Timing health policy development and change: The drug gap

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Paper presented to the Canadian Political Science Association
Waterloo, Ontario

May 2011

Introduction

A variety of factors, from public discontent to internal cost pressures or bureaucratic suggestion, can prompt consideration of new health policies. Significant changes are proposed more often than they are adopted, however, and understanding why they are implemented in some cases but are adopted partially or not at all in others, and why certain types of changes become more difficult over time, provides important insights into the policy dynamics of liberal welfare states. This paper asks how the *approach* to policy development, particularly the pace at which change is attempted, affects policy outcomes. I distinguish between radical "big bang" versus incremental change. If a country takes an incremental approach to policy development and starts by only adopting one element of a health program, can the rest of the plan eventually be implemented? What barriers arise to the adoption of additional services over time? These questions are prompted by an empirical puzzle: although Canada's earliest plans for public health insurance included pharmaceuticals, and there have been a number of attempts to introduce nation-wide drug benefits over the years, today Canada is the only OECD country with a universal public health system that does not include prescription drugs (Jacobzone 2000). This omission stands in contrast to Canada's own nation-wide, universal public hospital and medical insurance, and in contrast to the experience of similar welfare states like the UK and Australia. Existing literature on variation in national health systems cannot explain this puzzling outcome, and this gap suggests a need to reconsider some of the standard explanations for policy development and change.

This study compares Canada to two similar liberal welfare states, chosen with reference to the empirical puzzle. Both the UK and Australia have broad public pharmaceutical programs but took very different approaches to health policy development. The UK took a radical approach to policy development and introduced the National Health Service in 1946, with a full complement of hospital, medical and pharmaceutical services. Australia took an incremental approach and adopted its Pharmaceutical Benefits Scheme in 1944, although the program did not operate until 1950. After this time, further health policy development stalled until the adoption of public hospital and medical insurance between 1975 and 1984. Canada also took an incremental approach to health policy: the first federal proposals for universal health insurance were introduced in 1945 and nation-wide hospital and medical insurance programs were adopted in 1957 and 1966, respectively. However. There was no further policy development: this paper discusses the failure of a final federal proposal for universal pharmaceutical insurance in 1972.[1]

Canada, Australia and the UK vary with regards to the comprehensiveness of their health programs and the approach to health policy development, but they are in other respects very similar and thus avoid confounding factors. All three experienced a similar "welfare moment" at the end of World War II (see for example Hacker 1998, 81; Lynch 2006, 56) that motivated governments to take some action on health policy, but they made very different choices about how to proceed. This paper asks why the approach to policy development varies, and how the initial approach affects policy outcomes.

A theory of policy development and change

1. All cases focus on policy making at the national level. In Canada, provinces only began to offer pharmaceutical programs to limited populations in the early 1970s, and in Australia a 1946 constitutional amendment gave the Commonwealth government jurisdiction over pharmaceutical benefits, although states retained control over other aspects of health. Health policy making in Britain was synonymous with policy making in the UK during the study period, as it was not until the devolution of responsibility for health services (among many other policy areas) in 1997 that Scotland and Wales began pursuing independent pharmaceutical programs.

Until now, the accepted explanation for Canada's lack of a universal pharmaceutical program was based an assumptions about timing of policy choices relative to technological change. It was assumed that by the time nation-wide medical insurance was being implemented in the 1960s, it was simply too late for drugs, since "constant pharmaceutical cost-escalation" (Morgan and Willison 2004) had made drugs too expensive. However, this does not explain why Canada did not develop a program at the same time as similar countries, and cannot account for attempts to adopt pharmaceutical programs after this important policy window closed.

The national health insurance literature does not consider variation in pharmaceutical programs specifically, but given that that much of the literature emphasizes the importance of timing and sequence to policy development in this area (Hacker 1998; Maioni 1998; Tuohy 1999), we might expect the more general historical theories of policy making to capture the success and failure of significant health reforms,. In particular, two dominant streams of the literature characterize policy development as *path dependent,* with policies subject to self-reinforcing dynamics that make them increasingly difficult to change over time, or subject to *punctuated equilibrium,* where "long periods of institutional stasis are periodically interrupted by some sort of exogenous shock…allowing for more or less radical reorganization" (Streek and Thelen 2005, 1). Path dependence highlights the historically loaded nature of political development, the importance of timing and sequence, and the effect of small, unpredictable factors on long-term outcomes (Pierson 2004). Policies are stable because "the probability of further steps along the same path increases with each move down that path. This is because the *relative* benefits of the current activity compared with other possible options increases over time" (Pierson 2000, emphasis in original). Punctuated equilibrium also emphasizes the constraining effect of institutions and continuity in policy as the norm (Krasner 1984). It argues that change occurs rarely when there is a shift in both policy image (beliefs and values about a certain policy) and venues (basically, political institutions) (Baumgartner and Jones 1991).

While these literatures provide strong explanations for stability, they have more difficulty in explaining when and how change occurs, in part because there is ambiguity about the differing nature of major and minor change, and about specific mechanisms for both stability and change. How much minor adjustment might we expect to see within a path dependent process? Can we identify potential punctuation points before they happen, or is this only possible post-hoc? It is necessary to extend our theoretical understanding of the mechanisms by which barriers to policy change develop over time *and* to theorize the scenarios under which these barriers can be overcome. For the sake of space this paper addresses a restricted time period (1940s to 1970s) and focuses on the first question about the development of barriers, but I argue that similar mechanisms can help explain how barriers to change may be overcome, and provide some preliminary evidence in the conclusion.

