in more detail in the 1994 provincial budget. In the 1993 budget, the focus had been on an instrumental discourse around cost containment in health care – that is, controlling health expenditures in order to prevent a fiscal crisis in the province and protect Medicare in the long run. The 1994 Alberta Health Business Plan, which outlined the ministry's objectives for the coming year, incorporated the recommendations of the *Starting Points* report and reflected residualist principles for the health care system. In contrast to the principle of collective social responsibility underpinning Medicare, the Ministry's goals focused on the individual, stating that "individual responsibility for health will be encouraged and facilitated" and noted that "local community responsibility and contribution for funding some health services/facilities may be appropriate" (Alberta Health 1994a: 5-6). The Business Plan implied that universality and equal access were no longer the primary goals of Medicare in Alberta. Instead, the government's role was to offer a basic range and narrow scope of necessary services, and anyone who wanted or could afford more would have to seek care in the private system.

One of the four goals of the Business Plan was to move to a means-tested system of benefits: "for universal health programs where premiums or other charges are currently levied, [the Ministry will] seek financial contributions, regardless of age, based on an ability to pay" (Alberta Health 1994a:10). The reference to age is significant for two reasons. First, it meant that seniors, a strong ally of the government, were going to have to pay premiums from which they had been exempted in the past. This willingness to alienate one of its own strongest supporters revealed the strength of the government's ideological commitment to its reforms. The second reason was that age is a significant indicator of health care utilization or need, and removing the age exemption implied that premiums might, in the future, also be adjusted to incorporate other risk-based factors. A second goal articulated in the Business Plan was to "increase individual accountability and public acceptance of responsibility for maintenance of their own health" (Alberta Health 1994a:11). This goal compounded public concerns that lifestyle and other risk factors would have a role in either determining premium levels or curbing access to the system, forcing the health minister to publicly refute that this was indeed her government's intention.

Around this time, senior members of the Klein government also began to openly challenge the Canada Health Act principles. The Deputy Premier of Alberta, Ken Kowalski, said in a press conference that "if people want to provide services that individuals are prepared to pay for in their own way, that should be a positive, positive encouragement." (Kowalski, as quoted in Alberts 1994a). The Premier backed Kowalski, saying that private clinics could be supported within the Canada Health Act. "As long as it doesn't undermine our fundamental obligation to provide adequate and essential health services, then I can't see any law that would prohibit that" (Klein, as quoted in Crockatt 1994a). Klein's statement reflected and supported the government's challenging discourse in that he referred to obligatory services in minimalist terms – that is, using words such as 'adequate' and 'essential', which suggest a much smaller role for government in the provision of health care than terms such as 'comprehensive' and 'universal'. Additional support for private clinics came from another Conservative MLA, Dr. Lyle Oberg, a physician and the man responsible for determining how 'essential' and 'non-essential' services would be defined in Alberta. He argued that if "privatization of some facilities or clinics will increase access to the public system [by shortening waiting lists in the public system], then I have no problems with it" (Oberg, as quoted in Alberts 1994a). The government had begun to publicly make the argument universality and accessibility were expendable.

On January 28, 1994, the new federal health minister, Diane Marleau, addressed the federal parliament to outline her government's health program. She said:

> "...there are certain principles, policies and programs which must be maintained as part of our national heritage and our national fabric... Fundamental among them is our national health system which for many Canadians represents the essence of our unique experience as a country. (Diane Marleau, House of Commons, Friday January 28, 1994).

This brief speech laid the groundwork for the rhetorical discourse the federal Liberal government would pursue over the next two years in dealing with the issue of private clinics and user fees in Alberta and other provinces. This discourse built on the principles of the Canada Health Act and linked them to the idea of Canadian nationhood and citizenship. Thus the normative appeal to notions of pan-Canadian equity and collective solidarity, as articulated in the Act, was based on their inherent social value as well as their iconic status as symbols of nationality and identity.

Opposition to Alberta's challenging discourse grew in Alberta and across Canada, as various groups contested it on both principled and instrumental grounds. The federal health minister, whom the media referred to as Canada's "Joan of Arc of Medicare," was perhaps Alberta's most prominent detractor and, as the media moniker suggests, Medicare's preeminent defender. The federal government had been monitoring developments in Alberta, and had been critical of the deep expenditure reductions

proposed in the provincial budget. In April 1994, Marleau announced that her government would look into the private clinics in Alberta and, if necessary, withhold transfer payments if it was found that the clinics violated the Canada Health Act. She invoked a rhetorical discourse to defend Medicare, saying she was troubled by the cutbacks in services in the public system that might lead to longer waiting lists for necessary services, forcing people to turn to the private system. Using the two-tier metaphor, Marleau said she was

> ...deeply concerned over what's happening in Alberta, with trends that are developing toward a two-tier health system. Private clinics appear to run contrary to the spirit of the Canada Health Act. They do create a two-tier system, more accessible to the rich than to the poor (Marleau, as quoted in Alberts 1994a).

Marleau actively reinforced the dominant paradigm by using the rhetoric of the perils of "pocket-book medicine" for universality and accessibility, and the potential for queue jumping that were raised by private clinics.

> When a facility charges a facility fee and general taxpayers are paying the physician fee, they are in essence subsidizing queue jumping for those who have the money. That goes against our principles... That is a tax on illness. That is not a fair tax, at least in my book (Marleau, in Canada House of Commons Debates, April 27, 1994).

The Prime Minister echoed Marleau's rhetorical discourse, and supported her stance on the Canada Health Act. He declared that:

> ...we have a very clear law of Parliament that medicare in Canada is free for everybody. We have a law in Canada that says there will not be a two tier system of medicare, one for the rich and one for the poor. We also have a law in Canada which says that if one province is engaged in that direction we shall cut off funds to it. The minister is doing what is right. She is making sure that the laws of Parliament are respected. (Prime Minister Jean Chrétien, in Canada House of Commons Debates, April 27, 1994).

On this issue, the federal government had the backing of most provincial governments. In a September 1994 intergovernmental meeting of health ministers, the majority (with Alberta the only holdout) agreed to "take whatever steps are required to regulate the development of private clinics in Canada" (Canadian Press 1994a). Alberta's refusal to concur was interpreted by one senior Health Canada official as a sign that "Ralph Klein is pursuing a radical privatization agenda which violates the very spirit of the Health Act" (Richard Van Loon, Associate Deputy Minister, Health Canada, as quoted in Western Report 1994).

The war of words with Alberta heated up when Marleau issued an ultimatum on private clinics in a letter to all provincial health ministers. The letter invoked a rhetorical discourse to defend Medicare. Dated January 6, 1995, it outlined the federal policy on private clinics – namely, that the facility fees charged by these clinics:

> constitute user charges and, as such, contravene the principle of accessibility set out in the Canada Health Act... Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians (Marleau 1995).

The letter went on to express more general concerns about the potential of private clinics "to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system." Provinces were given until October 15, 1995 to enforce the prohibition against user charges, after which penalties would begin.

Premier Klein's reaction to the federal ultimatum was to deny that user fees were in any way undermining Medicare. He said:

> We don't think fundamentally that we are doing anything wrong... Perhaps we will challenge this [the prohibition on facility fees] on legal grounds. We have always been of the opinion that in no way, shape or form are we violating the Canada Health Act. Facility fees are an acceptable way of accommodating those who want to have a procedure...to have that procedure more quickly than you would get in the hospital. We don't see it as a two-tiered situation any more than we see private abortion clinics as part of a two-tiered system (Klein, as quoted in Ha & Feschuk 1995).[6]

In the months following the federal government's ultimatum on the private clinic issue, Alberta did little to conform to the deadline. Instead, the Premier made statements that suggested Alberta would continue to defy the Canada Health Act, with some government officials even expressing skepticism that the federal government would actually impose the penalties. Klein argued that instead of fining Alberta, the federal government should change the Canada Health Act. He asked, "On the question of equal access, does that mean that any arrangement that allows enhanced access beyond some agreed standard is a violation of the [Canada Health] Act? We don't know, and we want to know" (Klein, as quoted in Nagle 1995). He implied he was looking favourably on a proposal to sell two closed hospitals to a consortium of doctors that wanted to open an entirely private hospital in the

[6] In fact, the private abortion clinics the premier was referring to were also in violation of the CHA, and a number of provinces were later penalized for not providing adequate in-hospital abortion services, and/or not allowing the clinics to bill provincial plans.

province. He felt that "Albertans...simply want to say, 'Look, I want to get into this hospital quicker.' Maybe there's an opportunity for that person to get in quicker and have the operation done [in Alberta], just as that person might say, 'I'm going to take my own money and go to the Mayo Clinic or go to the Houston Medical Centre or go to a facility in the United States.'" He agreed that "it could perhaps be construed as a two-tiered system" (Klein, as quoted in Crockatt 1995a).

Premier Klein unexpectedly received the support of his provincial counterparts on the private clinic issue, although their reversal was driven less by the persuasiveness of Klein's argument than by intergovernmental politics. A few weeks after Marleau's letter was sent, the federal government announced cuts to provincial transfer payments of $7 billion over four years. Incensed by the magnitude of and lack of consultation on the cuts, premiers who had supported upholding the Canada Health Act on the clinics issue retracted that support, demanding that Ottawa "stop unilateral actions and arbitrary deadlines." Although the premiers were divided amongst themselves as to whether the Canada Health Act should be enforced at all, they all shared the sentiment expressed by Manitoba's premier that the federal government "can't be both gate-keeper and purse-snatcher at the same time" (as quoted in O'Neil 1995).

Alberta, with the backing of the other provinces, might have posed a serious challenge to Ottawa's position on the Canada Health Act. However, the force of provincial resistance against Ottawa was both shallow and short-lived. Medicare once again became entangled with national unity as a referendum on sovereignty in Quebec drew near, revealing deep divisions in the provincial alliance. Some provincial premiers used the centrality of Medicare in the national unity issue to argue against federal cuts to provincial transfers for health and social programs, as suggested by the Premier of British Columbia: "We have tried to make it clear to [Ottawa] the negative impact it would have on national unity. Medicare defines us as a nation" (Premier Mike Harcourt, as quoted in Hunter 1995). Others, like Saskatchewan's Roy Romanow, used Medicare as a positive example of how federalism could work in the interests of both the provinces and the federal government: "If we did not have federalism, [Saskatchewan] would not have been able to have invented medicare . . . and in inventing medicare, we gave to Canadians a gift" (Romanow, as quoted in Cordon 1995).

Alberta, backed by the Reform Party, made a different argument. Klein accused the federal government of sending the wrong message about federalism by "being inflexible" on health care issues (Klein, as quoted in Canadian Press 1995). In Parliament, Reform Party leader Preston Manning urged the Prime Minister to

> ...[seize] opportunities to respond to the demand for decentralization. Even today his health minister is in Victoria. She could advance the cause by simply

> agreeing to open up the Canada Health Act to permit the provinces greater flexibility in financing health care. Albertans want it. Ontarians want it. Quebeckers want it. Canadians want it. Is the Prime Minister willing to put some meaning into this phrase of flexible federalism and thus advance the no side by committing to amend the Canada Health Act?" (Preston Manning, Canada, House of Commons Debates, September 20, 1995).

Manning's proposal convinced neither Parliamentarians nor the Canadian public. As in earlier constitutional negotiations, Medicare became a symbol of pan-Canadian values that were shared by all Canadians and that held the nation together. The Prime Minister's response to Manning illustrates the rhetorical discourse that became the federal government's defense against dismantling the Canada Health Act:

> ...I do not think it would change the vote in Quebec if we agreed to have a two tier system of health care...Destroying the health care system in Canada will not persuade the Leader of the Opposition [the Bloc Québécois] and his leader in Quebec to vote no. However, the people of Canada would be very disappointed if I were to stand here just to maintain peace for 40 days and concede our national health system which makes everybody equal in Canada. (Jean Chrétien, Canada, House of Commons Debates, September 20, 1995).

The results of Quebec's sovereignty referendum were perilously close, with a very slim majority of Quebeckers voting against separation. Although the referendum did alter the dynamics of Canadian federalism towards a more collaborative approach on many other policy issues (Lazar 1997), Medicare and the Canada Health Act remained one area in which the federal government, backed by the support of a majority of Canadians, refused to yield.[7]

Contesting Legitimacy: Retrenchment and the Klein Revolution

Aside from the details of Alberta's health reform plans, the government itself lacked real credibility as an administration with a deep social conscience. The Klein government's unabashedly neo-liberal agenda was viewed with suspicion by many Albertans as well as some political leaders, in both Alberta and beyond, and Klein himself was labeled as a 'right-wing ideologue' by his detractors (Taras and Tupper 1994). Labels and suspicions notwithstanding, the Klein government undoubtedly undertook the most drastic public expenditure reductions and rapid deficit cutting exercise of any government in Canada, past or present. Lauded by the *Wall Street Journal* as 'Canada's Reagan,' Klein became the model politician of numerous

[7] In 1994, 75% of Canadians believed it was very important to keep the five principles of the Canada Health Act. Canada Health Monitor, *Highlights Report, Survey #10*, February 1994. (Toronto: PriceWaterhouse, 1994).

conservative groups and think tanks across the nation, receiving decorations and awards from the likes of the National Citizens' Coalition and the Fraser Institute.

The policies of the so-called Klein Revolution, and Klein's own sometimes abrasive personality, created friction amongst his provincial peers and revealed the very superficial nature of inter-provincial harmony. The source of this friction was both ideological as well political. For instance, a rather protracted and very public dispute broke out between Klein and the social democratic premier of neighboring British Columbia, Mike Harcourt. The B.C. government accused Alberta of encouraging Albertans receiving social assistance to move to other provinces by giving them a bus ticket out of town, and by deliberately reducing monthly assistance payments below those of other provinces (in fact, Alberta did have a program to help recipients leave the province to reunite with familial or other social support networks). Klein did not deny this, and in fact lauded his government's success in getting 23,000 people off Alberta's welfare rolls. The intergovernmental dispute escalated, with the premiers exchanging retaliatory threats and insults which simply highlighted the ideological differences between the two governments (Crockatt 1993d). Harcourt compared his government's approach with the 'slash and burn' policies of the Klein government and, in an address to British Columbians, argued that "the people of Alberta now face massive layoffs, closed hospitals across the province and lower quality of education. Is that what you want for your family? I know I don't." (Harcourt, as quoted in Nagle 1994).

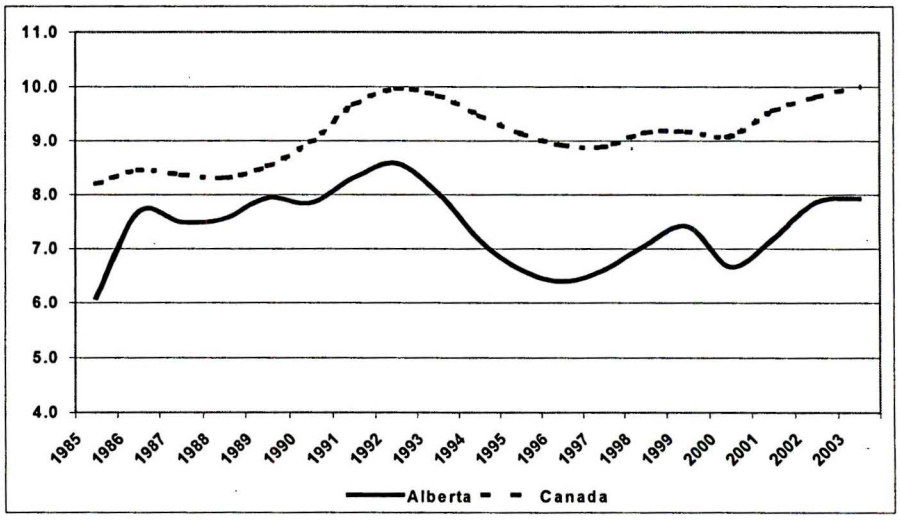
Conflicting ideologies led Saskatchewan's social democratic premier, Roy Romanow, to accuse Alberta's leaders of "...turning the clock back as fast as they can [on social programs]. Their solutions are simplistic and they amount to one: punish the poor" (Romanow, as quoted in Canadian Press 1995h). In a similar vein, Ontario's social democratic premier, Bob Rae, lashed out at the 'neo-conservative agenda' of political parties across Canada. Although he was directly targeting Ontario's Conservatives, Rae implicated Alberta's Tories as well: "You have parties which to a greater or lesser degree are committed to a wholesale destruction of the balanced partnership between the private sector and the public sector" – a partnership that created and reflects "our sense of decency that we're not going to allow people to starve and to fall through the cracks" (Rae, as quoted in the Windsor Star 1994).

In terms of political and economic relations in the federation, inter-provincial harmony was further threatened by the demands of the so-called 'have' provinces – Ontario, Alberta and British Columbia – to reduce their contributions toward federal equalization transfers. The economically weaker Atlantic provinces in particular relied heavily on federal transfers – both the targeted transfers for social programs and health care and equalisation payments – to maintain their social programs. These 'have less' provinces were understandably reluctant to speak out against federal

involvement in health programs, and in fact argued for a strong federal role (Bickerton 1996). Furthermore, any suggestion that renegotiation of national health standards would be accompanied by changes in equalisation payments, as the 'have' provinces were implying, was met with outright hostility. The 'have less' provinces accused the richer provinces of trying to solve their own fiscal problems by taking federal resources away them – just another twist on the 'politics of off-loading' that had characterised federal-provincial relations for the past decade (Taras and Tupper 1994). Thus, in the intergovernmental arena, the Klein government's position on the Canada Health Act was met with a great deal more scepticism than support.