To address limitations in these existing approaches, I begin by offering a more precise definition of policy change. I measure the degree of policy change based on policymakers' own plans: how much of the original program is eventually adopted? This approach is helpful in policy areas that can be disaggregated into a number of discrete components, such as environmental policies to address climate change and the public provision of various health services. To determine the significance of change, we can examine initial plans for policy development and ask whether policymakers go forward with all elements of plan at once (a radical change), or break plan down into incremental steps. Taking an incremental approach to policy development is significant because barriers to change increase over time, and "next steps" that perhaps were not radical when they were considered at the beginning of a policy process *become* radical as these barriers increase. This means that even if two jurisdictions start with similar plans for policy development, taking an incremental approach means one is less likely to adopt the entire program: incremental policy development stalls in predictable ways after the adoption of first priorities.

When does the politics of radical, "big bang" policy development incrementalism win out over the politics of? The agenda-setting literature, particularly on the role of "windows of opportunity" (Kingdon 1995), provides important lessons about the process of initiating major policy change. There is a range of literature debating how to identify windows of opportunity or critical junctures (Mahoney 2000; Thelen 1999), but this paper conceptualizes them as points in time when certain *conditions* for policy change coincide. Thus, the goal is to identify the moment where a certain set of conditions occurs, not only the particular decision that occurs in that moment. I argue that there are often parallel critical moments for policy change across countries, in response to exogenous world-historical events. However, the conditions for change during these critical moments will vary slightly between countries, and uncovering these variations can help explain different policy outcomes.

One of the most valuable contributions in this regard is Tuohy's (1999) discussion of health policy reforms in Canada, the US and the UK: she finds that windows of opportunity are a product of both institutional factors (consolidated authority over health) and political will, which in my hypotheses I interpret as a combination of ideational and electoral motivations. Therefore, I hypothesize that there are three factors that tend to support radical policy change during a critical moment: centralized authority as a result of a country's institutional structure; politicians' principled ideas about health policy; and politicians' electoral incentives to act. When certain institutional, ideational and electoral conditions are present, radical change occurs. When one or more of these factors are missing, change can still occur but it will tend to be smaller in scale – a single element of the initial plan rather than the entire program.

Centralized institutional authority

The main institutional difference between the incremental and radical cases, and thus the focus of discussion here, is federal versus unitary government. However, it is expected that a similar dynamic is applicable to other institutional arrangements that fragment or centralize authority – for example, congressional versus parliamentary systems (Tsebelis 1995). In federations, subnational governments may become veto players if they are a "collective actor whose agreement is required for policy change" (Tsebelis 1995). If subnational governments can veto unilateral action by the national government in a particular policy area, it will be more difficult to achieve the coordination necessary for a radical approach to policy development. Thus, I hypothesize that countries with institutions that centralize authority will be more likely to take a radical approach to policy than countries where institutional authority over that policy is fragmented. The nature of federalism places unique constraints on subnational governments as veto players, however. Since national and subnational governments face an overlapping constituency, a sufficiently motivated national government may bypass lower levels of government to appeal to directly to the shared public, and thus effectively make subnational governments an offer they can't refuse. States' or provinces' institutional veto power still exists, but they may make a political decision that blocking a popular federal policy is simply too costly.

Principled ideas

The second key variable in explaining radical versus incremental policy development and the downstream consequences of this choice is the presence or absence of a cohesive, principled idea about the policy area. In the case of health policy development, the relevant principled idea concerns the importance and value of universal and comprehensive health services, but each policy area will tend to have its own set of applicable "big ideas". Tuohy (1999) uses the case of health to argue that a window of opportunity for major policy change

> requires that substantial change in health care policy hold a high priority within the broader agenda of those who command the levels of authority…there must be a commitment to policy change on the part of key political actors… (Tuohy 1999).

Thus, a radical approach requires that significant policymakers (prime ministers, cabinet ministers, high level bureaucrats) support the adoption of a policy for principled reasons, although this does not preclude strategic motivations, as discussed below. This would mean that the government places high priority on the issue of health services and is willing to expend political capital (particularly vis-à-vis interest groups or other levels of government) to adopt the policy. I hypothesize that this type of principled commitment to policy change will only coalesce around a particular type of idea: what other authors have called "programmatic beliefs" (Blyth 2003) or "issue area doctrines," (Yee 1996). Hall (1993) distinguishes between "the overarching goals that guide policy in a particular field, the techniques or policy instruments used to attain those goals, and the precise settings of these instruments" (Hall 1993, 278). I propose that ideas about overarching goals, such as "the government should work towards a social democratic state" may be necessary but are insufficient to develop the principled commitment for radical policy change. Ideas about goals must be accompanied by a second type of idea about policy instruments, such as "the state should directly provide health services to all citizens." These instrumental ideas may still be fairly high-level but crucially, they provide a cohesive response to a policy problem and therefore a specific motivation for radical action.