Domestically, the Klein government faced the wrath of myriad groups united in their opposition to the government's plans to remove almost a billion dollars from the health budget. The magnitude of the reductions is illustrated in Figure 6.4. From 1992 to 1996, health care expenditures as a proportion of provincial GDP fell from 8.6% to 6.6% in Alberta, compared to the national average which fell from 10% to 9.1% in the same period. This translates into a 25% reduction in per capita health expenditures in Alberta, taking into account population increases and other demographic changes. Cuts to hospital funding, being the largest category of health expenditures, resulted in the planned closure of 44% of hospital beds (Plain 1997).

Figure 6.4: Health Expenditures as % of Provincial GDP (Current Dollars) Alberta and Average of All Provinces



Source: CIHI 2003

Less than a year into the cuts, health care horror stories filled media reports around the province, detailing the difficulties of average Albertans trying to access the health care system. Referring to his earlier comments, newspaper editorials and letters in the press urged the Premier to 'blink' on his health cutbacks and some even questioned

the government's real intentions regarding Medicare. The Premier, however, flatly denied the existence of any problems. Instead, consistent with a causal story in which health care providers were part of the over-spending and inefficiency problems, he accused both providers and the press of deliberately trying to make him look bad by publicizing "victim of the week" stories. He went so far as to suggest things were "deliberately going wrong in the system," that health care workers might be purposely sabotaging the system to "embarrass the government" (Klein, as quoted in Crockatt 1994b). The health minister described the protests and criticism of the government as a "communication problem" – "We should be talking about the positives in the system rather than the negatives... I can tell you that every time [the media] write a story about somebody who is unhappy or has had a bad experience, my office gets calls and I get letters from people who have had the opposite experience" (McClellan, as quoted in Pedersen 1995). This outright repudiation of the difficulties experienced by Albertans as a result of health system reforms earned the government a great deal of scorn and went a long way in undermining its credibility on the issue.

The credibility of the government's promises about protecting Medicare and the Canada Health Act principles was also challenged on other occasions. In the throes of the federal-provincial dispute on private clinics, and in the midst of the cuts and restructuring of the health care system, the government aggravated fears of privatization with the appointment of a high profile health economist, Jane Fulton, as Deputy Health Minister. Fulton had become a public figure in the media for her views about the virtues of privatization for Canada's health care system. The public interest group, Friends of Medicare (FOM) pointed out that Fulton was

> on record advocating a two-tier system with increased user fees, allowing the wealthy faster and better access to health services and leftovers for the rest of us. Combined with the recent wave of announcements regarding privately owned hospitals taking wealthy patients outside public medicare, this announcement should convince Albertans that the government is out to dismantle our medicare system. (Dr. Hubert Kammerer, spokesperson for FOM, as quoted in Canadian Press 1995b).

Alberta's opposition Liberal party also attacked the Klein government's credibility, suggesting suggested that "...when the premier talks about defining essential services versus non-essential services, he is talking about a two-tiered health care system, which is his philosophy and which he wants." (Mitchell, as quoted in Arnold 1995b). He went on to accuse the government of having

> ...a hidden agenda...to erode the Canada Health Act, its fairness of health-care delivery in this province, its comprehensiveness and its accessibility... I believe deep down inside they would very much like to see a two-tiered health-care system, a more Americanized system. And that system is more expensive and it doesn't work (Liberal Leader Grant Mitchell, as quoted in Arnold 1995a).

Finally, despite the stanch popularity of both the Premier and his government's agenda, the one area in which public confidence fell far short was health care. As the public opinion polls during 1995 indicated, concerns about the government's health policies quickly surpassed their concerns about the deficit or economy (Archer and Gibbins 1997; Hughes, Lowe and McKinnon 1996). Furthermore, Albertans were far less confident in their health care system (see Tables 6.4 and 6.5).

Table 6.4: How Albertans Rate the Health Care System

	January 1993	August 1995
Excellent	28%	6%
Very Good	37%	21%
Good	26%	34%
Fair	6%	22%
Poor	2%	16%

Source: Angus Reid, as reported in Walker 1995

Table 6.5: How Albertans View the Spending Cuts in Health Care

Strongly Support	10%
Moderately Support	28%
Moderately Oppose	20%
Strongly Oppose	39%

Source: Angus Reid, as reported in Walker 1995

The government's detractors were able to capitalize on these concerns and reinforce the doubts by pointing to the government's broader privatization agenda. Klein had campaigned on a promise to review every aspect of government and made no bones about reducing the role of the state. To this end, the government privatized the Alberta Liquor Control Board and various government registries, and also talked of contracting with the private sector for prison services, the management of provincial parks and hospitals, and of course, some health and diagnostic services (Feschuk 1994). One particularly controversial piece of legislation introduced by the government, Bill 57, the Delegated Administration Act (DAA), intensified the level of debate and brought the government's plans under sharp public scrutiny. Described by the minister who introduced it as a 'housekeeping' bill, the legislation would allow the government to contract out or delegate virtually any service or function in its purview simply by regulation. The opposition party accused the government of having 'fascist' aspirations and of "abandoning the public interest [in favour of] private control" (Bettie Hewes, Interim Liberal Leader, as quoted in Feschuk 1994). Hewes went on to warn that "Albertans need to remind the Premier that the mandate he obtained [in the June 1993 election] was to eliminate the deficit, not to eliminate government." Bowing to negative public pressure, the government eventually withdrew the controversial legislation. Nevertheless, the opponents of the private clinics often referred to it to undermine the government's credibility on health care as well (for example, see Alberta Association of Registered Nurses 1995).

"Klein Blinks": Cognitive Failures of the Residualist Challenge

By the middle of 1995, the impact of the cuts to the health care budget was well under way. The private clinics were in operation and making plans for increasing their volumes, while other corporations and business consortia were pursuing the possibility of expanding private services to include surgical procedures requiring an overnight stay. The premier talked openly of allowing private clinics and hospitals to expand in Alberta, and of meeting with groups of investors to discuss the possibility of selling closed hospital properties. However, increasingly, the 'facts' that the Klein government had been using to support the need for and benefits of private clinics and user charges were being questioned and challenged with counter-facts.

On Alberta's assertion that the private clinics would save money and reduce health expenditures, the federal health minister used the American system, in which overall health expenditures consumed a much larger proportion of GDP, as evidence that privatization proposals were unworkable. "Why would we be pushing for a US-style medicare system that does not serve people as well as our system does, and we know costs a lot more?" (Marleau, as quoted in Crockatt 1995a). Similarly, Wendy Armstrong, representing the Consumers' Association of Canada (CAC), said that with a parallel private system such as that proposed by Klein, "ten years from now, we'll be paying twice as much for half as much health care" (Armstrong, as quoted in Crockatt 1995a). As a case in point, the CAC argued that the cost of cataract surgeries being performed in Alberta's private clinics was higher than those performed in public hospitals – the private clinics charged patients anywhere from $750 to $1500 per case (not including physicians' fees which were still paid by Alberta Health), whereas the cost per case in hospital was estimated to be about half these amounts (Armstrong 1996).

Friends of Medicare (FOM), a public interest group expressly formed in December of 1994 to oppose Alberta's health reform plans, contested the government's claim that people in the public system would be better served if some – those who wished and could afford it – obtained their services privately. FOM spokesperson, physician Hubert Kammerer, argued that the Alberta government was leading the province "down a 'slippery slope' to an American-style health care system that provides one service for the rich and another for the poor" (Kammerer, as quoted in Necheff 1995). Kammerer said allowing private clinics to charge facility fees "is subsidizing private health care facilities with taxpayer dollars...facilities that can only be accessed by those with enough money" (Kammerer, as quoted in Necheff 1995). A representative of the Alberta Council on Aging added that "I am old enough to know what this country was like when we had a two tier health care system... If you were covered by [private] insurance, one episode of illness then they'd cancel the insurance. If you had chronic illness, that's just too bad" (Hazel Wilson, as quoted in Necheff 1995).

Both the FOM and the CAC also cited research and evidence from the United Kingdom, where a parallel private system operated alongside the National Health Service, to demonstrate that accessibility and quality of care for some services would actually decline. This evidence included the findings that NHS waiting times for services performed by physicians who divided their time between the public and private systems were much longer than those for physicians who practiced only in the public system. The CAC had conducted a survey of Albertans and reported the following:

> Albertans requiring cataract surgery who seek the services of a surgeon who performs the procedure as a regular component of his/her practice and offers the procedure *exclusively* in public hospitals can expect an initial appointment within 3 to 4 weeks and have the surgery performed within 2-6 weeks. Longer waiting periods for fully paid surgery in hospital are encountered *only* by patients whose surgeon offers both a public hospital option and an expedited private surgery clinic option with patient fees ranging from $700 to $1275 per eye. In both hospitals and private clinics, the surgeon and anesthesiologist bill the provincial health plan for their professional fees (Armstrong 1996, Appendix A).

Both FOM and the CAC also raised doubts about the quality of care in private clinics, suggesting that the rapid increase in cataract surgeries in Alberta should not simply be accepted as a response to increasing need. Instead, they provided anecdotal evidence that in some cases Albertans who apparently did not need the surgery were being recommended for it – by physicians who worked in both the public hospitals and private clinics. They cited research evidence of similar experiences from the United States to support this apparent trend in Canada. Dr. Kammerer from FOM further argued that private clinics "could be a license to print money because the number of inappropriate surgeries could increase." (as quoted in Arnold 1995d)

Meanwhile, the government was facing wildcat strikes by hospital employees, threats of service disruptions by regional health authorities that had run out of money, a province-wide publicity campaign by doctors, and a dissatisfied electorate. Public interest groups such as the Friends of Medicare and the Consumers' Association organized petitions, protests and hearings to urge Albertans to speak out against the government's reforms. In the face of this public pressure, the government decided to restore some of the original cutbacks health care in late 1995, prompting the *Calgary Herald* to run the headline, "KLEIN BLINKS". Klein himself denied his government was buckling under pressure, saying instead that "We're taking a bit of a detour...I think [the decision] alleviates concerns in that it demonstrates we are listening" (Klein, as quoted in Geddes, Dawson & Pommer 1995).

The government also appeared to be reconsidering its position on the facility fees issue. Two days short of the federal deadline, the Alberta health minister wrote to the federal minister asking for a six to eight month extension on the deadline so that the province could work out the details of a policy on private clinics. The new policy would be based on twelve principles, which pointed toward a hybrid public-private system. Marleau refused. The Premier expressed his frustration at the federal government's intransigence, using his typically ambiguous language to defend the province's position. He declared that "we are not capitulating, and we are not giving this up" (Klein as quoted in Henton 1995). He said, "We feel these clinics take pressure off the public system. We don't subscribe to Ms. Marleau's theory that better-off Canadians can jump the queue. This is giving an alternative, so that people can leave the line" (Klein, as quoted in Arnold 1995c). However, he failed to clarify the difference between 'jumping the queue' and 'leaving the line' to purchase services more quickly in the private sector.

On October 15, Ottawa began to deduct $420,000 per month from its transfer payment to Alberta. The Premier argued that the penalty was "totally and absolutely unfair. I don't think we've done anything to violate the Canada Health Act," saying he was more concerned about the principle than the actual penalty (Klein, as quoted in Canadian Press 1995c). When asked how the province would deal with the financial loss imposed by the federal penalties, the premier and his officials implied the fine was very small relative to the overall health budget and would not have much of an effect (Canadian Press 1995d). However, opponents scoffed, and generated long lists of services that might have been paid for with the forgone funds. Friends of Medicare spokesperson Hubert Kammerer pointed out that $420,000 would pay for 42 hip replacement surgeries, 19,100 hours of home care, or 800 cataract surgeries. (Vancouver Sun 1995). By January 1996, the cumulative federal penalty reached the $1 million mark, prompting the Edmonton Social Planning Council to come up with its own list of what might have been done with that money: about 20,000 eye exams which had been eliminated from provincial insurance coverage, 70 heart operations, 750 MRI scans, or 100 joint replacements (Canadian Press 1996a).

The government continued to deny the penalties were a problem, saying that there were no reductions in services as a result of the federal government's cuts to Alberta's transfer payments. "Alberta's response to Ottawa's demand is just arrogance" responded Phyllis Matousek, head of the Seniors Action and Liaison Team, which actively protested the government's reforms on behalf of seniors (as quoted in Henton 1995). Richard Plain, a health economist and active member of FOM suggested the government's "scheme is to try to get Ottawa to agree to some compromise and let this [private clinics] in and then push for private medicare. This is the first prong in a two-prong attack" (Plain, as quoted in Henton 1995). Even the province's professional association of opthamologists argued that "it makes no sense to have

several standards of care and to have some regions where patients have to pay for cataract extractions, and other regions where it is completely insured" (from a letter of the Opthamalogical Society of Alberta, to the Minister of Health, quoted in Canadian Press 1995c).

In March, an 80,000-signature petition was tabled in the Alberta legislature, asking the government to restore health care cuts and to stand by the Canada Health Act principles. An additional 50,000 postcards were sent by people opposed to the cuts as part of the Alberta Medical Association's publicity campaign. Various groups brought forward information about the extent and effects of the health care cuts. FOM pointed out that health care spending in Alberta had declined from $1800 per capita in 1989 to $1392 in 1996 – the lowest in the country. The CAC published a report detailing the impact of Alberta's reforms on Albertans, ranging from growing numbers and amounts of hospital and physicians' charges that were undermining accessibility and universality to variations in coverage and availability of insured services across regions that compromised comprehensiveness. Even hospital administrators admitted the cuts had gone too far in shutting down hospital beds, and that beds would need to be reopened to ensure adequate service levels.

The government finally capitulated on the private clinic issue in the spring of 1996, announcing that as of July 1, it would pay the facility fees for all private clinics in the province. After announcing a 'surprise' budgetary surplus of over $1 billion for 1995-96, the government decided it was time to reinvest in health care and other services. In a reversal of the government's earlier almost militant opposition to the Canada Health Act, the health minister said "the bottom line is that [Albertans] should have a feeling of stability in terms of the fact that we are complying with the Canada Health Act" (Health Minister Halvar Jonson, quoted in Canadian Press 1996b).

Policy Outcomes of the Challenging Discourse

This case illustrates the significant role political discourses can have in preventing certain types of policy change. Whereas the case study of German health care reforms demonstrated the power of discourses in facilitating change, the case of Alberta is an instance of their opposite effects. When it challenged the dominant Medicare paradigm, the government of Alberta was faced with a rhetorical discourse extolling and further entrenching the virtues of the Canada Health Act principles, both as normative ideals as well as critical elements of what it meant to be Canadian. Alberta's decision to yield to federal demands was a complete reversal of its earlier, aggressive stance on the role of private clinics and patient charges.

Although concern about the long-term fiscal viability of Medicare was rampant among many societal and provider groups across the country, as well as in Alberta, there was

scant evidence that the core principles of Medicare were being questioned. The Canada Health Act was also an important symbol of national unity and Canadian citizenship during a period of constitutional turmoil. The federal government's rhetorical discourse focusing on these principles served to rally provincial governments, interest groups and the public in opposition to Alberta's challenging privatisation discourse. Instead of weakening the dominant paradigm, Alberta's challenge actually had the effect of reinforcing it. The government was forced to concede that the ideas of universality and accessibility in Canada's Medicare system were far too deeply entrenched to be effectively challenged. It consistently failed to convey to the public and most provider groups that its particular set of solutions to the health care cost crisis was legitimate. Even the provincial health minister seemed to acknowledged that the government had been unable to convince the public: "If you have the total restructuring that we're having, you're going to have some challenges..." (McClellan, as quoted in Canadian Press 1995f).

Notwithstanding its continued high level of popular support, the Alberta government had much less credibility on the health care issue than on any other part of its agenda. It was faced with daunting opposition to its reform plans from the public, which rallied around a number of very persuasive public interest groups, such as Friends of Medicare and the Consumers' Association, as well as from the federal government, provider groups and even other provincial governments. Almost 70% of Albertans believed that the provincial government had failed to maintain the quality of the health care system, and more than half felt that health was the most important issue facing the province – more than double any other issue, including the provincial deficit (Canadian Press 1995a). Furthermore, having targeted providers as part of the problem in the system, the government had difficulty defending itself against accusations that it was catering to a small group of physician-entrepreneurs when it supported private clinics. Friends of Medicare spokesperson, Dr. Hubert Kammerer cast the stubbornness of the Alberta government this way: "Premier Ralph Klein is going to use our money to pay a fine of $420,000 a month so a handful of Alberta doctors can extra bill and line their pockets"(as quoted in Canadian Press 1995g).

Central to a challenging discourse is the use of 'facts' to persuade various publics that alternative policy instruments would permit a better realisation of core principles of the dominant policy frame. Citizens' groups such as Friends of Medicare, the Consumers' Association and the Canadian Health Coalition, as well as labour unions, provider groups and even other governments, attacked the Alberta government's facts by drawing upon evidence from other jurisdictions, particularly the United States, suggesting that greater privatisation of financing would only lead to higher costs and greater inequality, contrary to the government's contentions. They aggressively defended the principles of Medicare, and demanded that its institutional foundations be strengthened to prevent future challenges.

Other factors also contributed to the failure of the privatisation discourse. The Alberta government's legitimacy as a defender of social welfare was weak amongst its constituents as well as its peers. Its neo-conservative agenda had been the first of its kind at the provincial level and its aggressive budgetary cuts were viewed with alarm both within and outside the province. Its particular ideological approach was at odds with the prevailing political climate in most other provinces and the federal government. British Columbia, Saskatchewan, and, until 1995 Ontario, had social democratic governments strongly wedded to the dominant policy frame representing Medicare for historical reasons. Manitoba and Quebec had effective social democratic parties as leaders of the opposition. The government of the Atlantic provinces, traditionally sympathetic to a strong federal leadership role in many policy areas, including health, were not at all sympathetic to Alberta's repudiation of the national standards represented by universal Medicare.

Chapter 7

Ideas, Discourse and Policy Change

Health policy reform has proven to be a thorny issue for many governments in the past two decades. Although political and institutional hurdles to policy change have been significant, the role of discourse in framing and reframing the issues has it made it possible, in some instances, to overcome those hurdles. Discourse is central to the analysis of policy change because, as Schmidt and Radaelli (2004:192) note, it gives "shape to new institutional structures, as a set of ideas about new rules, values and practices, and as a resource used by entrepreneurial actors to produce and legitimate those ideas, as a process of interaction focused on policy formulation and communication."

The two case studies discussed in this report illustrate how policy discourses can be used to analyse the process of policy change. Certain types of discourses – challenging discourses that are broadly targeted and intended to persuade using facts and arguments – help to make policy change possible. However, the different outcomes with respect to health care reform in Germany and Canada also suggest that not all challenging discourses are equal – some will create conditions for successful policy change whereas others will fail to do so. In Germany, important reforms in the central features of its social insurance-based health care system were made possible by the existence of a strong challenging discourse that proposed a coherent and convincing alternative to the government's failed policy strategies. In contrast, the challenging discourse posed by the Alberta government in Canada questioned the fundamental principles underlying Medicare but failed to persuade a sceptical audience of its merits.

As elaborated in chapter two, discourses are comprised of both *policy frames* – that is, normative and cognitive ideas – and *policy framing* – that is, the process by which those ideas are legitimated and communicated. In both Canada and Germany, an alternative policy frame challenged the dominant health policy frame. However, only in Germany did the alternative frame come to replace the dominant frame and lead to significant policy change. In Canada, the alternative frame was rejected, and as a result, the dominant paradigm continued to prevail. The reasons for the success in one case and failure in the other are related to both the contents of the various policy frames as well as the discourses used by their proponents to convey their ideas and persuade their publics.

Policy Ideas and Policy Frames

The contents of the dominant policy frame circumscribe the boundaries of what is considered possible or impossible at any given point in time and limit the range of alternatives that are considered acceptable. The key constraining factors are its normative elements: the social norms and values that shape the definition of the policy problem and its potential solutions. The findings of the two case studies in this research support the contention that in order to be successful, an alternative frame in a challenging discourse must be consistent with and build upon central normative elements of the dominant frame. It cannot make a 'clean slate' of core values but rather must accommodate them in some way (Surel 2000). Core values – variously referred to as deep core beliefs or worldviews – are very difficult to change and only do so under rare and unusual circumstances, such as deep political crisis, exogenous shocks or war, that demand a re-evaluation of the entire policy frame or paradigm. In such cases, we might expect some political actors to develop a truth-seeking discourse.

The successful challenging discourse in Germany broadened the already familiar and respected core principle of solidarity (*Solidaritätsprinzip*) in the statutory health insurance system – the idea that the risk of illness should be shared among the population. In fact, the SPD 'modernised' solidarity by renouncing the historical class bias inherent in another principle of the system – structured membership (*Gliederungsprinzip*) – in favour of a more equitable and justifiable concept that incorporated the vast majority of Germans on more equal terms.

Apart from the normative appeal of a more inclusive understanding of solidarity, the long history of failed reforms, growing premium and service differentials between blue and white collar workers and the increasing costs of the GKV pointed clearly to the anomalies of the dominant frame in meeting the needs of German society. The accumulation of such cognitive anomalies and policy failures may eventually reach a critical point, forcing the re-evaluation of the dominant frame and opening a window for new alternatives to be considered. In Germany, this critical juncture was reached early in 1992, when it became apparent that the previous reform package had failed to rein in costs and that reforms planned for that year were likely doomed to the same fate. At this juncture, a new health minister, Horst Seehofer, was able to strategically marginalise key opponents to his reform plans by suggesting that, due to the exigencies of the situation, the traditional decision-making processes with corporatist groups – that is, the principle of subsidiarity (*Subsidaritätsprinzip*) – would need to be temporarily moderated.

In the search for viable policy alternatives and a politically feasible solution, the coalition government turned to their rivals in the SPD. The role of ideas in this informal coalition was significant in that the beliefs of many CDU/CSU members of

the governing coalition, including the minister himself, were much more aligned with the normative elements of the SPD's proposed alternative than with the policy preferences of their FDP colleagues. Furthermore, the policy frame posed by the SPD offered clearly articulated politically and administratively feasible alternatives to deal with the most immediate problems associated with the costs of the system and the growing premium inequalities between white and blue collar workers. This frame, which was adopted in the *Gesundheitsstrukturgesetz* (GSG), was based on a more broadly defined principle of solidarity in which all Germans would have the right to freely choose their health insurance fund. This free choice, in turn, would strengthen competitive forces in the regulated insurance market and force providers and insurers to be more cognisant of both the quality of their services as well as their expenditures (and premiums). To minimise risk selection biases between funds and across regions, an equalisation funding scheme was established. Generally speaking, the traditional self-management and corporatist structures of the system were either protected or enhanced with the reforms, but the government had established an important precedent for direct intervention if necessary.

In contrast, the alternative privatisation policy frame posed by the Alberta government was a repudiation of the principles of universality and accessibility that were at the heart of Canada's dominant Medicare paradigm. The privatisation of some elements of health care financing, whether through de-listing of services, user charges for others or private fee-charging clinics, was an unequivocal contravention of both the letter and the spirit of the Canada Health Act – something that even the Klein government eventually acknowledged. Unlike the German case, there was little evidence or agreement that a critical juncture or crisis had been reached with the dominant Medicare policy frame. Although governments and other key political actors acknowledged there were problems associated with controlling the costs of the system, most were arguing that more had to be done to protect Medicare rather than suggesting that the solutions to the problems lay in dismantling the Canada Health Act and its core principles. Moreover, the view that Medicare should be protected was reinforced by an event external to the health domain – the national unity crisis. Medicare, and the values of collective social responsibility it represented, were widely accepted as an important part of Canadian identity. When the form and substance of that identity were threatened by the separation of Quebec from Canada, Medicare was held up a national program that united all Canadians and represented the best of what a successful federal social and political union could accomplish. Thus the privatisation alternative presented by the Klein government in Alberta was contrary to both the norms underlying the Medicare paradigm as well as Medicare as a central idea or aspect of Canadian national identity.

When Discourse Matters

Clearly, however, the success or failure of the alternative policy frames in these two cases cannot simply be attributed to the contents of the frames themselves. In order to be successful, the ideas contained in policy alternatives must be communicated and legitimised in the polity. Transformative discourses accompanying alternatives help to make policy change possible by either seeking consensus on the need for re-evaluation of the underlying norms and values of the dominant paradigm, as in a truth-seeking discourse, or by providing a compelling and persuasive set of facts and truth assertions to convince people that significant policy change is both necessary and desirable, as in a challenging discourse. Conversely, augmentative discourses may inhibit the adoption of new policy alternatives by reinforcing and justifying the dominant frame, either by asserting the moral superiority of the status quo over any other alternatives, such as in rhetorical discourses, or by offering incremental modifications and adjustments to the status quo to address small inconsistencies, as with instrumental discourses.

In Canada, the rhetorical discourse in favour of protecting and reinforcing the Medicare paradigm proved to be much more powerful than the challenging discourse of the Alberta government in promoting privatisation. Alberta's challenge foundered not only on normative grounds, as discussed earlier. It was also hampered by the weakness of its cognitive arguments that Medicare was no longer sustainable as a universal system and that private financing mechanisms would control costs and simultaneously improve accessibility to high quality services for all Albertans, regardless of their ability to pay. In contrast, the challenging discourse accompanying the GSG reforms in Germany was based on an appeal to accepted norms. Equally important, it offered compelling and acknowledged evidence of the failures of the dominant paradigm. It also offered a persuasive argument that its proposed restructuring of the statutory health insurance system would contain costs and enhance solidarity, without compromising self-administration and the corporatist bargain.

The findings of the case studies illuminate a number of factors that appear to be central to the persuasiveness of a challenging discourse. First, as we have noted, unlike a truth-seeking discourse, a challenging one must be framed in ways that are consistent with, and reinforcing of, core values and norms. Second, there must be a broad degree of consensus on the gravity of the problem: the more serious a problem is perceived to be, the more likely it is that policy actors will succeed in convincing people of the need for change. In Germany, the legacy of failure left by previous reforms was incontrovertible: premium rates for health insurance funds had continued to rise almost unabated. It was widely believed that health insurance costs were threatening the viability of other social insurance programs, such as pensions, and compromising Germany's international competitiveness. Furthermore, the issue of

solidarity became central in German reunification following the collapse of the DDR in late 1989. The gross income and class disparities between the eastern and western Länder would have exacerbated premium and service differentials between German citizens had the *Gliederungsprinzip* remained in force, and without risk-equalisation between insurance funds. Regardless of their position on reform, by the early 1990s, virtually all actors in the German system were in agreement that the current state of affairs in the GKV should not be allowed to continue. The federal government collaborated with both its political partners and opponents in resolving the reform impasse, and was able to arrive at an 'historical compromise' – the GSG – to address the problems.

In Canada, the severity of the problem of rising costs in health care was disputed by the provincial and federal governments, as well as by providers' and consumers' groups. Although most groups argued that more money was needed to improve Medicare, Alberta's argument that private financing was necessary to supplement public funds was vehemently challenged by consumer groups and the federal government. The plan's opponents argued that cost problems in the health care system were not so severe that they could not be effectively addressed within the confines of the Canada Health Act principles.

Third, a challenging discourse is likely to be more successful if it is developed and promoted by broadly representative political actors. In Germany, proponents of the challenge discredited the governing coalition by recalling its past failures and by questioning its ability and willingness to arrive at a compromise that would serve the interests of the public above the interests of the powerful health care lobby. The new health minister played an important role in expanding the reform deliberations to include the opposition SPD. He was motivated by a degree of congruence between the views of the SPD and the social wing of his own party, as well as by a commitment to arriving at a substantive reform package. By including the SPD, but excluding corporatist players, in the negotiation of the GSG reforms, the government broadened the range of views represented in the policy process and was able to build a sustainable and politically legitimate 'grand' coalition in support of reform.

In contrast, the Klein government's attempts to portray a transparent and consultative image by holding roundtables and devolving authority to regional boards, among other things, failed to convince people that the decisions were truly the product of these processes. Instead, the government's critics complained that the roundtables and consultations were simply a cover for reform plans that had already been made. They pointed to the limited and selective information that was made available for the public deliberations, questioned the representativeness of groups invited to consultations, and argued that the government's unexpected announcements of wage rollbacks and hospital cuts pre-empted any recommendations the roundtables might have made.

Furthermore, although the issue of rising costs in Canada's Medicare system were not in dispute, Premier Klein and his government had little credibility to address them as reformers with a social conscience. The Alberta government openly questioned and then defied the principles of the Canada Health Act, while at the same time denying it was doing anything to compromise them. Moreover, it had gained the mistrust of many of its constituents and peers by engaging in the most drastic cost-cutting in the health sector of any Canadian government. As a result, the government's reform plans and the discourse that accompanied them were perceived as having been constructed by a small group of neo-conservative politicians and business leaders with both ideological and financial interests in promoting private health care.

Finally, a challenging discourse must offer a convincing solution to the policy problem at hand. In order to be persuasive, a discourse must discredit the cognitive elements of the dominant policy frame – the 'facts' brought to bear on the problem and its solutions, as well as the legitimacy and credibility of those who promote those facts. The accumulated failures of cost containment policies of the German government seemed incontrovertible – premium rates had continued to increase, the disparity between benefits offered by different types of insurance funds had widened, insurers were running large and growing deficits, and patients were paying ever-increasing user-charges. Even the government made no attempt to deny them. The SPD's challenging discourse drew upon these facts and concluded that a complete break with past policy instruments was necessary to effect lasting reforms. The proposed reform of the GKV offered a pragmatic alternative to past policy failures, and accommodated the concerns of both government and the public.

In contrast, Alberta's privatisation challenge lacked the supporting 'facts' the public and other policy actors in the health care system demanded. The government failed to provide convincing rationales or evidence to support a greater role for private financing. Opponents of the plan claimed that privatisation of financing would actually lead to higher costs for patients since user fees and other charges were simply shifting the burden of expenditures from public insurance to private pockets. They contested the government's claims that queue-jumping would not occur with private clinics by providing contrary anecdotal evidence from eye clinics in Alberta. They raised concerns, based on the experience of other jurisdictions, that inequalities in accessibility and in service quality were the inevitable outcomes of privatisation. In the face of evidence of negative outcomes of such policies in other jurisdictions, most notably the U.S., the government's counter-arguments fell short. Eventually, it withdrew its privatisation proposals and conceded that it had not sufficiently persuaded Albertans of their merits.

Policy Ideas and Discourse in the Study of Public Policy

The research presented here proffers an alternative framework for understanding how policy change may be facilitated or impaired by the ideas embedded in policy discourses. Ideas have a particularly prominent role to play in the consideration of health policy since government intervention in this area is almost always prefaced on normative grounds. However, or perhaps as a result, health care reform in many countries has been an intractable policy issue, since struggles over normative and cognitive ideas are at the heart of many, if not most, such policy controversies. And yet, in some instances, rather significant health policy changes have been made possible. In these instances, new ideas have played an important role in overcoming long-standing barriers to reform. But ideas alone have only limited persuasive power: they must be communicated and legitimated or discarded through discourses that engage key actors in the debate. Discourses may be enabling or transformative in that they bring about a new understanding or formulation of a problem and thus create opportunities for different policy alternatives to be considered, or they may be augmentative by reinforcing, modifying and further institutionalising extant policy prescriptions.

This study of health reforms in Canada and Germany has explored two related questions about the role of ideas in policy change. First, it has identified some conditions under which ideas become important elements in policy change, focusing on the accumulation of policy anomalies and failures of the dominant paradigm. Perceptions of crisis or exogenous events may magnify or intensify the failures and generate an ever-greater impetus for change. Second, the analytic framework for analysing discourse as a mechanism for policy change suggests why some ideas rise to prominence whereas others do not. It examines the interaction of new ideas with pre-existing norms and values, as well as, in the case of Canada, their possible interactions with broader cultural frameworks such as identity. It posits that the internal structure and logic of the ideas themselves – that is, the content of and relationship between the normative and cognitive elements of policy frames – must be consistent with and reinforcing of broader social norms. The discourse framework also expands existing work on ideas by linking policy frames with the discursive processes by which framing takes place. It develops a typology for identifying and categorising discourses, based on the focus they place on either normative or cognitive ideational elements of a policy, and links these different discourses to the nature and degree of policy change they may initiate. The findings from the case study research suggest that transformative discourses are more likely to succeed in changing policy when they are constructed and promoted by policy actors representing a fairly broad range of views and interests. Challenging discourses are more persuasive when they engage in frank discussion of the specific failures of the dominant policy frame and call upon different forms of knowledge to construct alternative solutions, including both expert and

experiential information. Only in very unusual and rare circumstances will discourses that draw attention to normative values and beliefs (that is, truth seeking discourses) succeed in making major policy changes.

Although this research has focused on the role of ideas and discourse in policy change, it is not intended to repudiate the importance of political institutions and the role of interests in mediating that change. During times of 'normal' politics, the path dependent influences of interests and institutions are indeed very powerful in shaping, if not determining, the incremental nature, direction and extent of policy change. However, as this research demonstrates, significant departures from existing policy pathways are accompanied and made possible by ideational factors which serve to reframe policy problems and draw attention to policy solutions that would otherwise remain unnoticed or considered unviable. A focus on ideas and discourse offers a useful and compelling approach to improve our understanding situations in which institutional and interest-based explanations alone often fall short.

Appendix 1:

Research Methodology

This research project was essentially conceived as a means to explore a policy puzzle. It began as an investigation into the role of institutional variables – conceived broadly as rules and norms – and their influence on the capacity of governments to undertake health care reforms, but evolved into its current form, as a study of the influences of ideas and discourse. The puzzle arose from my initial investigations of the role of institutional factors in shaping the health policy impasses that were encountered with predictable regularity in many federal countries, and in Canada and Germany in particular. In both countries, the conventional wisdom attributed policy immobility in the health arena to institutional factors, such as federalism and corporatism. However, in theory, the institutional features of the Canadian polity would suggest that a determined and resourceful provincial government should encounter few institutional barriers to enacting significant policy change. In contrast, the complexities of German federalism and the strongly corporatist network of health policy negotiations would suggest that significant policy change is virtually impossible. And yet in each country, the reverse of what would be expected actually occurred.

These puzzles led me to examine the role of ideas and discourse in the two cases, and how they may have a role in framing policy problems in ways that render proposed solutions more or less possible and desirable. In this approach, policies are not simply instrumental to achieving particular ends, but also expressive of the ideas – normative and cognitive – that underpin political action. The research design involved two methodological approaches: comparative case study design and discourse analysis.