Electoral motivations

Politicians' decisions are also driven by strategic considerations. If "political parties in a democracy formulate policy strictly as a means of getting votes," (Downs 1957, 137) sometimes this will produce incentives to develop distributive policies, such as health insurance or benefits. I hypothesize that when there is evidence of public awareness of and support for a policy, policymakers will be more likely to support a radical approach to policy development. When this public interest and support is lacking, or more difficult to anticipate, politicians prefer the less risky incremental approach. There may be both electoral and principled reasons for policymakers to support the adoption universal and comprehensive health policies, and if these two factors motivate the same policy response it may not be possible to disentangle them perfectly. However, we should expect that this would often be the case: "good policies" that promote principled commitment in politicians are frequently beneficial to many people, who recognize their potential benefit and in turn provide strategic electoral motivation for politicians to adopt these policies. As discussed below, this paper uses a methodological approach designed to distinguish between motivations that are primarily strategic, and those that also contain an element of principled commitment to a policy idea.

Barriers to policy change

The choice between a radical versus an incremental approach to policy development would not be significant if they eventually produced the same outcome, but this does not tend to be the case. It is therefore necessary to explain why incremental programs stall even when they are initially designed to be implemented in steps or stages. I hypothesize that the conditions that determine a country's initial approach to policy development also affect its ability to continue that process. If these conditions initially limited the pace of change and they persist, they become more limiting over time. Specifying barriers to policy change in this way provides an opportunity to explain how barriers are (sometimes) overcome: changes that initially would have been small steps become more radical when they are considered later in the policy process, and therefore require the same three conditions for change that allowed for radical change at the beginning of a process.

As noted above, the literature on path dependence sets out a number of features of the policy process that tends to make it self-reinforcing and difficult to change: in his seminal article Pierson (2000) discusses large set-up costs, learning and coordination effects, and adaptive expectations. These factors tend to provide clearer explanations for why it is difficult to change *existing* policies, rather than why it is difficult to expand by adopting *additional* policies, an important issue in discussions of health systems. The combination of factors that is most helpful on this question is the way alternative institutional arrangements can arise in the absence of government programs. Private actors make investments (pay set-up costs) and create networks (developing expertise and coordinating actors), essentially staking a claim on the service area so it is very difficult to displace them with later public policy development. This is an important factor in blocking the development of public health insurance in the US (Hacker 1998) and one reason that the introduction of public medical insurance in Canada was more difficult than hospital insurance (Shillington 1972). However, it is not as helpful in the specific case of Canadian pharmaceutical policy, which was basically a blank slate until the mid-1970s, when provinces began adopting limited programs for the elderly and social assistance recipients (Grootendorst 2002), and private companies began offering drug insurance (Commission on Pharmaceutical Services 1971). This points to a need for some new specific, mechanisms to explain why this type of change – the expansion of programs or addition of new services – becomes more difficult over time. The mechanism proposed here addresses this need, although it is also applicable to more general problems of policy stability. It builds on the idea of adaptive expectations, that people base their expectations for the future on what has happened in the past, and I find there is a particularly strong effect of adaptive expectations when we consider how the reciprocal relationship between elite ideas and public expectations affects policy priorities.

Adaptive expectations shape both policymakers' and the public's view of what a policy "should" do. This mechanism is linked to Pierson's (1994) insights about the way welfare policies develop "supportive constituencies" of beneficiaries, but extends them to include more explicitly the reciprocal causal relationship between principled ideas and electoral motivations. Early elite expressions of health policy ideas influence public expectations for service by increasing awareness of the potential benefits, which in turn promote greater commitment from policymakers. This dynamic can be observed in countries taking a radical approach to health policy development, as elite ideas and public expectations reinforce one another to support a radical pace of change. Crucially, this relationship between elite ideas and public expectations can also work in a more negative fashion to restrict policy development and is a key factor in explaining why incremental processes tend to stall. In incremental processes, early public promises for a comprehensive system or additional services are typically vague, in keeping with the lack of principled ideas, and the best evidence of plans for additional services come from internal policy documents. Little elite discussion of later services means public expectations are less likely to develop, and this lack of electoral motivation feeds back into policymaker's priorities. As Jacobs (2009) argues, elites deal with an overwhelming amount of information about policy choices by using mental models that structure the types of information they need to pay attention to and bias the way they deal with new or disconfirming information (Jacobs 2009, 256, 260). Without an initial principled idea or electoral motivation, politicians tend to focus on managing the problems of existing services, rather than adding new services. Over time, a more restricted mental model regarding what a health system "should" do directs elite attention away from additional services and biases their ability to deal with new information about these services.

Method

This paper uses a process tracing approach to evaluate evidence for the hypothesized set of causal mechanisms. This strategy is often useful for small-N, qualitative research (Hall 2006; Hall 2003; Bennett and George 1997; George and Bennett 2005), as it allows the researcher to "unpack" the different variables involved in what might otherwise be an indeterminate causal relationship. The

paper relies on archival and published primary documents as well as secondary historical sources to provide detailed, chronological accounts of the policy process and explain how causal relationships work in each case. Process tracing solves a major challenge of studying the role of ideas, one of the key causal factors in the theoretical framework, by distinguishing principled ideas and beliefs from policymakers' strategic or electorally motivated beliefs or preferences. There is no reason to believe that these two types of motivations are mutually exclusive, particularly in a policy area like health that involves the distribution of goods to voters. However, the method and type of data used here provides good opportunities for distinguishing between principled ideas and electoral motivations because archival documents provide records of both public and private policy discussions and the sequence of different types of ideas can be determined. Statements of principled ideas may be more common in public fora, such as election platforms or manifestos and speeches in parliament. Process tracing allows for a comparison of when these public statements of principled ideas were made, relative to both private statements and the collection of information relevant to electoral incentives, such as the publication of opinion polls. Furthermore, when politicians in discuss policy in private settings, such as cabinet meetings and departmental memos, they have an opportunity to be more frank about electoral motivations. If they still reference principled ideas, there is more evidence for the fact that their support for a policy is genuinely motivated by "good policy" thinking and a principled commitment to the idea.