Comparative Case Study Design

In order to understand the influence of ideas and discourse on health care system reform, a comparative case study design was selected. This approach has a number of advantages in social science research since it combines the strengths of case studies and of the comparative method. The case study approach allows for the collection of detailed, context-rich information about a single, time- and activity-bound phenomenon. It is a form of 'thick description' – what happened, how and when – that reveals underlying complexities and relationships that might be missed by other approaches (Fischer 2003). Furthermore, the case study approach emphasises the study of processes rather than outcomes or products. This is consistent with and supportive of my research objective, which was to explore the processes by which ideas and discourse can change or consolidate particular understandings of policy problems and their solutions. Finally, comparison enables the discovery and analysis of patterns

across cases, and facilitates the generation of broader hypotheses and theory development (Collier 1993).

In this study, the cases in question are Canada and Germany. As described earlier, Canada and Germany were selected because of the particular policy puzzles they presented with regard to the prominent position of institutional explanations in health policy reforms. Two different types of comparisons were made. The first was a 'within case' comparison, examining each case over a period of time. In Germany, discourses during two periods were studied and compared: discourses that occurred between 1987 and 1989 and led to the incremental changes contained in the GRG, and discourses that occurred between 1990 and 1992 and led to the major reforms contained in the GSG. In Canada, discourses during the 1984 to 1992 period, when the Medicare paradigm was consolidated, were compared with those in the 1993 to 1995 period, when the issue of privatization was raised. This 'within case' element of the research design allowed me to isolate the effects of ideas and discourse by holding institutional and interest variables constant over time. It enabled me to identify different patterns of 'discourse characteristics' in four situations, and formed the backbone of the theoretical framework presented in Figure 2.1 (page 18).

The second comparison was across cases, that is between health care reform in Canada and in Germany. The cross-case comparative analysis was limited to the latter period in each case, comparing the successful challenging discourse in Germany with the failed challenging discourse in Canada. This comparison enabled me to further develop my framework by highlighting conditions or factors which may facilitate the success or failure of similar discourses.

Discourse Analysis

Discourse analysis forms the central methodological approach of my research. As elaborated and discussed in chapter 2, discourse is the process by which policy frames are created, altered and communicated. Discourse analysis is the study of those processes, as "embodied and enacted in a variety of texts... Texts can thus be considered the discursive 'unit' and a material manifestation of discourse." (Phillips and Hardy 2002:4). These 'texts' are comprised of language, symbols and metaphors that are used to construct and communicate meaning about a particular phenomenon.

Data Collection

Following Yanow (2000), the first steps in the research are to identify the texts that are the carriers of meaning – namely, the sources of data which express the content of

ideas and the communicative component of discourse – and to identify groups of people with shared understandings of policy ideas.

Phillips and Handley (2002:75) propose that researchers address the following questions when making decisions about data collection for discourse analysis:

- What texts are most important in constructing the object of analysis?
- What texts are produced by the most powerful actors, transmitted through the most effective channels, and interpreted by the most recipients?
- Which of the above texts are available for analysis?
- Which of the above texts is it feasible to analyse?
- How will I sample these texts?

The textual sources used in this study were drawn from material widely used and available in the public domain, primarily: print media accounts, including newspapers, magazines, journals and the internet; public newsletters, reports, policy statements and submissions of organizations of key actors; and, publicly available government documents, hearings and testimonies, reports and debates. These texts are important in constructing discourses because they are 'naturally occurring' – that is, they are actual examples of language and narrative used (Phillips and Handley 2002:71). Newspapers and records of parliamentary debates were particularly important in the analysis since they reported the original language used by communicators to express their ideas, such as with quotes of speeches and interviews with key actors in the policy network. Public media reports, when studied systematically over a period of time, also reflect the prevailing tenor of the debate and the broader political and social context within which it was occurring. Furthermore, as public texts, these data sources were widely disseminated during the periods under study and thus reached extensive audience, including other members of the policy network as well as the public. They were disseminated through the media and made available in libraries, or mailed out with newsletters or journals. Because of their widespread availability, they reached large numbers of their target populations, both professional and lay audiences, as well as political and bureaucratic leaders. These materials were also selected because they are in the public domain and thus readily available for analysis through libraries, archives, or upon request from the groups that produced them. Table A-1 summarises the sampling methodology used to search each of the different types of textual sources for both Canada and Germany.

For the Canadian case study, newspaper and newsmagazine searches yielded over 5500 documents, of which 3500 were eliminated due to duplications and lack of relevance (e.g., such as referring to unrelated issues). The remaining articles were consulted in the analysis. The search of government hansards resulted in over 1100 citations, of which approximately three-fifths were either duplicates or not relevant to the issue under study. Government policy documents and newsletters, reports, policy

statements and submissions from societal groups numbered approximately 250 in total.

The German component of the study yielded well over 4000 newspaper and newsmagazine articles, both through electronic database and manual searches, and an additional 1200 articles from association journals, with very few duplications. Of these 5200 results, approximately half were eliminated due to lack of relevance. Using the electronic full text search engines of the German Bundestag and Bundesrat, about 625 documents (including hansards, proposed bills etc.) were retrieved. About half of these proved to be duplicates or unrelated to the issues studied.

The next research step is to identify key actors who are "significant carriers of meaning" in a given policy issue (Yanow 2000:20). This is done by examining the texts themselves to ascertain who are the dominant actors in the policy network. In this study, the dominant actors are the political members of government who are directly involved in constructing and communicating a particular set of policy ideas about health reform. Opposition party members, provider groups and public interest groups are other key actors who are also regularly engaged in the policy network, either challenging or supporting the policy frame put forward by government. These actors were identified by their institutionally-defined positions of authority and/or by their involvement in discourse construction, as well as by the regularity and relative frequency of their interactions (Coleman and Skogstad 1990).

Data Analysis

Once the texts and actors were identified, the collected texts were analyzed chronologically. Policy arguments made by key actors were reconstructed, common themes or policy frames that dominated the debates were identified, and their various meanings for the community of actors involved were explored. Following Campbell (1998), Rochefort and Cobb (1993), and Yee (1996), these questions were considered in analysing and interpreting the meanings associated with the *content* of a policy frame:

1. What is the problem definition?
2. What are the causal relationships proposed?
3. Who is blamed for the problem and who is responsible for its solution?
4. What basis of knowledge or information is used? What are the relevant social facts cited?
5. What are the strategies and actions proposed for resolving the problem?

These questions were used to structure the analysis and reconstruct the policy frames at the beginning and end of the time periods studied in both Canada and Germany. In order to structure the analysis and reduce the volume of text to be searched, specific

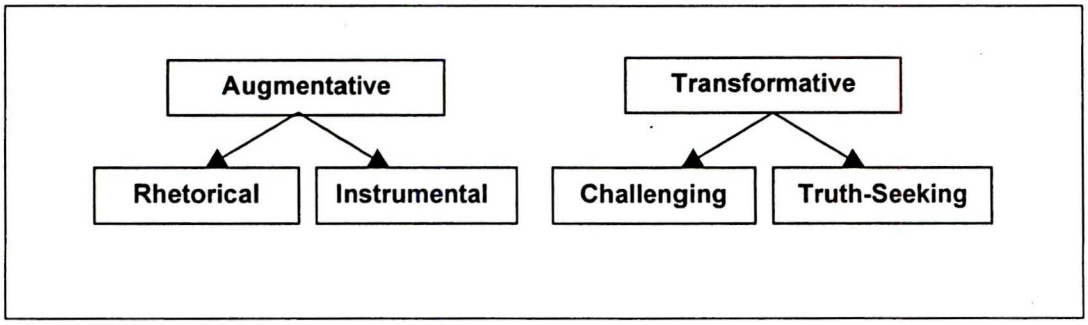
events or debates during which prominent policy frames would have been articulated were identified. These events or debates formed the starting point for the analysis. In Germany, two junctures were identified. The first was the 1988 GRG reform, and the second was the 1992 GSG reform. In Canada, three junctures were identified. The first was the Canada Health Act debate in 1984, the second was the 1991 federal budget which announced significant reductions in health transfers and coincided with national unity debates, and the third was the announcement of Alberta's 1993 budget and Ministry business plans.

Based on this analysis, two prominent policy frames were identified in each country: a 'dominant' frame, which had persisted over a long period of time and reflected the status quo or 'normal' policy making, and an 'alternative' frame which proposed at minimum a second order degree of change (as identified by Hall 1993) and was receiving widespread attention in the study texts. In Canada, the dominant policy frame was identified as Medicare, and the core normative and cognitive elements of that frame were based on the Canada Health Act provisions. The 'alternative' policy frame, developed by the government of Alberta, was identified as the privatization frame. The core of this frame was based on a shift toward greater emphasis on private financing policy instruments for services covered by the Canada Health Act, such as user charges and private clinics. In Germany, the dominant policy frame was identified as the segmented statutory health insurance system (or segmented solidarity), based on the principles of the Social Code Book (SGB V). The alternative frame was based on the principle of unified or universal solidarity, which required risk sharing across the entire population and risk equalisation between insurance funds.

The next step was to address the 'how possible?' question regarding policy change – that is, how did policy frames shift from the beginning to the end of the period studied? The discourses associated with each type of policy frame were compared, and discourse characteristics were identified and grouped into two categories, each with two sub-categories. Using this methodology, two broad categories of discourse were identified, each with two sub-categories, based on the characteristics of the content of the policy frame and the type of communicative strategies used, as described in chapter 2, and depicted in Figure A-1 below. Drawing on work by Schmidt (2001, 2002), the following characteristics were used to classify the discourse into one of the four types:

- Which groups and how many are involved in constructing the discourses?
- What are the main objectives (action-imperatives) of the discourses?
- What are the generic elements at stake in the discourse?
- What are the specific elements at stake in the discourse?
- What are the consequences of success of the discourse?

Figure A-1: Categories of Discourse



The final step of the analysis was the comparative component, as described above. The comparative analysis enabled the identification of patterns of policy change and the discourses that accompanied them. This information was used to make more general propositions about the nature of policy change that would accompany a particular discourse, and the conditions under which different discourses might be most likely to facilitate significant policy change.

Table A-1: Sampling Methodology

Text Type	Sources	Sampling Strategy
Canada		
Newspapers, news magazines	Electronic Databases: ▪ ProQuest (Fulltext) ▪ Globe and Mail (Fulltext) ▪ Lexis Nexis (Fulltext) ▪ CBCA (Fulltext) ▪ Medline ▪ Healthstar	Search terms for 1984-1996 period: ▪ 'Alberta' AND 'privatization' AND 'health care' OR 'medicare' ▪ 'Klein' AND 'privatization' AND 'health care' OR 'medicare' ▪ 'Klein' AND 'health care reform' ▪ 'two-tier' AND 'medicare' OR 'health care' ▪ 'private clinics' AND 'health care' OR 'medicare' ▪ 'user fees' AND 'health care' OR 'medicare'
Government policy documents	▪ Libraries (Government Documents Collections) ▪ Health Canada Library	▪ All budget documents for time periods ▪ All commissioned reports on health care, health care reform ▪ All public Ministry of Health policy documents concerning health reforms ▪ Press releases
	▪ Government Hansards (Electronic, Fulltext)	Search terms for 1994-1996 period: ▪ 'Canada Health Act' ▪ 'Health Insurance' ▪ 'Health care system' ▪ 'Diane Marleau'
	▪ Government Hansards (Print)	Debates for selective dates identified through other public texts
Newsletters, reports, policy statements, submissions of key societal groups	▪ Libraries (Government Documents Collections) ▪ Health Canada Library ▪ Website	Searches by corporate author, all documents during 1984 to 1996 period. ▪ Health Action Lobby (HEAL) ▪ Friends of Medicare (FOM) ▪ Canadian Consumers' Association (CAC) ▪ Alberta Medical Association/Canadian Medical Association ▪ Alberta Association of Registered Nurses (AARN) ▪ Canadian Hospital Association (CHA)

Text Type	Sources	Sampling Strategy
Germany		
Newspapers, news magazines	Electronic databases: ▪ Lexis Nexis (Fulltext)	Search terms for 1992 to 1993 period: ▪ 'gesundheitspolitik' OR 'gesundheitsreform' ▪ 'gesundheitsstrukturgesetz' ▪ 'gesundheitsreformgesetz' ▪ 'Seehofer'
	Print archives of the AOK-Bundesverband (Bonn)	Key headline search terms (manual) for 1987 to 1992 period: ▪ 'gesundheitspolitik', 'gesundheitsreform' ▪ 'gesundheitsstrukturgesetz', ▪ 'gesundheitsreformgesetz', 'strukturreform' ▪ 'Seehofer', 'Dreßler' ▪ 'kostenexplosion' ▪ 'kassenwahl'
Government policy documents	▪ Libraries (Government Documents Collections)	▪ All budget documents for time periods ▪ All government-commissioned reports on health care, health care reform ▪ All public BMG policy documents, publications concerning health care
	▪ Government debates and bills (Electronic, Fulltext) PARFORS Dokumentenserver	Search terms for 1987 to 1993 period: ▪ 'gesundheitspolitik' OR 'gesundheitsreform' ▪ 'gesundheitsstrukturgesetz' ▪ 'gesundheitsreformgesetz' ▪ 'Seehofer' OR 'Blüm' OR 'Dreßler' OR 'Cronenberg'
Newsletters, reports, policy statements, submissions of key societal groups	▪ Libraries (Government Documents Collections) ▪ Max-Planck-Institut für Gesellschaftsforschung Library	Key headline search terms (manual) for association journals for 1987 to 1992 period: ▪ Soziale Sicherheit, Gesellschaftspolitische Kommentare ▪ Ärzte-Zeitung, Deutsches Ärzteblatt ▪ Die Ortskrankenkassen (DOK); Die Ersatzkasse, Die Betriebskrankenkasse

Bibliography

Abel, T. & van der Zee, J. (1995). Public and Private Responsibility for Health: A Comparative Analysis of Attitudes Towards Financing and the Right for Health Care. In G. Luschen, W. Cockerham, J. van der Zee, & et al. (Eds.), *Health Systems in the European Union: Diversity, Convergence and Integration.* (pp 113-126). Munchen: R. Oldenbourg Verlag.

Adams, D. (2001). Canadian Federalism and the Development of National Health Goals and Objectives. In D. Adams (ed.), *Federalism, Democracy and Health Policy in Canada.* Kingston: McGill-Queen's University Press.

Aikenhead, S. (1993a). Musings shouldn't be misconstrued as policy - Klein. *Edmonton Journal*, January 16, A1.

Alber, J. (1992a). *Das Gesundheitswesen der Bundesrepublik Deutschland: Entwicklung, Struktur und Funktionsweise.* Frankfurt (Main): Campus Verlag.

Alber, J. (1992b). Bundesrepublik Deutschland. In J. Alber and B. Bernardi-Schenkluhn [Eds.] *Westeuropäische Gesundheitssysteme im Vergleich.* Frankfurt: Campus Verlag.

Alber, J. & Bernardi-Schenkluhn, B. (1992). *Westeuropaeische Gesundheitssysteme im Vergleich: Bundesrepublik Deutschland, Schweiz, Frankreich, Italien, GroSbritannien.* Frankfurt (Main): Campus Verlag.

Alberta (1991). *Partners in Health: The Government of Alberta's Response to the Premier's Commission on the Future of Health Care for Albertans.* Edmonton.

—— (1993a). *Budget '93: A Financial Plan for Alberta.* Presented by Jim Dinning, Provincial Treasurer, Thursday May 6. Edmonton: Treasury Department

—— (1993b). *Starting Points: Recommendations for Creating a More Accountable and Affordable Health System.* Edmonton: Alberta Health Planning Secretariat

—— (1994a). *Healthy Albertans Living in A Healthy Alberta. A Three Year Business Plan.* February 24. Edmonton: Alberta Health

Alberta Association of Registered Nurses (1995). *Towards a Stance of Privatization in Health Care: A Background Paper.* Edmonton.

Alberts, S. (1992a). The constitution question: Division of power: Part 7 of 8. *Calgary Herald*, October 16, A5

—— (1993a). Health care taking a heavy hit. *Calgary Herald*, May 7, A6

—— (1994). Private-care trend rapped. *Calgary Herald* 17 April, A1

Alberts, S. and R. Walker (1993a). Klein wants more health cuts. *Calgary Herald*, July 13, A1.

Allen, G. and R. Séguin (1991). Provinces criticize reduction in transfer payments. *The Globe and Mail*, February 27, A7.

Altenstetter, C. (1974). *Health Policy-Making and Administration in West Germany and the United States.* Sage Professional Papers in Administrative and Policy Studies, Volume 2, 03-013. London: Sage Publications.

—— (1980). Health Policy Implementation and Corporate Participation in West Germany. In C.R. Foster [Ed.] *Comparative Public Policy and Citizen Participation: Energy, Education, Health and Urban Issues in the U.S. and Germany.* New York: Pergamon Press.

—— (1985). Hospital policy and resource allocation in the Federal Republic of Germany. In A.J. Groth and L.L Wade [eds.] *Public Policy Across Nations: Social Welfare in Industrial Settings.* Greenwich CT: JAI Press Inc.

—— (1989). An end to a consensus on health care in the Federal Republic of Germany? In W.M. Chandler & C.W. Zollner (Eds.), *Challenges to Federalism: Policy Making in Canada and the Federal Republic of Germany.* (pp 103-140). Kingston: Queen's University Institute of Intergovernmental Relations.