The United Kingdom: "something bolder than a mere extension and adaptation of existing services"[2]

The NHS was a groundbreaking achievement in welfare state development, providing universal coverage for a comprehensive range of health services that was "free at the point of use." Although there were important elements of continuity with previous policies,[3] it represented a significant innovation in terms of the population covered, the range of services included, and the mechanism for coverage, moving from an insurance principle to a nationalized service.

There is a range of excellent scholarly literature that seeks to explain why the UK was able to introduce this radical policy change (see for example Hacker 1998; Tuohy 1999; Klein 1995; Pater 1981). I look for evidence of centralized authority in institutional terms, a principled idea on the part of policymakers, and strong electoral incentives, and contrast the UK situation with the absence these factors in Canada and Australia.

Centralized authority

Policymakers in the UK did not have to contend with other levels of government as veto players, as the unitary system ensured that the national government had the final say over health policy development. Additionally, the centralization of power inherent in the UK's Westminster parliamentary system was heightened in 1945, when a "landslide upset" election (Jacobs 1993) moved the country from the wartime coalition government to a Labour majority government.

The role of centralized authority becomes apparent when comparing the language of the Canadian federal government in the early days of health policy development with the UK's Ministry of Health. After the Canadian government's first proposal for comprehensive health insurance failed,

2. Labour Health Minister Aneurin Bevan, Memorandum: Proposals for a National Health Service, Minister of Health, 13 December 1945. The National Archives of the United Kingdom (Hereafter cited as "TNA"). CAB 129/5.

3. Hacker (1998) in particular emphasizes links to the National Health Insurance Act of 1911, discussed below. Furthermore, an early NHS planning document notes that establishing a universal and comprehensive health service is *not* "a question of a wholly new service, but of one with many roots already well-established" (Ministry of Health 1944)

the federal Cabinet Working Committee on Health Insurance recommended that, "further consideration of the second stage of the Health Insurance Proposals be deferred pending the outcome of the reports from the provinces regarding planning and organization."[4] This deference to other levels of government was not present in the UK: the Ministry's 1944 White Paper argued that a nationalized service was necessary because "medical resources must be better marshaled for the full and equal service of the public, and this must involve organisation – with public responsibility behind it" (Ministry of Health 1944, 8). A year later, the Minister of Health noted that when the nationalization of hospitals was approved there were some concerns about "the risk of losing from the health service the benefits of local interest and local knowledge in day-to-day administration,"[5] but it was determined that the benefits of a single national service outweighed these risks. Local authorities did in fact oppose the nationalization of hospitals, for which they had previously been responsible, but national policymakers were able to easily overcome this and to introduce the type of program favored by the central government (Tuohy 1999; Klein 1995). Institutional authority therefore provided a crucial prerequisite for radical policy development, but it remains to explain why the post-war Labour government took this path: institutions suggest they *could*, but ideas and electoral incentives help explain why they *did*.

Principled ideas and electoral motivations

There was a mixture of strategic and principled reasons for the post-war government to place a high priority on the adoption of the NHS, but the key element of this decision from the point of view of prescription services is that it occurred in a situation where the comprehensiveness of health services (i.e. range of services provided) was taken for granted by all actors. Although there were controversies over issues such as hospital administration or doctors' remuneration, even before Labour took power in 1945 there was what Klein calls a "remarkable…shared assumption that the health service should be both free and comprehensive" (Klein 1995, 24). Thus, the earliest archival records of pharmaceutical policy discussions, from 1943 and 1944, focus on questions of *how* prescription services were to be delivered, not *whether* they should be included or where they fell in the order of priority for services, as was the case in Canada. [6]

The release of the Beveridge Report in 1942 provided a powerful, cohesive idea for health policy development in the UK that set out both the goals for a national welfare state and the type of health policy instruments that might help achieve them. A review of previous health services reports notes that "the principles most frequently reoccurring in the presentation of plans for the future developments are the following: (1) that there should be made available to every individual in the community whatever type of medical care and treatment he may need; (2) that the scheme of services should be a fully integrated scheme" (Ministry of Health 1944, 76). The Beveridge Report took these principles as a basis for its recommendations, and described "comprehensive health and rehabilitation services" as a key assumption for its proposed program of social security (Great Britain. Inter-departmental Committee on Social Insurance and Allied Services 1942, 158). The report was both very prominent and broadly supported by the British public. A special Gallup poll conducted the month of its release found that "Fully 95 percent of the public had heard about the Beveridge Report," and "88 percent of respondents favored its implementation" (Jacobs 1993). Although the

4. Meeting of the Cabinet committee on Dominion-Provincial Relations: Report of the Working Committee on Health Insurance, 4 January 1946. Library and Archives Canada (Hereafter cited as "LAC"). Brooke Claxton fonds. MG 32-B5 Vol 138 File: "Dom-Prov Conferences DP-2 Committees and Meetings."
5. Minister of Health, Memorandum: Proposals for a National Health Service, 13 December 1945. TNA. CAB 129/5.
6. Memorandum, March 1944. TNA. MH 77/120 "Formation of Policy under National Health Service Act/ Pharmaceutical services. 1944 March-1946 November."