—— (1997). Health policy making in Germany: Stability and dynamics. In C. Altenstetter & J.W. Bjorkman (Eds.), *Health Policy Reform, National Variations and Globalization.* (pp 136-160). New York: St Martins Press.

AOK-Bundesverband (1992). Dokumentation: Gesundheitsreformstrukturgesetz 1993 – Eckpunkte zur Sicherung und zur Strukturverbesserung in der Krankenversicherung. *DOK* 13, 412-413.

Apter, D.E. (1964). Introduction. In D.E. Apter (Ed.), *Ideology and Discontent.* (pp 15-46). New York: The Free Press.

Archer, K. & Gibbins, R. (1997). What do Albertans think? The Klein agenda on the public opinion landscape. Kneebone, R.D. & McKenzie, K.J. (1997). The process behind institutional reform in Alberta. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

Archer, K., R. Gibbins and S. Drabek (1990). *Canadian Political Life: An Alberta Perspective.* Dubuque:Kendall/Hunt Pub.

Armstrong, W. (1996). *Taking Stock: A Report on the Risk to Consumers (and their Employers) from Current Health System Reform in Alberta.* Consumers Association of Canada (Alberta).

—— (2003). *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft* (Rep. No. Revised electronic edition). Consumers Association of Canada (Alberta).

Arnold, T. (1995a). Liberals promise to fight for health care. *Edmonton Journal,* February 7, A7.

—— (1995b). Klein, McClellan urge PM to spell out basic services. *Edmonton Journal,* April 6, A6.

—— (1995c). Time's up, Marleau tells Alberta. *Edmonton Journal,* October 13, A1

—— (1995d). Clinics come up with a deal to bypass two-tier medicine. *Edmonton Journal,* October 5, A1.

Ärzte Zeitung (1992). "Wenn wir nun einen Baustein herausreißen, stürzt das Konzept," 11(103): 1.

—— (1992b). "Und das beabsichtigte Strukturgesetz wird jetzt durchgestanden!"

July 24-25.

—— (1992c). Zimmert Seehofer in Lahnstein die große Koalition mit der SPD? October 5.

Baer, N. (1997). Tory plan puts health care in danger. *The Toronto Star*: A29

Bakvis, H. & MacDonald, D. (1993). The Canadian cabinet: organization, decision-rules, and policy impact. In M.M.Atkinson (Ed.), *Governing Canada: Institutions and Public Policy* (pp. 47-80). Toronto: Harcourt Brace Jovanovich Canada Inc.

Ball, W. J. (1995). A pragmatic framework for the evaluation of policy arguments. *Policy Studies Review, 14,* 3-24.

Bandelow, N. (1994). *Korporatismus und Partienkonkordanz: Die Durchsetzung von Strukturreformen in deutschen Gesundheitswesen durch den taktischen Wechsel der Arena*. Forschungsstelle fuer Sozialwissenschaftliche Innovations- und Technologieforschung (SIT), Ruhr-Univeristät. Working Paper 1/94.

Bandelow, N. (1998). *Gesundheitspolitik: Der Staat in der Hand der Interessengruppen?* Opladen: Leske+Budrich

Banting, K. G. (1987). *The Welfare State and Canadian Federalism*. (Second ed.) Kingston: McGill-Queen's University Press.

Banting, K. G. (1995). The welfare state as statecraft: Territorial politics and Canadian social policy. In S.Leibfried & P. Pierson (Eds.), *European Social Policy: Between Fragmentation and Integration* (pp. 269-300). Washington, D.C.: The Brookings Institution.

Banting, K. G. (1997). The Past Speaks to the Future: Lessons from the Post-War Social Union. In H.Lazar (Ed.), *Canada: The State of the Federation 1997: Non Constitutional Renewal* (pp. 39-70). Kingston: Institute of Intergovernmental Relations, Queen's University.

Behaghel, K. (1994). *Kostdaempfung und aerztliche Interessenvertretung: Ein Verbandssytem unter Streß.* Frankfurt (Main): Campus Verlag.

Bell, E. (1993). The rise of the Lougheed Conservatives and the demise of Social Credit in Alberta: A reconsideration. *Canadian Journal of Political Science, 26,* 455-475.

Berman, S. (1998). *The Social Democratic Movement: Ideas and Beliefs in the Making of Interwar Europe.* Cambridge: Harvard University Press.

Berman, S. (2001). Ideas, norms, and culture in political analysis. *Comparative Politics,* 231-250.

Bewerunge, M. (1992) Die SPD will Seehofers Pläne zu Fall bringen. *Rheinische Post,* 13 August.

Bhatia, V. and W.D. Coleman (2003). Ideas and Discourse: Reform and Resistance in the Canadian and German Health Systems. *Canadian Journal of Political Science,* 36(4): 715-739.

Bickerton, J. (1996). Atlantic Canada and the CHST. *Policy Options,* 17(5):18-22.

Bickerton, J., A.G. Gagnon and P.J. Smith (1999). *Ties That Bind: Parties and Voters in Canada*. Toronto: Oxford University Press.

Birkland, T.A. (1998). Focusing events, mobilization, and agenda setting. *Journal of Public Policy*, 18(1): 53-74.

Blanke, B. & Perschke-Hartmann, C. (1994). The 1992 health reform victory over pressure group politics. *German Politics*, 3(2):233-248.

Bleich, E. (2002). Integrating ideas into policy-making analysis: frames and race policies in Britain and France. *Comparative Political Studies, 35,* 1054-1076.

Blüm, N. (1985). Zehn Grundsätze. *Bundesarbeitsblatt* 5, 8-10.

—— (1987). Solidarität und Eigenverantwortung in ein neues Gleichgewicht bringen. *Handelsblatt*, 31 December.

—— (1988a). Der Zug fährt auf den Abgrund zu. *Der Spiegel* 10.

Blyth, M.M. (1997). "Any More Bright Ideas?" The Ideational Turn of Comparative Political Economy. *Comparative Politics*, 29(2):229-250.

BMAS (1983). *Sozialbericht 1983. Unterrichtung durch die Bundesregierung*. Deutscher Bundestag 10. Wahlperiode, Drucksache 10/842.

—— (1985). Zehn Grundsätze. *Bundesarbeitsblatt* 5(März):8-10.

—— (1986). *Sozialbericht 1986. Unterrichtung durch die Bundesregierung*. Deutscher Bundestag 10. Wahlperiode, Drucksache 10/5810.

—— (1987). Solidarität und Eigenverantwortung: Entscheidungen über Grundsätze der Strukturreform im Gesundheitswesen.). *Sozialpolitische Informationen*, 21(19):1-16.

Boase, J.P. (1996). Institutions, institutionalized networks and policy choices: Health policy in the US and Canada. *Governance*, 9(3):287-310.

—— (2001). Federalism and the Health Facility Fees Challenge. In D. Adams (ed.), *Federalism, Democracy and Health Policy in Canada.* Kingston: McGill-Queen's University Press.

Bonner Rundschau (1988). Kassenärzte kritisieren die Gesundheitsreform. 13 January.

Bonoli, G. (1998). State Structures and the Process of Welfare State Adaptation. Paper presented at the Workshop "The New Politics of the Welfare State", Centre for European Studies, Harvard University, Cambridge.

Boothe, P. (1997). A new approach to budgeting in Alberta. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

Börngen, D. and Heinz G. (1988). Organisationsreform. *Die Betriebskrankenkasse*, 6.

Bouchard, Benoit (1991). Ministers committed to Medicare. Letter to the Editor. *Calgary Herald*, November 12.

BPI (1985). *Stellungnahme zu den 10 Grundsätzen des Bundesministers für Arbeit und Sozialordnung für ein gesundheitspolitisches Gesamtkonzept*. Frankfurt am Main: Bundesverband der Pharmazeutischen Industrie e.v.

Braid, D. (1993a). Albertans must forget 'Cadillac' services. *Calgary Herald*, March 3,

A3.

Brandt, Michael (1988). Schweres Geschütz: Gesundheitsreform unter Beschuß; Auch CSU und FDP kritisieren Blüm. *Kölner-Stadt Anzeiger*. 7 March.

Braun, D. (1999). Interests or ideas? An overview of ideational concepts in public policy research. In D. Braun & A. Busch (Eds.), *Public Policy and Political Ideas.* (pp 11-29). Cheltenham: Edward Elgar.

Braun, B., H. Kühn and H. Reiners (1998). *Das Märchen von der Kostenexplosion. Populäre Irrtümer zur Gesundheitspolitiks*. Fischer Taschenbuch Verlag.

Bräuninger, T. & König, T. (1999). The checks and balances of party federalism: German federal government in a divided legislature. *European Journal of Political Research*. 36:207-234.

Braunthal, G. (1998). Opposition in the Kohl era: The SPD and the Left. *German Politics*, 7(1):143-162.

Brodie, J. & Jenson, J. (1996). Piercing the smokescreen: Stability and change in brokerage politics. In A.B.Tanguay & A.-G. Gagnon (Eds.), *Canadian Parties in Transition* (pp. 52-72). Scarborough: Thompson Canada.

Bruce, C. J., Kneebone, R. D., & McKenzie, K. J. (1997). Introduction. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

Burau, V. (2001). Medical reform in Germany: the 1993 health care legislation as an impromptu success. In M. Bovens, P. 't Hart, & G.B. Peters (Eds.), *Success and Failure in Public Governance: A Comparative Analysis.* (pp 199-218). Cheltenham: Edward Elgar.

Burnell, P. & Reeve, A. (1984). Persuasion as a political concept. *British Journal of Political Science, 14,* 393-410.

Busse, R. (1999). Priority-setting and rationing in German health care. *Health Policy*, 50(1-2):71-90.

Busse, R., Howorth, C. & Schwartz, F.W. (1997). The future development of the rights based approach to health care in Germany: more rights or fewer? In J. Lenaghan (Ed.), *Hard Choices in Health Care: Rights and Rationing in Europe.* (pp 21-47). London: BMJ Publishing Group.

Caldarola, C. (1979). The Social Credit in Alberta, 1935-1971. In C. Caldarola (Ed.), *Society and Politics in Alberta: Research Papers*. Toronto: Methuen Publications

Campbell, Colin and William Christian (1990). *Parties, Leaders, and Ideologies in Canada.* Toronto: McGraw-Hill Ryerson Limited.

Calgary Herald (1987a). Ads fighting rising health care use. *Calgary Herald*, February 28, A3.

—— (1992a). Klein promises balanced budgets. *Calgary Herald*, October 2, A16

—— (1993). Here's what they said. *Calgary Herald*, November 3, 1993, A1

Campbell, J.L. (1998). Institutional analysis and the role of ideas in political economy. *Theory and Society*, 27(3):377-409.

Canada, Task Force on Federal-Provincial Fiscal Arrangements (1981). *Fiscal Federalism in Canada*. Ottawa: Minister of Supply and Services.

Canada, Minister of National Health and Welfare (1983). *Preserving Universal Medicare*. Ottawa: Minister of Supply and Services.

Canada, Office of the Auditor General (1987). *Report of the Auditor General of Canada to the House of Commons*. Ottawa: OAG.

Canada, Department of Finance (1991). *The Budget*. Tabled February 26 in the House of Commons. Ottawa

Canadian Bar Association (1994). *What's Law Got To Do With It – Health Care Reform in Canada*. Report of the Canadian Bar Association Task Force on Health Care. Ottawa.

Canadian Institute for Health Information (2003). *National Health Expenditure Trends, 1975-2003*. Ottawa.

Canadian Press (1984). Provincial health ministers encouraged by PC victory. *The Globe and Mail*, September 7, p. 5.

—— (1986). Alberta hospitals, MDs agree to end extra-billing, user fees. *Toronto Star*, August 1, A5

—— (1991a). Federal budget to spell end for medicare, Wilson told. *The Vancouver Sun*, March 4, B2.

—— (1991b). Quebec tackles health costs; Hospital room-and-board charges included in proposals. *The Globe and Mail*, 18 December, A5.

—— (1992a). Health care system joins unity debate. *Hamilton Spectator*, January 28, A8.

—— (1993). Klein to seek medicare user fees. *The Globe and Mail*, 13 January, A5

—— (1995a). Klein says Ottawa's health care threats will hurt No side. *Canadian Press Newswire*, September 18.

—— (1995b). Controversial consultant gets key Alberta health job. *Canadian Press Newswire*, June 30.

—— (1995c). Doctors back alternative to private clinics for eye surgery. *Canadian Press Newswire*, October 27.

—— (1995d). Klein condemns Ottawa for cuts to Alberta's transfer payments. *Vancouver Sun*, 16 November, A3

—— (1995e). Alberta health-care crisis nears boiling point. *Canadian Press Newswire*, November 16.

—— (1995f). Federal health penalties kick in today against Alberta. *Canadian Press Newswire*, November 16.

—— (1995g). Klein puts kinder face on Alberta Tories. *Canadian Press Newswire*, December 2.

—— (1995h). Saskatchewan shows federalism works: Romanow. *Canadian Press Newswire*, November 4.

—— (1996a). Alberta criticized over growing health fines imposed by Ottawa. *Canadian Press Newswire*, January 4.

—— (1996b). Alberta gives doctors choice of public or private care. *Canadian Press Newswire*, June 27.

Carty, R. K. (1991). Three Canadian Party Systems: An Interpretation of the Development of National Politics. In H.G.Thorburn (Ed.), *Party Politics in Canada* (6th Edition ed., pp. 125-143). Scarborough: Prentice-Hall Canada Inc.

Cernetig, M. (1993a). Health-care clinics taking a U.S. twist. *The Globe and Mail*, April 10, A1, A7.

Charles, C., Lomas, J., Giacomini, M., Bhatia, V. & Vincent, V.A. (1997). Medical necessity in Canadian health policy: four meanings and ... a funeral? *The Milbank Quarterly*, 75(3):365-394.

Checkel, J.T. (1999). Social construction and integration. *Journal of European Public Policy*, 6(4):545-560.

Choudhry, S. (2001). Bill 11: The Canada Health Act and the Social Union: The Need for Institutions. In T.A. Caulfield and B. von Tigerstrom (eds.), *Health Care Reform and the Law in Canada: Meeting the Challenge*. Edmonton: University of Alberta Press.

Clarke, H.D. & Kornberg, A. (1994). The politics and economics of constitutional choice: Voting in Canada's 1992 referendum. *Journal of Politics*, 56(4): 940-962.

Clarke, H. D., Jenson, J., LeDuc, L., & Pammett, J. H. (1996). *Absent Mandate: Canadian Electoral Politics in an Era of Restructuring*. (Third Edition ed.) Toronto: Gage.

Cobb, R.W. & Ross, M.H. (1997). Agenda setting and the denial of agenda access: Key concepts. In R.W. Cobb & M.H. Ross (Eds.), *Cultural Strategies of Agenda Denial: Avoidance, Attack and Redefinition.* (pp 3-24). Lawrence: University of Kansas Press.

Coburn, D. (1993). State authority, medical dominance, and trends in the regulation of the health professions: the Ontario case. *Social Science and Medicine, 37,* 841-850.

Cohn, D. (1996). The Canada Health and Social Transfer: transferring resources or moral authority between levels of government? In P.C. Fafard & D.M. Brown (Eds.), *Canada: The State of the Federation 1996.* (pp 167-187). Kingston: Institute for Intergovernmental Relations.

Coleman, W.D. (1998). From protected development to market liberalism: paradigm change in agriculture. *Journal of European Public Policy*, 5(4):632-651.

Coleman, W. D. & Skogstad, G. (1990). Introduction. In W.D.Coleman & G. Skogstad (Eds.), *Policy Communities and Public Policy in Canada: A Structural Approach.* Mississauga: Copp Clark Pitman Ltd.

Collier, D. (1993). The Comparative Method. In A. Finifter (Ed.), *Political Science: The State of the Discipline II.* Washington: American Political Science Association.

Commission on the Future of Health Care in Canada (2002). *Building on Values: The Future of Health Care in Canada, Final Report.* Saskatoon.

Conference of Provincial/Territorial Ministers of Health, (199x). *A Renewed Vision for Canada's Health System.* Edmonton: Government of Alberta.

Conradt, D.P. (1972). The West German party system: an ecological analysis of social structure and voting behavior, 1961 – 1969. *Sage Comparative Politics Series.* Volume 3, Number 01-028. Beverly Hills: Sage Publications.

Converse, P.E. (1964). The nature of belief systems in mass publics. In D.E. Apter (Ed.), *Ideology and Discontent.* (pp 206-261). New York: The Free Press.

Cordon, S. (1995). Federalism works, proclaims Romanow. *Edmonton Journal,* November 5, A3.

Crockatt, J. (1993a). Klein eager to avoid Kiwi credit squeeze. *Edmonton Journal,* March 26, A7.

—— (1993b). Consumers' group urges Ottawa to ban private medical clinics. *Edmonton Journal,* September 30, A1

—— (1993c). Patients to face extra fees. *Edmonton Journal,* December 10, A1

—— (1993d). Harcourt wants Klein to explain extent of Alberta's welfare policy. *Edmonton Journal,* November 25, A9.

—— (1994a). Klein gives green light to for-profit health-care; Two-Tiered Care. *Edmonton Journal,* April 13, A1

—— (1994b). Hospital workers out to embarrass government, says Klein. *Edmonton Journal,* September 16, A3.