report received international attention from experts, its ideas did not reach the public of other countries in the same way. For example, in 1943, only one in four Canadians could recognize the phrase "the Beveridge Report,"[7] and the Gallup news service noted that,

> despite the wide publicity given the report in Canada, some Canadians had a confused idea of the subject matter contained in the Beveridge proposals. This includes the man who, when asked by the Gallup interviewer whether he had heard of the Beveridge plan said: "Yes, but one quart a day is enough for me."[8]

This high degree of public support in the UK provided incentives for government action on health policy, and the war time coalition government announced in February 1943 that it accepted Beveridge's assumption "that a comprehensive national health service, for all purposes and for all people, would be established" (Ministry of Health 1944, 76). The next two years were marked by debate regarding the means of achieving this, but disagreement on methods became moot after the 1945 election. Klein argues that Labour's landslide win meant that, "The way was open for the politics of ideology to take over from the politics of compromise" (Klein 1995). Certainly the Labour election manifesto emphasized health, saying, "the best health services should be available to all. Money must no longer be the passport to the best treatment" (Craig 1975). There is clear evidence of electoral motivation for bold action on health policy: in 1948, the Gallup Poll of Britain noted that "The Health Service is scheduled to start July 15 next, and [pollsters] ascertained that over six in every ten adult Britons were sufficiently interested in the service to know this date," and 61% reported that they felt the new health service was a "good thing."[9]

However, there is also evidence of a principled component to Labour's commitment. In 1937, future Prime Minister Clement Attlee wrote about the Labour Party's preference for radical action, saying, "The Labour Government will not dissipate its strength when returned to power by dealing only with minor matters. It will proceed at once with major measures while its mandate is fresh" (Attlee 1937, 176). He added that, in terms of priorities for action, "Labour does not intend to delay the introduction of measures calculated to effect an immediate improvement of a far-reaching character in the social services" (Attlee 1937, 192). Others have emphasized the values and charisma of the Labour Minister of Health, Anuerin Bevan (Klein 1995, 13; Webster 2002, 13), and argued that for Bevan "and for many others", the idea of a free health service "represented the embodiments of a pure Socialist ideal"(Ryan 1973, 219). Besides the commitment demonstrated in election manifestos, there is also evidence of commitment in more private forums. In a 1945 Memorandum to Cabinet, Bevan argued for major reforms: "As I see it, the undertaking to provide all people with all kinds of health care…creates an entirely new situation and calls for something bolder than a mere extension and adaptation of existing services."[10] Bevan further demonstrated his commitment to the NHS' founding principles in 1949 by opposing the new legislative powers to impose charges for certain services,[11] and in 1951 by resigning from cabinet temporarily when prescription charges were first introduced, arguing that this represented "the beginning of an avalanche" eroding NHS principles (Ryan 1973, 225). It should also be noted that Labour was, in part, elected in 1945 because

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7. CIPO/Gallup Poll of Canada, *Public Opinion News Service Release*, 6 February 1943.
8. Ibid.
9. BIPO/Gallup Poll, 17 May 1948.
10. Memorandum: Proposals for a National Health Service, Minister of Health, 13 December 1945. TNA. CAB 129/5.
11. Chancellor of the Exchequer, Memorandum EPC(49)111: Consideration of proposed cuts in public expenditure including the introduction of prescription charges. 14 October 1949. TNA. CAB 134/220/34, "Internal financial situation." See also Ryan (1973, 224)

of their ideas, since the public found them more credible on health policy than the Conservative party (Jacobs 1993, 169). Although it is not possible to say whether Labour would have taken radical action without electoral motivations, the two factors appear to reinforce one another in important ways.

These ideational and electoral pressures for the introduction of a broad public health service, combined with institutional centralization, resulted in the simultaneous adoption of hospital, medical, pharmaceutical, and other auxiliary services in 1946, and their implementation in 1948. This radical approach to health policy development meant that pharmaceuticals were just one element of a comprehensive system and were adopted without controversy or fanfare – although the issue of patient charges for prescriptions would soon become an key point of contention with regards to the feasibility of a "free" system, and by 1966 a Treasury official would comment that "I imagine the question of charges will always be political dynamite."[12] However, in Canada and Australia conditions did not allow for a radical approach to health policy development, and the process of adopting one service at a time meant that some of the distinct problems of pharmaceutical policy, such as price controls, patents, and drug formularies were important earlier in the policy process.

Canada: Health insurance "capable of being introduced by several stages"[13]

Canada's path to public health insurance was slow and difficult. In the immediate postwar period, Canada lacked the conditions that make a radical, simultaneous approach to health policy more likely, and the incremental approach to policy development proved limiting. Although the federal government presented its first proposals for health insurance to the provinces in 1945, Canada did not achieve nation-wide hospital insurance until 1957. Medical insurance followed even later, with a federal-provincial agreement in 1966, and gradual provincial implementation between 1966 and 1972. Despite the inclusion of pharmaceutical insurance in the original federal proposal and repeated calls for its development from various bureaucratic and research bodies, this component of health insurance has never been implemented. In 1972, the federal cabinet rejected a proposal that attempted to link a national drug insurance program to better control over drug prices, and there is no evidence of further consideration of a nation-wide program until the late 1990s.