—— (1995a). Faster care – at a price. Klein wants Medicare changes. *Edmonton Journal,* April 5, A1

Daniels, A. (1988). Die Armen Kassen: Norbert Blüm hat keine Lösung für die Probleme der Arbeiter-Krankenversicherung. *Die Zeit* 4, 22

Deber, R., E. Ross, and M. Catz (1993). *Comprehensiveness in Health Care: Report to the Health Action Lobby.* Ottawa: HEAL

Delacourt, S. (1993a). Campbell ready for medicare user fees: Principle of universality no longer acceptable for all programs, minister tells Alberta audience. *The Globe and Mail,* 30 April, A6.

—— (1993b). Maritime premiers embrace Chrétien. *The Globe and Mail,* August 14, A4.

De Landtsheer, C. (1998). Introduction to the study of political discourse. In O. Feldman & C. De Landtsheer (Eds.), *Politically Speaking: A Worldwide Examination of Language Used in the Political Sphere.* (pp 1-16). Westport: Praeger.

Defever, M. (1995). Health care reforms: the unfinished agenda. *Health Policy,* 34:1-7.

Deutscher Bundestag (1984). *Plenarprotokoll.* Drs 10/98 (8 November). Bonn.

—— (1985a). *Plenarprotokoll.* Drs 10/130 (29 March). Bonn.

—— (1985b). *Antwort der Bundesregierung: Leistungsfähigkeit des Gesundheitswesens und Qualität der gesundheitlichen Versorgung der Bevölkerung.* Drs 10/3374 (22 May).

Bonn.
—— (1985c). *Unterrichtung durch die Bundesregierung: Jahresgutachten 1985/86 des Sachverständigenrates zur Begutachtung der gesamtwirtschaftlichen Entwicklung*. Drs 10/4295 (22 November). Bonn.
—— (1986). *Plenarprotokoll.* Drs 10/208 (21 March). Bonn.
—— (1987a). *Regierungserklärung.* Drs 11/4 (18 March). Bonn.
—— (1987b). *Plenarprotokoll.* Drs 11/47 (4 December). Bonn.
—— (1988a). *Plenarprotokoll.* Drs 11/78 (6 May). Bonn.
—— (1988b). *Plenarprotokoll.* Drs 11/103 (27 October). Bonn.
—— (1991a). *Plenarprotokoll.* Drs 12/5 (30 January). Bonn.
—— (1991b). *Plenarprotokoll.* Drs 12/6 (31 January). Bonn.
—— (1992a). *Antrag der Fraktion der SPD: Reform des Gesundheitswesens*. Drs 12/3226 (08 September). Bonn.
DGB – Deutscher Gewerkschaftsbund (1988). Stellungnahme zum Entwurf eines Gesundheitsreform-Gesetzes (GRG). *Soziale Sicherheit* 7, 194-7.
—— (1992). Forderungen des DGB zur Qualität und Wirtschaftlichkeit im Gesundheitswesen bei stabilen Beitragssätzen. *Soziale Sicherhiet*, 3: 75-83.
Die Neue Ärztliche (1988). Freiberuflichkeit wird ausgehöhlt. 10 February.
Die Welt (1992a). Zahnärzte töten Seehofer den Nerv. *Die Welt*, 173 (July 27).
—— (1992b). Horst Seehofer: "Das Maß ist voll." *Die Welt*, 206 (September 3).
Die Zeit (1992). "Der Zug fährt an die Wand." *Die Zeit*, 40 (September 25).
Döhler, M. (1990). *Gesundheitspolitik nach der "Wende": Policy-Netzwerke und ordnungspolitischer Strategiewechsel in Großbritannien, den USA und der Bundesrepublik Deutschland*. Berlin: Ed. Sigma Rainer Bohn Verlag.
—— (1991). Policy networks, opportunity structures and neo-conservative reform strategies in health policy. In B. Marin & R. Mayntz (Eds.), *Policy Networks: Empirical Evidence and Theoretical Consideration.* (pp 235-296). Frankfurt: Campus Verlag.
—— (1993). Ordnungspolitische Ideen und sozialpolitische Institutionen. In R. Czada & M.G. Schmidt (Eds.), *Verhandlungsdemokratie, Interessenvermittlung, Regierbarkeit.* (pp 123-141). Opladen: Westdeutscher Verlag.
—— (1995). The State as Architect of Political Order: Policy Dynamics in German Health Care. *Governance*, 8(3):380-404.
Döhler, M. & Manow, P. (1995). *Formierung und Wandel eines Politikfeldes -- Gesundheitspolitik von Blank zu Seehofer*. Max-Planck-Institut fuer Gesellschaftsforschung. 95/6:1
DOK (1992a). Gefährdung der Beitragstabilität durch Ausbleiben dauerhafter GRG - Kostensenkungseffekte. *DOK* 1/2(1-15 Jan): 2-18.
—— (1992b). Grußadressen: Wilkommen in Hamburg zur AOK-Bundestagung 1992. *DOK*, 18 (September 14-15): 595-611.
Donaukurier (1992) 'Wir brauchen eine Sofortbremsung'. *Donaukurier*, 12 May.
Dreßler, R. (1988a). Thema: Kostendämpfung. *Neue Westfällische*, 16 March.

—— (1988b). Strukturreform im Gesundheitswesen: Das GRG geht in die Irre! *Teleskop* August, 24-25.
—— (1989). Mit unserem Konzept jedoch muß man sich auseinandersetzen. *Arbeit und Sozialpolitik* 12, 369-72.
—— (1992a). Zur Lage im Gesundheitswesen. *Niedersächsisches Ärzteblatt*, 3, 9-10.
—— (1992b). Strukturreform statt Kostendämpfung. *Gesellschaftspolitische Kommentare*, Sonderausgaben 1:48.
Dunn, C. (1996). Premiers and cabinets. In C.Dunn (Ed.), *Provinces: Canadian Provincial Politics* (pp. 165-204). Peterborough: Broadview Press.
Dupré, J. S. (1988). Reflections on the Workability of Executive Federalism. In R.D.Olling & M. W. Westmacott (Eds.), *Perspectives on Canadian Federalism* (pp. 233-255). Scarborough: Prentice-Hall of Canada.
Dyck, R. (1996). *Provincial Politics in Canada: Towards the Turn of the Century*. (3rd ed.) Scarborough: Prentice-Hall Canada Inc.
Dyson, K. (2001). The German model revisited: From Schmidt to Schröder. *German Politics*, 10(2):135-154.
Edelman, M. (1976). *The Symbolic Uses of Politics*. Urbana: University of Illinois Press.
—— (1977). *Political Language: Words that Succeed and Policies that Fail.* New York: Academic Press..
Edmonton Journal (1993a). Feds checking legality of MRI clinics. 'Reasonable access' in doubt. *Edmonton Journal*, April 15, A1
—— (1993b). Ask the leaders: Health care. *Edmonton Journal*, June 11, A7.
Eichhorn, F.J. (1992). Gerda Hasselfeldt – ratlos, hilflos, machtlos. *Stuttgarter Zeitung*, April 15.
Elections Alberta (2003). *Summary of Results for Past General Elections (1905 - 2001).* Accessed from URL www.electionsalberta.ab.ca/ on 18 August 2003.
Elections Canada Online (2003a). *Thirty-Sixth General Election 1997: Official Voting Results*. Accessed from URL www.elections.ca/ on 11 Aug 2003
Elections Canada Online (2003b). *Thirty-Seventh General Election 2000: Official Voting Results*. Accessed from URL www.elections.ca/ on 11 Aug 2003
Elton, D. K. & Goddard, A. M. (1979). The Conservative Takeover, 1971 -. In C. Caldarola (Ed.), *Society and Politics in Alberta* (pp. 49-70). Toronto: Methuen.
Engelen-Kefer, U. (1992). Die Nachfragemacht der Kassen stärken. *Gesellschaftspolitische Kommentare*, Sonderausgabe 1: 56-58.
Esping-Andersen, G. (1996). After the Golden Age? Welfare State Dilemmas in a Global Economy. In G.Esping-Andersen (Ed.), *Welfare States in Transition: National Adaptions to Global Economies* (pp. 1-31). London: Sage Publications.
Estes, C.L. (1983). Social security: The social construction of a crisis. *Health and Society*, 61(3):445-461.
European Observatory on Health Care Systems, (2000). *Health Care Systems in Transition -- Germany.* Copenhagen: WHO.
Evans, R.G., Barer, M.L. & Stoddart, G.L. (1995). User fees for health care: Why a

bad idea keeps coming back (or, what's health got to do with it?). *Canadian Journal on Aging*, 14(2):360-390.

Falcone, D. & Van Loon, R.J. (1983). Public Attitudes and Intergovernmental Shifts in Responsibility for Health Programs: Paying the Piper without Calling the Tune? In A. Kornberg & H.D. Clarke (Eds.), *Political Support in Canada: The Crisis Years.* (pp 225-251). Durham: Duke University Press.

Fay, B. (1975). *Social Theory and Political Practice.* London: George Allen and Unwin Ltd.

FAZ – *Frankfurter Allgemeine Zeitung* (1992a). Ärzte rügen die Gesundheitspolitik Frau Hasselfeldts, Janaury 14.

—— (1992b). Kontroverse über Reformen im Gesundheitswesen. Wie können die Krankenkassen entlastet werden? April 16.

—— (1992c). Hoffackers Vorschläge zur Reform des Gesundheitswesens vielfach kritisiert, April 18.

—— (1992d). Gerda Hasselfeldts Rückzug aus dem Bonner Ministeramt, April 28, p. 2.

—— (1992e). Die Vorschläge Seehofers erfahren ein zwiespältiges Echo, June 4.

—— (1992f). Die Länder streben regionale Einheitskassen an, July 20.

—— (1992gi). Widerstand gegen Regionalisierung wächst. July 24.

—— (1992g). Bei den Ärzten wächst der Protest gegen die Pläne Minister Seehofers, August 3.

—— (1992h). Die FDP gibt Weg für Seehofers Spargesetz frei, August 11.

—— (1992i). Die "Sozialliberalen" in der FDP wenden sich gegen Lambsdorffs. August 22.

—— (1992j). Seehofer bietet SPD Zusammenarbeit bei Gesundheitsreform an. September 12.

—— (1992k). Dreßler lobt die Umgestaltung der Krankenversicherung. October 6.

FDP (1988). Cronenberg: Korrekturen am Referentwurf Notwendig. *FDP Tagesdienst* 130: 2 February.

Feehan, J.P. (1995). The federal debt. In S.D. Phillips (ed.), *How Ottawa Spends 1995-96: Mid-Life Crisis.* Ottawa: Carleton University Press.

Ferguson, Derek (1987a). Medicare reductions under fire in Alberta. *Toronto Star*, July 11, B1.

Feschuk, S. (1994). Albertans balk at privatization bill. *Globe and Mail*, November 5, A1, A2.

Finkel, A. (1989). *The Social Credit Phenomenon in Alberta.* Toronto: University of Toronto Press.

Finnemore, M. & Sikkink, K. (1998). International norm dynamics and political change. *International Organization*, 52(4):887-917.

Fischer, F. (2003). *Reframing Public Policy. Discursive Politics and Deliberative Practices.* Oxford: Oxford University Press.

Flora, P. (1986). Introduction. In P. Flora (Ed.), *Growth to Limits: The Western European Welfare States Since World War II.* Berlin: Walter de Gruyter.

Forster, J. (1991). Der Patient Krankenkasse im Osten; SZ-Gesprache mit Prof. Martin Pfaff: Risikoausgleich ist zwingend. *Süddeutsche Zeitung*, May 3.

Forster, J. and H. Graupner (1992). "Brandschutz betreiben, bevor das ganze System in Flammen steht," SZ-Interview mit Horst Seehofer. *Süddeutsche Zeitung,* 140 (June 20/21): 11.

FR – *Frankfurter Rundschau* (1992a). SPD stellt sich vor Patienten, 2 June.

—— (1992b). Von Seehofer hart getroffen. August 8.

—— (1992c). FDP trotz Bedenken für Seehofers Plan, August 11.

Fraser, Graham (1991a). Opposition, activists attach plan to limit social spending. *The Globe and Mail*, February 27, A7.

—— (1991b). Budget revives power-sharing debate. *The Globe and Mail*, February 28, A3.

Gabriel, O.W. (1989). Federalism and party democracy in West Germany. *Publius* 19(4):65-80.

Geddes, A. (1991a). Impact is still uncertain. *Calgary Herald*, February 28, A9.

—— (1991b). Health report no 'quick fix'. *Calgary Herald*, December 6, B1.

—— 91993a). Budget: Deficit attacked: Health, welfare hit hard. *Calgary Herald*, May 7, A1.

Geddes, A., C. Dawson & D. Pommer (1995). *Klein blinks.* Calgary Herald, November 23, A1.

General Anzeiger (1992). Die Länder lehnen Seehofers Sparpaket ab. September 26/27.

Giaimo, S. (1995). Health Care Reform in Britain and Germany: Recasting the Political Bargain with the Medical Profession. *Governance*, 8(3):354-379.

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

Giaimo, S. & Manow, P. (1999). Adapting the welfare state: the case of health reform in Britain, Germany and the United States. *Comparative Political Studies*, 32(8):967-1000.

Gibbins, R. (1985). Alberta: Looking Back, Looking Forward. In Peter Leslie (Ed). *Canada: The State of the Federation 1985.* Kingston: Institute for Intergovernmental Relations, Queen's University.

—— (1992). Alberta and the National Community. In A.Tupper & R. Gibbins (Eds.), *Government and Politics in Alberta* (pp. 67-84). Edmonton: University of Alberta Press.

Godt, P.J. (1987). Confrontation, Consent and Corporatism: State Strategies and the Medical Profession in France, Great Britain and West Germany. *Journal of Health Politics, Policy and Law*, 12(3):459-480.

Goldstein, J. & Keohane, R.O. (1993). Ideas and foreign policy: An analytical framework. In J. Goldstein & R.O. Keohane (Eds.), *Ideas and Foreign Policy:*

Beliefs, Institutions and Political Change. (pp 3-30). Ithaca: Cornell University Press.

Goodin, R.E., Headey, B., Muffels, R. & Dirven, H. (1999). *The Real Worlds of Welfare Capitalism.* Cambridge: Cambridge University Press.

Gray, Charlotte (1991). If the Reformers have their way, we'll have a very different health care system. *Canadian Medical Association Journal* 145:999-1000.

Gray, Gwendolyn (1991). *Federalism and Health Policy: The Development of Health Systems in Canada and Australia.* Toronto: University of Toronto Press.

Ha, T.T. & S. Feschuk (1995). End extra fees, Marleau demands. *Globe and Mail,* January 7, A1-2.

Hacker, J.S. (1998). The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian and US Medical Policy. *Studies in American Political Development,* 12(Spring):57-130.

Hackey, R.B. (1997). Symbolic politics and health care reform in the 1940s and 1990s. In R.W. Cobb & M.H. Ross (Eds.), *Cultural Strategies of Agenda Denial: Avoidance, Attack and Redefinition.* (pp 141-157). Lawrence: University of Kansas Press.

Hagopian, M. N. (1978). *Regimes, Movements, and Ideologies: A Comparative Introduction to Political Science.* New York: Longman Inc.

Hall, P.A. (1989). Conclusion: The Politics of Keynesian Ideas. In P.A. Hall (Ed.), *The Political Power of Economic Ideas: Keynesianism Across Nations.* (pp 361-391). Princeton: Princeton University Press.

—— (1993). Policy Paradigms, Social Learning and the State. *Comparative Politics,* 25(3):275-287.

—— (1997). The role of interests, institutions and ideas in the comparative political economy of the industrialized nations. In M.I. Lichbach & A.S. Zuckerman (Eds.), *Comparative Politics: Rationality, Culture and Structure.* (pp 174-207). Cambridge: Cambridge University Press.

Handelsblatt (1988). Blüms Krankenkassenplan gefährdet die Arbeitsplätze. 19 January.

—— (1992a). SPD und Gewerkschaften warnen vor erneuter Belastung der Patienten, June 2, p. 6.

—— (1992b). Krankenkassen begrüßen Seehofers Sparpaket, June 4.

—— (1992c). Forderung der SPD-Fraktion nach einem kasseninternen Finanzausgleich kritisiert, August 7-8.

—— (1992d). FDP: Das Ziel bleibt mehr Markt im Gesundheitswesen. August 7-8.

—— (1992e). Tenor der Empfehlungen ist "lediglich ein Umbau, nicht der Abbau des Sozialstaats." August 24.

—— (1992f). SPD zur Konsenssuche mit Seehofer bereit. September 12/13, p. 4.

—— (1992g). Cronenberg verteidigt den Kompromiß von Lahnstein. October 6.

—— (1992h). Große Koalition. In der Lahnstein blieb der FDP die Statistenrolle. October 6.

Health Canada, (1997). *Canada Health Act Annual Report 1996-97.* Ottawa: Minister of Public Works and Government Services, Canada.

Heclo, H. (1974). *Modern Social Politics in Britain and Sweden.* New Haven: Yale University Press.

Heiber, S. & Deber, R. (1987). Banning extra-billing in Canada: just what the doctor didn't order. *Canadian Public Policy, 13,* 62-74.

Heidenheimer, A.J. and Kommers, D.P. (1975). *The Governments of Germany.* Fourth Edition. New York: Thomas Y. Crowell Company.

Helm, R. (1993a). MRI clinics no threat to medicare – Minister. *Edmonton Journal,* April 13, A1.

Hemerijck, A. & van Kersbergen, K. (1999). Negotiated policy change: Towards a theory of institutional learning in tightly coupled welfare states. In D. Braun & A. Busch (Eds.), *Public Policy and Political Ideas.* (pp 168-185). Cheltenham: Edward Elgar.