Fragmented authority

Federalism potentially allows subnational governments to block a radical approach to policy development, which requires an extraordinary degree of intergovernmental coordination and consensus. In Canada, the exigencies of federalism appear to have ruled out a radical approach quite early. The 1945 federal proposals envisaged a complete health program provinces would "have to take, in its entirety, and in a fixed order, within a certain time limit."[14] This proposal failed after being linked to tax rental agreements (where provinces were to give up powers of direct taxation in return for a fixed payment from the federal government) that the provincial governments would not accept (Maioni 1998; Taylor 1987). In 1946, the Cabinet Working Committee on Health Insurance recommended that further policy development be deferred until provinces provided input.[15]

The subsequent deliberations on health insurance were directed towards an incremental approach. In 1949, the Department of National Health and Welfare (DHW) was asked "to arrange

12. Letter from O.L. Williams, 1966. TNA. T 227/2522.
13. Canada. 1945. *Dominion-provincial conference on post-war reconstruction: Plenary session*. Ottawa: King's Printer.
14. Department of National Health and Welfare Memo 22 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 pt 1: "Health Insurance Studies – Health Insurance Proposals 1949-1950."
15. Meeting of the Cabinet Committee on Dominion-Provincial Relations: Report of the Working Committee on Health Insurance, 4 January 1946. LAC. Brooke Claxton fonds. MG 32-B5 Vol 138 File: "Dom-Prov Conferences DP-2 Committees and Meetings."

the various features of an over-all Health Insurance program into related parts which might be treated as separate units for introduction at different times."[16] When health insurance proposals were discussed at the 1955 Federal-Provincial Conference, the Prime Minister's opening statement demonstrated both deference to provincial governments and acceptance of the principle of incremental policy development: he noted that the federal government would not "wish to be party to a plan for health insurance which would require a constitutional change or federal interference in matters which are essentially of provincial concern," and solicited provincial input "as to the order of priority of the various services" (Canada 1955). Provincial preferences for a slower pace of change, mainly due to the financial risk involved in the policy, persisted even after nation-wide hospital insurance was adopted in 1957.[17]

Although the institutional barriers to a radical approach to policy development were considerable, it is possible that a high level of commitment to a principled idea about health services, or a high degree of electoral motivation on the part of the federal government could have overcome them. Given the right motivation, the federal government could have bypassed provincial governments to appeal directly to the Canadian public and used its constitutional power to spend even in areas of provincial jurisdiction to overcome provincial governments' reluctance to shoulder the costs of a significant new social program. However, neither clear, principled ideas nor public attention and electoral motivation were present in Canada.

Lack of principled ideas

Post-war Britain provides an example of the extraordinary level of principled ideational commitment that is necessary to achieve the simultaneous implementation of a broad range of health services, but ideas about health care were much more divided in Canada. In 1944, the Liberal party under Prime Minister Mackenzie King had been in power for almost a decade, and had included health insurance in its platform since 1919 (Boychuk 2008). However, the main reason that the Liberals promised action on social security, including health insurance, at this time was the electoral pressure from the Co-operative Commonwealth Federation (CCF), a social democratic party that was gaining power at both the provincial and federal level (Hacker 1998; Maioni 1998). Pressure from the CCF meant the Liberals were forced to act on health insurance, but action was a political compromise rather than an ideological imperative for the party, and this favoured the slow, staged introduction of actual policy.

The lack of consensus on health policy within the Liberal party is well documented in the memoirs of Paul Martin Sr., who was appointed Minister of National Health and Welfare in December 1946. He discusses his difficulty in getting cabinet to approve public health and hospital improvement grants to provinces after 1945, and his concerns that these grants would not lead to an insurance plan as he hoped, saying that

> Although the party had proclaimed its support for such a scheme on many occasions, I had my work cut out to keep it fully committed to proceeding towards this objective (Martin 1985).

16. Minutes of the Second Meeting of the Interdepartmental Working Committee on Health Insurance, 9 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 pt 1.

17. Statement of Principle advocated by British Columbia Respecting Preliminary Observations of the Report of the Royal Commission on Health Services, volume I, prepared for meeting 20-21 July 1964. LAC. RG 29 Vol 1133 File 504-5-11 pt 1: "Health Insurance – Federal-Provincial Conferences 1964;" Consolidated Report of views expressed by the provinces on health services, 1965. LAC. RG 29 Vol 1133 File 504-5-12: "Health Insurance – Federal-Provincial Conferences 1965."

Martin struggled to get support for health insurance from Prime Minister Mackenzie King, and from King's successor, Louis St. Laurent (Maioni 1998; Martin 1985). This lack of support, especially at the highest level, made it difficult for the DHW to keep health insurance on the agenda. A 1950 memo from Martin's deputy expresses the hope that "we can keep this whole matter [of health insurance] a live issue," and advises preparing health insurance materials for the upcoming federal-provincial conference despite St. Laurent's desire to avoid the problem.[18] After the 1953 election, Martin was faced with a cabinet where "most ministers supported voluntary health insurance and opposed government involvement" (Martin 1985). Although there was more support for the idea of broad government-sponsored health insurance in caucus, Martin says, "the division of opinion made it obvious that I would never get a combined hospital and medical plan into operation, so I opted for hospital insurance as the easier route" (Martin 1985).

The adoption of hospital and medical insurance as first priorities appears logical since these are clearly the larger programs, and particularly in the case of hospital care, are more likely to impose costs the individual is unable to deal with herself. However, Canadian policymakers at this time were also making an explicit decision to take pharmaceuticals off the agenda, rather than simply arguing other services were comparatively more urgent. When the DHW reconsidered the order of priority for services in preparation for the 1950 Federal-Provincial Conference, officials recommended leaving pharmaceuticals off the agenda entirely, because, "All the experience to date indicates that *it is almost impossible to control the costs in such services* (emphasis added)".[19] Thus, Canadian policymakers lacked a clear, positive idea about the value of a comprehensive approach to health services. They were also beginning to develop a strong, negative idea about the nature of drug costs and the feasibility of public coverage.[20]

Lack of electoral motivation

The lack of cabinet support for a bold health policy is linked to the low salience of health insurance among the Canadian public at this time. Since neither federal nor provincial governments outside Saskatchewan were providing clear proposals, there was little opportunity for public expectations to develop and therefore no clear electoral motivation at the national level for the Liberal government to act radically or quickly. Martin reports the results of a Gallup poll from mid-1947, saying that the public wanted more funds for research, hospitals and free clinics, but "National health insurance unfortunately received scant support" (Martin 1985, 45). Gallup polls reveal high levels of support for a national health plan between 1942 and 1944, and in 1949 when the question was asked again, but this was when respondents were questioned directly about their support for health insurance.[21] When Canadians were asked variations of a "most important problem" question (a standard measure of salience that provides information on the unprompted top-of-mind issues) between 1945 and 1951 the top answers were jobs, taxes, prices or price control, housing, or threat of war. "Health and hospitalization" were ranked among the top ten problems in 1953, but the

18. G.D.W. Cameron to Paul Martin, 27 November 1950. LAC. RG 29 Vol 1061 File 500-3-4 pt. 2.
19. Health Insurance brief, 7 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 pt.1.
20. Why Canadian officials were so pessimistic about the possibility of controlling the costs of pharmaceuticals is unclear. By 1949, higher-than-expected costs of prescription services were becoming an issue in the UK, but Canadian officials did not explicitly cite British experience at this time. Australian policymakers were more concerned about pharmaceutical costs than the British initially, but they focused on designing tools that would allow some measure of cost control. Tom Kent, the architect of Liberal health policy in the 1960s, notes that at that time, drugs were seen as more difficult to ration than doctor's visits, and that it was easier to "want too much" in terms of pharmaceutical products, and it seems likely that this thinking played a role at this earlier juncture as well (Author's interview with Tom Kent, Kingston, 11 February 2008).
21. CIPO/Gallup Poll of Canada, *Public Opinion News Service Release,* 8 April 1942; 22 May 1943; 8 April 1944; 13 July 1949.

percentage of respondents listing health as the most important problem fell well below those concerned about taxation and the economy, the number one problem.[22] No attention from the public meant there was no clear incentive for the federal government to take radical action, given the opposition from the provincial governments. This meant that health policy would follow a less risky, and ultimately less comprehensive, incremental approach.[23]

Barriers to policy change: the 1972 Drug Price Program

Pharmaceutical insurance initially was a low priority on the Canadian health policy agenda, and this position was persistent. In 1955, a meeting of federal and provincial deputy ministers of health concluded that pharmaceutical benefits were "not considered to be feasible at this stage…except for the necessary drugs which would be provided as part of the in-patient treatment services under a hospital care program."[24] In 1963, the federal Departmental Group to Study Health Insurance suggested "that in view of the difficulties inherent in the control of costs and in light of the availability of drugs provided in hospitals, that pharmaceutical benefits might be excluded from any Canadian medical care program."[25] Despite the very limited discussion of pharmaceutical insurance, however, drugs were not entirely absent from the public agenda. In the late 1950s and throughout the 1960s, Canadian publics and governments became very concerned about the high prices of prescription drugs. [26] It is curious that this issue was not linked to the problem of public drug insurance, but it nonetheless affected the consideration of later proposals for a federal pharmaceutical program.

Federal investigation of drug prices began in 1958 with an internal report by the Director of Investigation and Research, Combines Investigation Act, which was prompted by "informal complaints about the high cost of drugs" (Director of Investigations and Research 1961). Between 1958 and 1969, drug prices were the subject of at least four more government inquiries, both internal and public.[27] The problem was identified as drug patents, which produced a monopoly situation and high prices, and the solution was a series of changes to patent law and tariffs on drugs. Although this had a significant impact on drug prices (Gorecki 1981, xii), an unintended consequence was to restrict politicians' views of pharmaceutical policies in a way that made it very difficult for them to consider later proposals for pharmaceutical insurance. The failure of a 1972 proposal for a universal, nation-wide program demonstrates the way the reciprocal relationship between elite ideas and public