Henton, D. (1995). Health care duel backfires for Alberta's Klein. *Toronto Star,* October 15, F1.

Hinrichs, K. (1995). The Impact of German Health Insurance Reforms on Redistribution and the Culture of Solidiarity. *Journal of Health Politics, Policy and Law,* 20(3):653-687.

Hogwood, B.W. and L.A. Gunn (1994). *Policy Analysis for the Real World.* Oxford: Oxford University Press.

Hughes, K. D., Lowe, G. S., & McKinnon, A. L. (1996). Public Attitudes Toward Budget Cuts in Alberta: Biting the Bullet or Feeling the Pain? *Canadian Public Policy, 22,* 268-283.

Hunter, J. (1995). Western leaders invite Parizeau to talk about Canadian issues. *The Vancouver Sun,* Novermber 3, A1.

Hurley, J. & Card, R. (1996). Global physician budgets as common-property resources: Some implications for physicians and medical associations. *Canadian Medical Association Journal, 154,* 1161-1168.

Hurst, J.W. (1991). Reform of health care in Germany. *Health Care Financing Review* 12(3):73-86.

Immergut, E.M. (1992). The rules of the game: The logic of health policy making in France, Switzerland and Sweden. In S. Steinmo, K. Thelen, & F. Longstreth (Eds.), *Structuring Politics: Historical Institutionalism in Comparative Analysis.* (pp 57-89). Cambridge: Cambridge University Press.

Jeffery, B. (1992). *Breaking Faith.* Toronto: Key Porter Books.

Jeffery, C. (1999). Party politics and territorial representation in the Federal Republic of Germany. *West European Politics,* 22(2):130-166.

Jervis, R. (1976). *Perception and Misperception in International Politics.* Princeton: Princeton University Press.

Jost, T. (1998). German health care reform: the next steps. *Journal of Health Politics, Policy & Law,* 23(4):697-711.

Kamke, K. (1998). The German health care system and health care reform. *Health Policy*, 43:171-194.

Katz, S. J., Charles, C., Lomas, J., & Welch, H. G. (1997). Physician relations in Canada: Shooting inward as the circle closes. *Journal of Health Politics, Policy & Law, 22,* 1413-1431.

Katzenstein, P.J. (1987). *Policy and Politics in West Germany: The Growth of a Semisovereign State*. Philadelphia: Temple University Press.

KBV - Kassenärtzlichen Bundesvereinigung (1992). Klares Nein zu einem simplen Spargesetz. Kassenärzte wollen von der Politik gehört werden. *Deutsches Ärzteblatt*, 21(11): B-1171.

Keeler, John T.S. (1993). Opening the window for reform: Mandates, crises, and extraordinary policy making. *Comparative Political Studies*, 25(4): 433-486.

Kingdon, J.W. (1994). Agendas, Ideas and Policy Change. In L. Dodd & C. Jillson (Eds.), *New Perspectives on American Politics.* (pp 215-229). Washington: Congressional Quarterly Inc.

Kingdon, J. W. (1995). *Agendas, Alternatives and Public Policies.* (Second ed.) New York: HarperCollins College Publishers.

Kneebone, R.D. & McKenzie, K.J. (1997). The process behind institutional reform in Alberta. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

Kohl, Helmut (1991). Aufgaben der Gesundheitspolitik im vereinten Deutschland. *Bulletin: Presse- und Informationsamt der Bundesregierung*. Number 50, pp. 401-404.

Kornberg, A., Mishler, W., & Clarke, H. D. (1982). *Representative Democracy in the Canadian Provinces*. Scarborough: Prentice-Hall Canada, Inc.

Kudella, P. (1987). Rettet das Gesundheitswesen. Zum Positionspapier Gesundheitspolitk der Christlich Demokratischen Arbeitnehmerschaft. *Gesellschaftliche Kommentare* 2(February):11-12.

Kuhn, T.S. (1996). *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press.

Lamping, W. (1994). Finanzierungsstrukturen, Verteilungskonflikte und politische Gestaltung der GKV. In B. Blanke [Ed.]. *Krankheit und Gemeinwohl: Gesundheitspolitik zwischen Staat, Sozialversicherung und Medizin*. Opladen: Leske+Budrich.

Lau, R. R., Smith, R. A., & Fiske, S. T. (1991). Political beliefs, policy interpretations, and political persusasion. *Journal of Politics, 53,* 644-675.

Lauer-Kirschbaum, T. (1994). Kollektivverhandlungen und Selbstverwaltungkonsens: Interessenegoismus und Gemeinwohlorientierung in der Entwicklung und Reform der Gesetzlichen Krankenversicherung. In B. Blanke [Ed.]. *Krankheit und Gemeinwohl: Gesundheitspolitik zwischen Staat, Sozialversicherung und Medizin.* Opladen: Leske+Budrich.

Laumann, E.O. and D. Knoke (1987). *The Organizational State: Social Choice in National Policy Domains.* Madison: University of Wisconsin Press.

Lazar, H. (1997). Non-constitutional renewal: Toward a new equilibrium in the federation. In H. Lazar (ed.), *Canada: The State of the Federation 1997. Non-Constitutional Renewal.* Kingston: Institute of Intergovernmental Relations, Queen's University.

Lazar, H. & McIntosh, T. Federalism, Democracy, and Social Policy: Towards a Sectoral Analysis of the Social Union. Unpublished work.

Legro, J.W. (2000). The transformation of policy ideas. *American Journal of Political Science*, 44(3):419-432.

Lees, C. (2001). Coalitions – beyond the politics of centrality? *German Politics*, 10(2):117-134.

Lehmbruch, G. (1978). Party and federation in Germany: A developmental dilemma. *Government and Opposition*, 13(2):151-177.

Lewis, J.M. (1999). The durability of ideas in health policy making. In D. Braun & A. Busch (Eds.), *Public Policy and Political Ideas.* (pp 152-167). Cheltenham: Edward Elgar.

Lieberman, B. (2000). From economic miracle to Standort Deutschland: exchanging economic metaphors in the Federal Republic of Germany. *German Politics and Society*, 18(2):30-65.

Lipsky, M. & Smith, S. R. (1989). When social problems are treated as emergencies. *Social Service Review, 63,* 5-25.

Little, B. (1991). User fees favoured to pay rising health costs. *The Globe and Mail*, 5 November.

Maioni, A. (1995). Nothing succeeds like the right kind of failure: postwar national health insurance initiatives in Canada and the United States. *Journal of Health Politics, Policy and Law*, 20(1):5-30.

Maioni, A. (1998). *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada.* Princeton: Princeton University Press.

Maioni, A. and M. Smith (2004). Health care and Canadian federalism. In F. Rocher and M. Smith (eds.), *New Trends in Canadian Federalism, 2nd Edition.* Peterborough: Broadview Press.

Manga, P. & Weller, G.R. (1991). Health policy under conservative governments in Canada. In C. Altenstetter & S.C. Haywood (Eds.), *Comparative Health Policy and the New Right: From Rhetoric to Reality.* (pp 207-224). New York: St. Martins.

Manow, P. (1994). *Strukturinduzierte Politikgleichgewichte: Das Gesundheitsstrukturgesetz (GSG) und seine Vorgaenger.* Koeln: Max-Planck-Institut fuer Gesellschaftsforschung. :1(94/5) MPIfG Discussion Paper.

Mansell, R.L. (1997). Fiscal restructuring in Alberta: An overview. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

Marleau, D. (1995). Text of Letter sent on January 6, 1995, to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau. Available at Health Canada Online: http://www.hc-sc.gc.ca/medicare/Marleau.htm

Maslove, A.M. (1996). The Canada Health and Social Transfer: Forcing the Issues. In G. Swimmer (Ed.), *How Ottawa Spends 1996-97: Life Under the Knife.* (pp 283-301). Ottawa: Carleton University Press.

Maslove, A. M. & Rubashewsky, B. (1987). Cooperation and Confrontation: The Challenges of Fiscal Federalism. In M.J.Prince (Ed.), *How Ottawa Spends, 1986-87. Tracking the Tories.* (pp. 95-117). Ottawa: Carleton University Press.

Marshall, A. (1993). Round table system 'flawed'. *Calgary Herald*, September 4, B3.

Mazy, S. (2000). Introduction: Integrating gender - intellectual and 'real world' mainstreaming. *Journal of European Public Policy, 7,* 333-345.

McConnell, Rick (1989). Alberta medicare flying on autopilot. *Edmonton Journal*, October 20, B9

McCormick, P. (1996). Provincial Party Systems, 1945-1993. In A.B.Tanguay & A. G. Gagnon (Eds.), *Canadian Parties in Transition* (Second Edition ed., pp. 349-371). Scarborough: Nelson Canada.

McKenzie, K.J. (1997). Institutional design and public policy: A microeconomic perspective. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

McMillan, M. (1996). *Leading the Way or Missing the Mark? The Klein Government's Fiscal Plan.* (Rep. No. 37). University of Alberta, Faculty of Business.

Meekison, J. P. (1992). Alberta and the Constitution. In A.Tupper & R. Gibbins (Eds.), *Government and Politics in Alberta* (pp. 247-268). Edmonton: University of Alberta Press.

Mendelsohn, M. (2001). *Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation*. Saskatoon, Commission on the Future of Health Care in Canada.

Mhatre, S. & Deber, R. (1992). From equal access to health care to equitable access to health: a review of Canadian provincial health commissions and reports. *International Journal of Health Services, 22,* 645-668.

Mickleburgh, Rod (1992). Ministers pessimistic about Medicare. *The Globe and Mail*, June 17.

—— (1992b). CMA delegates direct ire at health care monopoly: Private insurance resolution sails through. *The Globe and Mail*, 19 August.

Moore, M. H. (1988). What sort of ideas become public ideas? In R.B.Reich (Ed.), *The Power of Public Ideas* (pp. 55-84). Cambridge: Harvard University Press.

Moran, M. (1994). Health care policy. In J. Clasen & R. Freeman (Eds.), *Social Policy in Germany.* (pp 83-101). New York: Harvester Wheatsheaf.

—— (1999). *Governing the Health Care State: A Comparative Study of the United Kingdom, the United States and Germany*. Manchester: Manchester University Press.

Moulton-Barrett, Donalee (1991). NS to consider implementing other user fees to pay for rising health costs. *The Medical Post*, 30 April.

Muller-Mundt, G. (1997). Trends in hospital restructuring and impact on the workforce in Germany. *Medical Care*, 35(10 Suppl):OS132-42.

Mulroney, B. (1991a). *Notes for an address by Prime Minister Brian Mulroney to the Canadian and Empire Clubs of Toronto.* Toronto, Ontario. February 12. Ottawa: Office of the Prime Minister.

—— (1991b). *Notes for a speech by Prime Minister Brian Mulroney to the Chamber of Commerce.* Montreal, Quebec. October 23. Ottawa: Office of the Prime Minister.

Murswieck, A. (1985). Health policy making. In K. von Beyme and M.G. Schmidt [Eds.] *Policy and Politics in the Federal Republic of Germany*. New York: St. Martin's Press.

Nagel, P. (1994). Ideological split lies at the heart of row between two premiers. *The Vancouver Sun*, March 12, A10.

—— (1995). PM, Klein differ on Health Act; Alberta premier says there is a dollar figure attached to universal benefit. *Hamilton Spectator*, April 15, A16.

Nahrath, S. (1999). The power of ideas in policy research: A critical assessment. In D. Braun & A. Busch (Eds.), *Public Policy and Political Ideas.* (pp 41-58). Cheltenham: Edward Elgar.

National Council on Welfare (1991*). Funding health and higher education : Danger Looming.* Ottawa: The Council.

Naylor, C. D. (1986). *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance*. Montreal: McGill-Queen's Univeristy Press.

Necheff, J. (1995). Friends of Medicare want end to facility fees in private clinics. *Canadian Press Newswire*, January 30.

O'Donnell, J. (1984). Mulroney pledges to consult with provinces over cutbacks. *Toronto Star*, November 15, A8.

O'Neil, P. (1995). Premiers call Ottawa two-faced. *Calgary Herald*, August 26, A1

O'Neill, M. (1996). Health as an irreversible part of the welfare state: Canadian government policy under the Tories. *International Journal of Health Services, 26,* 547-559.

Organization for Economic Cooperation and Development OECD (1992). *The Reform of Health Care Systems: A Comparative Analysis of Seven OECD Countries.* Paris: OECD.

—— (2001). *OECD Health Data 2001*. Paris.

Orren, G.R. (1988). Beyond self-interest. In R.B.Reich (Ed.), *The Power of Public Ideas*. Cambridge: Harvard University Press.

Ottawa Citizen (1987). Private companies can't compete with Alberta Medicare, Getty

says. *The Ottawa Citizen*, March 18, A15.

Padgett, S. and Burkett, T. (1986). *Political Parties and Elections in West Germany: The Search for a New Stability.* London: C. Hurst & Company.

Pal, L. A. (1992). The political executive and political leadership in Alberta. In A.Tupper & R. Gibbins (Eds.), *Government and Politics in Alberta* (pp. 1-30). Edmonton: University of Alberta Press.

Panzeri, A. (1993a). New diagnostic clinic leaves Klein unruffled. *Edmonton Journal*, April 14, A7.

—— (1994). Avoding the mistreatment of bad risks in a democracy: universal health insurance from a constitutional perspective. *Constitutional Political Economy*, 5(3):307-318.

—— (1995). When Does Curbing Health Costs Really Help the Economy? *Health Affairs*, (Summer 1995):68-82.

Pedersen, R. (1995a). Are there problems with health care? 'Absolutely none'. *Edmonton Journal*, August 12, G1

Perschke-Hartmann, C. (1994). *Die doppelte Reform: Gesundheitspolitik von Bluem zu Seehofer.* Opladen: Leske + Budrich.

Phillipon, D. J. & Wasylyshyn, S. A. (1996). Health care reform in Alberta. *Canadian Public Administration, 39,* 70-84.

Phillips, N. and C. Hardy (2002). *Discourse Analysis: Investigating Processes of Social Construction*. Thousand Oaks: Sage Publications.

Pierson, P. (1993). *Dismantling the Welfare State?* Cambridge: Cambridge University Press.

—— (1994). *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment.* New York: Cambridge University Press.

—— (1995). Fragmented welfare states: Federal institutions and the development of social policy. *Governance, 8,* 449-478.

Pierson, P. & Smith, M. (1993). Bourgeois Revolutions? The Policy Consequences of Resurgent Conservatism. *Comparative Political Studies*, 25(4):487-520.

Plain, R. H. M. (1997). The role of health care reform in the reinventing of government in Alberta. In C.J.Bruce, R. D. Kneebone, & K. J. McKenzie (Eds.), *A Government Reinvented: A Study of Alberta's Deficit Elimination Program.* Toronto: Oxford University Press.

Poguntke, T. (2001). The Germany party system: Eternal crisis? *German Politics*, 10(2):37-50.

Pole, Ken (1991). Feds now hint Canada Health Act disposable. *The Medical Post*, 7 May, p.1, 72.

Radwanski, G. (1984). An Interview with Brian Mulroney: "Deficit and jobs a two-pronged battle." *Toronto Star*, November 17, B5

Ramsey, Joan (1991). Some hard choices: Medicare is sucking up too many tax dollars. *Calgary Herald*, May 11, p. A5

Redden, C. (2002). *Health Care, Entitlement, and Citizenship*. Toronto: University of Toronto Press.

Reich, R.B. (1988). Policy making in a democracy. In R.B.Reich (Ed.), *The Power of Public Ideas*. Cambridge: Harvard University Press.

Reiners, Hartmut (1992). Die Organisationsreform der GKV – Eine unedliche Geschichte? *Arbeit und Sozialpolitik*, 45(11-12): 26-32.

Renzsch, Wolfgang (1998). Financing German unity: Fiscal conflict in a complex federation. *Publius*, 28(4): 127-46.

Rich, Pat (1984). Alberta loner in health act war with feds. *The Medical Post*, 20(6): 1.

Richards, J. (1998). Reducing the Muddle in the Middle: Three Propositions for Running the Welfare State. In L.A.Pal (Ed.), *Canada: The State of the Federation 1997. Non-Constitutional Renewal* (pp. 71-104). Kingston: Institute for Intergovernmental Relations, Queen's University.

Risse, T. (2000). "Let's argue!" Communicative action in world politics. *International Organization*, 54(1):1-39.

Roberts, G.K. (2000). *German Politics Today*. Manchester: Manchester University Press.

Rochefort, D. A. & Cobb, R. W. (1993). Problem definition, agenda access and policy choice. *Policy Studies Journal, 21*, 56-71.

—— (1994). Problem Definition: An Emerging Perspective. In D.A.Rochefort & R. W. Cobb (Eds.), *The Politics of Problem Definition: Shaping the Policy Agenda* (pp. 1-31). Lawrence, KS: University Press of Kansas.

Rock, A. (1997). Speaking Notes for Allan Rock Minister of Health. Canadian Medical Association 130th Annual Meeting, Victoria, B.C., August 20. Accessed at: http://www.hc-sc.gc.ca/english/media/speeches/cma97e.htm

Rosenhaft, E. (1994). The historical development of German social policy. In J. Clasen & R. Freeman (Eds.), *Social Policy in Germany*. (pp 21-41). NY: Harvester Wheatsheaf.

Rosewitz, B. & Webber, D. (1990). *Reformversuche und Reformblockaden im deutschen Gesundheitswesen*. Frankfurt (Main): Campus Verlag.

Ross, F. (1997). Cutting Public Expenditures in Advanced Industrial Democracies: The Importance of Avoiding Blame. *Governance, 10*, 175-200.

Ruf, T. (1987). Eine Reform ist unerläßlich. Der Wirtschaftsrat der CDU zur gesetzlichen Krankenversicherung. *Gesellschaftliche Kommentare* 2(February):13-14.

Ruggie, J.G. (1998). What makes the world hang together? Neo-utilitarianism and the social constructivist challenge. *International Organization*, 52(4):855-885.

Ruggie, M. (1996). *Realignments in the Welfare State: Health Policy in the United States, Britain and Canada*. New York: Columbia University Press.

Ruimy, J. (1984). Mulroney attacks Turner's social policy. *Toronto Star*, August 18, A6.

Russell, Frances (1991). User fees will not reduce costs of health care. *Winnipeg Free Press*, 1 May.

Saalfeld, T. (1999). Coalition politics and management in the Kohl era, 1982-98. *German Politics*, 8(2):141-173.

Sabatier, P. A. (1993). Policy change over a decade or more. In P.A.Sabatier & H. C. Jenkins-Smith (Eds.), *Policy Change and Learning: An Advocacy Coalition Approach* (pp. 13-39). Boulder: Westview.

—— (1998). The advocacy coalition framework: revisions and relevance for Europe. *Journal of European Public Policy, 5,* 98-130.

Safran, W. (1967). *Veto-Group Politics: The Case of Health-Insurance Reform in West Germany*. San Francisco: Chandler Publishing Company.

Sanches, Miguel (1992). Wir haben die Krankenkassen für alle Versicherten geöffnet. *NRZ*, 234 (October 6).

Sartori, G. (1994). Compare Why and How. In M.Dogan & A. Kazancigil (Eds.), *Comparing Nations* (pp. 14-34). Oxford: Blackwell.

Scharpf, F. W. (1988). The joint decision trap: Lessons from German federalism and European integration. *Public Administration, 66,* 239-278.

—— (1997). *Games Real Actors Play: Actor Centred Institutionalism in Policy Research.* Oxford: Westview Press.

Schmidt, M.G. (1983). Two logics of coalition policy: The West German case. In V. Bogdanor [Ed.]. *Coalition Government in Western Europe*. London: Heinemann.

Schmidt, V.A. (2000). Values and discourse in the politics of adjustment. In F.W.Scharpf & V. A. Schmidt (Eds.), *Welfare and Work in the Open Economy. Volume 1: From Vulnerability to Competitiveness.* (pp. 229-309). Oxford: Oxford University Press.

—— (2001). The politics of economic adjustment in France and Britain: when does discourse matter? *Journal of European Public Policy*, 8(2):247-264.

—— (2002). Does discourse matter in the politics of welfare state adjustment? *Comparative Political Studies* 35(2):168-193.

Schmidt, V. A. & Radaelli, C. M. (2004). Policy change and discourse in Europe: Conceptual and methodological issues. *West European Politics, 27,* 183-210.

Schneider, M. (1991). Health care cost containment in the Federal Republic of Germany. *Health Care Financing Review* 12(3):87-101.

Schön, D.A. & Rein, M. (1995). *Frame Reflection: Toward the Resolution of Intractable Policy Controversies.* Basic Books.

Schram, S.F. (1993). Postmodern policy analysis: Discourse and identity in welfare policy. *Policy Sciences*, 26:249-270.

Schulenburg, J.M.G. (1992). Germany: Solidarity at a price. *Journal of Health Politics, Policy an d Law*. 17(4):715-738.

Schwartz, H. (1997). Reinvention and retrenchment: lessons from the application of the New Zealand model to Alberta, Canada. *Journal of Policy Analysis and Management, 16,* 405-422.

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

Seehofer, Horst (1987). Mehr Wettbewerb auf der Anbieterseite auslösen. *Die Neue Ärztliche* 247, 29 December.

—— (1992) Horst Seehofer Bundesminister für Gesundheit Rede anlässlich der Beratung des Berichts zur Entwicklung der Beitragssätze in der GKV vor dem Deutschen Bundestag. *BMG-Pressemitteilung*, June 24.

—— (1992a) Gesundheit ist für Menschen das höchste Gut. (speech to the Bundestag). *BMG-Pressemitteilung*, September 11.

—— (1992b). 'Wir müssen härter rangehen' *Der Spiegel* 32.

—— (1992d). Rede von Bundesgesundheitsminister Horst Seehofer zur 1. Lesung des GSG im Bundesrat am 25. September 1992. *BMG-Pressemittelung*.

—— (1992e). Der Konsens von Lahnstein zeigt Handlungsfähigkeit der Politik. *BMG Pressemitteilung*, 07 October.

Séguin, R. (1990). Scrap Canada Health Act, Rémillard urges Ottawa. *The Globe and Mail*, December 12.

—— (1993). Grits' cutting of some health services predicted. *The Globe and Mail*, September 20, A6

Séguin, R. and R. Mickelburgh (1991). Quebec says budget feeds separatism. *The Globe and Mail*, February 28.

Sherlock, Karen (1989). Report urges special lessons for health-care abusers. *Edmonton Journal*, November 28, A7

—— (1990). 'Myth' in health costs attacked. *Edmonton Journal*, February 14, A10.

Silvia, S.J. (1999). Reform gridlock and the role of the Bundesrat in German politics. *West European Politics*, 22(2):167-181.

Simeon, R. (2002). *Political Science and Federalism: Seven Decades of Scholarly Engagement*. Kingston: Institute of Intergovernmental Relations.

Singer, O. (1990). Policy communities and discourse coalitions. *Knowledge: Creation, Diffusion, Utilization*, 11(4):428-458.

Smith, P. J. (2001). Alberta: experiments in governance - from Social Credit to the Klein revolution. In K.Brownsey & M. Howlett (Eds.), *The Provincial State in Canada: Politics in the Provinces and Territories* (pp. 277-308). Peterborough: Broadview Press.

Smith, S.R. (1995). The role of institutions and ideas in health care policy. *Journal of Health Politics, Policy and Law*, 20(2):385-389.

Spiegel, Der (1992a). Kampf gegen die Haie. June 8, pp. 112-119.

—— (1992b). "Wir müssen härter rangehen," Gesundheitsminister Horst Seehofer über Ärztehonorare und seine Pläne für eine neue Krankenversicherung. August 2.

—— (1992c). Ausgebufft, mit allen Wassern gewaschen. October 5, pp. 158-61.

Spiers, R. (1994a). 'No tax on sickness' federal Liberals vow. Health Minister won't permit user fees. *Toronto Star*, January 29, A1.

Starr, P. (1982). The Right to Health Care: Ethical Imperatives vs Enforceable Claims. In R.L. Numbers (Ed.), *Compulsory Health Insurance: The Continuing American*

Debate. (pp 115-143). Westport: Greenwood Press.

Starr, P. & Immergut, E.M. (1987). Health care and the boundaries of politics. In C.S. Maier (Ed.), *Changing Boundaries of the Political.* (pp 221-254). New York: Cambridge University Press.

Stevenson, Michael, Paul Williams and Eugene Vayda (1988). Medical politics and Canadian Medicare: Professional responses to the Canada Health Act. *The Milbank Quarterly*, 66:65-104.

Stoddart, G.L. & Labelle, R.J. (1985). Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology and Options. Health and Welfare Canada.

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

—— (1988). *Policy Paradox and Political Reason*. Boston: Harper Collins.

—— (1989). Causal Stories and the Formation of Policy Agendas. *Political Science Quarterly*, 104(2):281-300.

Streeck, W. and Schmitter, P.C. (1985). Community, market, state – and associations? The prospective contribution of interest governance to social order. In W. Streeck and P.C. Schmitter [Eds.] *Private Interest Government: Beyond Market and State.* London: Sage Publications.

Struzik, E. (1993a). Revolutionizing the world of medicine. *Edmonton Journal*, April 25, D7.

—— (1993b). Government paper has hospitals on its hit list; Suggestions for health cuts. *Edmonton Journal*, August 22, A1

Sturm, R. (2001). *Föderalismus in Deutschland*. Berlin: Landeszentrale für politische Bildungsarbeit Berlin.

SZ - *Süddeutsche Zeitung* (1991a). Sonderabgabe auf Sozialversicherung empfohlen. February 19.

—— (1992a). SPD attackiert Gesundheitspolitik der Koalition: "Kostendämpfung ist fehlgesclagen". March 20.

—— (1992bi). SPD will Gesundhietsreform im Bundesrat stoppen. June 2.

—— (1992b). 'Brandschutz betreiben, bevor das ganze System in Flammen steht.' June 20-21, pp. 11-12.

—— (1992c). DGB warnt vor Ruin der Krankenkassen. August 7.

—— (1992d). Seehofer will Sparziel von 11,4 Milliarden Mark und Lastenverteilung notfalls gegen SPD durchsetzen. August 13.

—— (1992e). Koalition und SPD wollen bei Reform zusammenarbeiten. Seehofer: 1993 auf jeden Fall elf Milliarden Mark sparen. September 12-13, p. 2.

—— (1992f). Seehofers Balanceakt zwischen FDP und SPD. September 12-13, p. 4.

—— (1992g). Der Erfolg von Lahnstein. October 5.

Surel, Y. (2000). The role of cognitive and normative frames in policy-making. *Journal of European Public Policy, 7,* 495-512.

Taft, K. (1997). *Shredding the Public Interest*. Edmonton: University of Alberta Press and the Parkland Institute.

Taras, D. & A. Tupper (1994). Politics and Deficits: Alberta's Challenge to the Canadian Political Agenda. In Douglas M. Brown & Janet Hiebert (eds.). *Canada: The State of the Federation 1994*. Kingston: Institute of Intergovernmental Relations.

Taylor, M.G. (1986). The Canadian Health Care System 1974-1984. In R.G. Evans & G.L. Stoddart (Eds.), *Medicare at Maturity: Achievements, Lessons and Challenges.* (pp 3-39). Calgary: University of Calgary Press.

—— (1987). *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Care System and their Outcomes.* Kingston: McGill-Queen's University Press.

Telford, H. (1999). *The Federal Spending Power in Canada: Nation-Building or Nation-Destroying?* (Rep. No. 1999:4). Kingston: Institute for Intergovernmental Relations, Queen's University.

Thelen, K. & Steinmo, S. (1992). Historical Institutionalism in comparative politics. In S.Steinmo, K. Thelen, & F. Longstreth (Eds.), *Structuring Politics: Historical Institutionalism in Comparative Analysis* (pp. 1-32). Cambridge: Cambridge University Press.

Tholl, W.G. (1994). Health care spending in Canada: Skating faster on thin ice. In Å. Blomqvist and D.M. Brown (eds.), *Limits to Care: Reforming Canada's Health System in an Age of Restraint*. C.D Howe Institute.

Thompson, A. (1991). *Federal Support for Health Care. A Background Paper for the Health Action Lobby*. June.

Thorburn, H.G. (1991). Interpretations of the Canadian party system. In H.G. Thorburn (ed.), *Party Politics in Canada, 6th Edition*. Scarborough: Prentice-Hall Canada.

Tichy, R. (1987). Blüms gegenschäft. *WirtschaftsWoche* 18 December:24-25.

Toneguzzi, M. (1993). AFL leader blasts round table talks. *Calgary Herald*, August 26, B2.

Tuohy, C.H. (1976). Private government, property and professionalism. *Canadian Journal of Political Science, 9,* 668-681.

—— (1988). Medicine and the state in Canada: The extra-billing issue in perspective. *Canadian Journal of Political Science*, 21: 267-296

—— (1989). Federalism and Canadian Health Policy. In W.M. Chandler & C.W. Zollner (Eds.), *Challenges to Federalism: Policy Making in Canada and the Federal Republic of Germany.* (pp. 141-160). Kingston: Queen's University Institute of Intergovernmental Relations.

—— (1992). *Policy and Politics in Canada: Institutionalized Ambivalence*. Philadelphia: Temple University Press.

—— (1999). *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*. New York: Oxford University Press.

Vancouver Sun (1995). Klein condemns Ottawa for cuts to Alberta's transfer payments. *Vancouver Sun*, November 16, A3.

Verband der Angestellten-Krankenkassen und Verband der Arbeiter-Ersatzkassen (1988). Position der Ersatzkassen zur Organisationsreform der gesetzlichen Krankenversicherung. *Die Ersatzkasse* 68: 237.

von Beyme, K. (2001). Elite relations in Germany. *German Politics*, 10(2):19-36.

Walker, R. (1993a). Health care: Forum groups demand 'major reform'. *Calgary Herald*, August 28, A1

Walker, R. (1995). Tories get failing health care grade. *Calgary Herald*, September 18, A1.

Walker, R. & S. Alberts (1993a). Seniors feel betrayed by premium proposal. *Calgary Herald*, December 10, A5.

—— (1993b). Health care overhaul: Report aims for quality, affordability. *Calgary Herald*, December 10, A1

Walker, R. and J. Heinrich (1991). Is he Canada's richest MD? Calgary eye doctor, spurred by professional and religious zeal, billed $6.6 million in '90. *The Gazette*, May 16, A6.

Walsh, J.I. (2000). When do ideas matter? Explaining the successes and failures of Thatcherite ideas. *Comparative Political Studies*, 33(4):483-516.

Wassener, D. (2001). Federalism and the German Health-Care System. In K.G. Banting and S. Corbett [Eds.] *Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance*. Kingston: McGill-Queen's University Press.

Watts, R.L. (1989). Executive Federalism: The Comparative Context. In D.P. Shugarman & R. Whitaker (Eds.), *Federalism and Political Community*. (pp 439-457). Peterborough: Broadview Press Inc.

Weaver, R. K. (1986). The politics of blame avoidance. *Journal of Public Policy, 6,* 371-398.

Weaver, R. K. (1999). The Politics of Pension Reform in Canada and the United States. Paper presented at the Annual Meeting of the Canadian Political Science Association, Sherbrooke, Quebec; June 6-8, 1999

Weaver, R. K. & Rockman, B. A. (1993). Assessing the Effects of Institutions. In R.K.Weaver & B. A. Rockman (Eds.), *Do Institutions Matter? Government Capabilities in the United States and Abroad* (pp. 1-41). Washington: Brookings Institute.

Webber, D. (1988). Krankheit, Geld und Politik: Zur Geschichte der Gesundheitsreformen in Deutschland. *Leviathan: Zeitschrift fuer Sozialwissenschaft*, 16(2):156-203.

—— (1989). Zur Geschichte der Gesundheitsreformen in Deutschland -- II. Teil: Norbert Bluem's Gesundheitsreform und die Lobby. *Leviathan: Zeitschrift fuer Sozialwissenschaft*, 17(2):262-300.

—— (1991). Health Policy and the Christian-Liberal Coalition in West Germany: The Conflicts over the Health Insurance Reform, 1987-8. In C. Altenstetter & S.C. Haywood (Eds.), *Comparative Health Policy and the New Right: From Rhetoric to Reality.* (pp 49-91). New York: St. Martins.

—— (1992). The Politics of Regulatory Change in the German Health Sector. In K. Dyson (Ed.), *The Politics of German Regulation.* (pp 209-234). Aldershot: Dartmouth.

Weingast, B.R. (1995). A rational choice perspective on the role of ideas: Shared belief systems and state sovereignty in international cooperation. *Politics & Society*, 23(4):449-464.

Wendt, A. (1999). *Social Theory of International Politics.* Cambridge: Cambridge University Press.

Western Report (1993). The once and future province. 8:6-10.

—— (1994). Why no one listens when the Minister speaks: Alberta assembles its case against Marleau's attack on private clinics. 9(47):8-11.

White, G. (1996). Comparing provincial legislatures. In C.Dunn (Ed.), *Provinces: Canadian Provincial Politics* (pp. 205-228). Peterborough: Broadview Press.

Wilsford, D. (1991). *Doctors and the State: The Politics of Health Care in France and the United States.* Durham: Duke University Press.

—— (1994). Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Public Policy*, 14(3):251-283.

—— (1995). States facing interests: Struggles over health care policy in advanced industrial democracies. *Journal of Health Politics, Policy and Law*, 20(3):571-613.

Windschild, G. (1991). Notizen aus Bonn. *Die Krankenversicherung*, 44(1):1-2.

Windsor Star (1994). Premier raises the spectre of a less caring society. *The Windsor Star*, November 25, C12.

Wismar, M. (1996). *Gesundheitswesen im Uebergang zum Postfordismus: Die gesundheitspolitische Regulierung der Fordismuskrise in GroSbritannien und der Bundesrepublik Deutschland.* Frankfurt (Main): VAS.

Wysong, J.A. & Abel, T. (1996). Risk equalization, competition, and choice: a preliminary assessment of the 1993 German health reforms. *Sozial- und Praventivmedizin*, 41(4):212-223.

Yanow, D. (2000). *Conducting Interpretive Policy Analysis.* (Vols. 47) Thousand Oaks: Sage Publications.

Yee, A.S. (1996). The causal effects of ideas on policies. *International Organization*, 50(1):69-108.

York, G. (1991). PC delegates' vote for user fees called threat to medicare. *The Globe and Mail*, 10 August, A5

Ziller, P. (1992). Ein Opfer der 'Gymnastik im Haifischbecken'. *Frankfurter Rundschau*, 28 April, p. 8.