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22. CIPO/Gallup Poll of Canada, *Public Opinion News Service Release*, 1 August 1953; 14 November 1953.
23. Although medical insurance was always discussed alongside hospital insurance as a closely related second priority, the nine-year gap in adoption resulted in increased opposition from provincial governments and the medical associations. I have argued elsewhere that medical insurance in Canada was only adopted because of a coincidence of principled ideas on the part of a new Liberal government, an electorate that had come to expect medical coverage based on a significant amount of public discussion, and a temporary willingness to overcome institutional barriers posed by federalism (Boothe 2010).
24. Draft Report to the Chairman of the Preparatory Committee for the Federal-Provincial conference 1955 on a Personal Health Care Program. LAC. RG 29 Vol 1132 File 504-5-6 pt.1: "Health Insurance – Dominion-Provincial Conference – 1955."
25. Meeting of the Departmental Group to Study Health Insurance, 27 March 1963. LAC. RG 29 Vol 1129 File 504-4-15 pt 1: "Comments on Hall Commission, 1963-1966."
26. *Globe & Mail* 16 December 1955, p.39; 6 October 1960, p.3; 24 January 1961, p.25; see also Cabinet memo 2 February 1972. LAC. RG 29 Vol 1549 File 1006-5-2: "Office of the Deputy Minister, Memoranda to Cabinet 1969-1972, volume 3"; Cabinet memo 24 November 1972. LAC. RG 29 Vol 1572, File 1016-1-2: "Office of the Deputy Minister of Health and Welfare – Health Programs Branch – Pharmacare (Registry files 1971-1975)."
27. The studies were by the Restrictive Trade Practices Commission (Report Concerning the Manufacture, Distribution and Sale of Drugs, 1963), the Interdepartmental Committee on Drugs in 1964, the Royal Commission on Health Services, (Hall Commission, 1964), and the Special Committee of the House of Commons on Drug Costs and Prices (Harley Commission 1966/1967).

expectations made the low priority position of pharmaceuticals self-reinforcing. Elite ideas regarding pharmaceuticals became more restricted over time, and the lack of public discussion about pharmaceutical insurance meant voters came to accept a more limited health system.

Adaptive expectations: elites

The last internal federal government proposals for pharmaceutical insurance was presented to cabinet by the DHW between 1971 and 1972. Despite the significant changes to patent laws, concerns about high drug prices persisted (Lang 1974). In 1971, the Minister of Consumer and Corporate Affairs and the Minister of Health proposed a Drug Price Program that would include the extension of medicare (as nation-wide health insurance was known) to cover prescription drugs.[28] The proposal called for a national formulary that would list which drugs were covered and their prices, created by an expert group,[29] and drug benefits that could be phased in for different age groups starting with seniors, although the proposal's authors argued in favour of a universal program. It anticipated that the cost of the program would be shared with provinces, and it was suggested that the program might not even require new legislation.[30]

The bureaucratic authors of the proposals, mainly from with the DHW, clearly saw them as a principled policy choice that would not only reduce drug prices, but also fill a gap in the present provision for health services and rationalize the use of existing public services. A draft memo entitled "Some Social Reasons for Pharmacare" argues that "society has come to think of health care as being part of a total system and as a result has recognized that an important segment of the health care system is not presently being covered by an insurance program," and furthermore, that "[i]t does not make much sense to pay a physician under Medicare to examine and prescribe for his patient if the patient is unable to benefit" because the prescription is unaffordable.[31] They recommended that benefits be introduced on a universal basis, as the federal government must be the single purchaser of drugs in order have a bargaining advantage with regards to drug prices.[32]

These ideas about the importance of pharmaceutical insurance, particularly as a way to lower the *social* cost of pharmaceuticals, contrast with the position of cabinet ministers, who did not even consider the department's recommendation for a universal program, and seemed most concerned with containing the cost of pharmaceuticals *to the government.*

Concerns about governments' capacity to deal with the costs of a pharmaceutical program also posed a barrier to policy development, However, Prime Minister Pierre Trudeau said he did not wish to extend medicare to drugs "because of the considerable expenditures involved and the difficulty of getting the provinces to pay their share," although he added that if the minister of health could show "the great majority of provinces wanted and were willing to pay for such service the question might be raised again."[33] Later, the Cabinet Committee on Social Policy noted that in principle it supported "the provision of a prescription Drug Insurance Benefit for Canadians *when budgetary conditions permit*" (emphasis added).[34] However, various ministers thought pharmaceutical insurance should be avoided

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28. The Drug Price Program, 23 September 1971. LAC. RG 2 Vol 6381 Series A-5-a: "Canada – Cabinet documents."

29 Report of meeting of the Cabinet Committee on Social Policy, 7 February 1972. LAC. RG 2 Volume 6397 File 145-72.

30. Memorandum to Cabinet: Measures to lower the unit cost of prescription drugs including a drug benefit program [*Pharmacare- handwritten]*, 2 February 1972. LAC. RG 2 Volume 6397 File 120-72.

31. "DRAFT – Some Social Reasons for Pharmacare" and "Arguments for Pharmacare." LAC. RG 29 Vol 1572 File 1016-1-2.

32. Memorandum to Cabinet, 2 February 1972. LAC. RG 29 Vol 1549 File 1006-5-1.

33. Ibid.

34. Memorandum to Cabinet: "Measures to lower the unit cost of prescription drugs including a drug benefit program [*Pharmacare*]," 8 February 1972. LAC. RG 2 Vol 6397 File 145-72.

because "the government's first priority should be to restore public confidence in its economic policies" (and pharmacare would detract from this priority)[35], and that "pharmacare would be the beginning of a very expensive program which would undermine the confidence of the middle-income groups in the government's ability to control the budget."[36]

Cabinet deliberations also focused on potential opposition to the scheme, although since the proposal never left the confines of cabinet the validity of these concerns were not tested. The Prime Minister noted the provinces did not like being "forced into Medicare", and would "undoubtedly object to the proposed extension of the scheme to drugs."[37] The president of the Treasury added that "provinces should be given time to increase the effectiveness of the present Medicare scheme, before any significant additions were made to it."[38] At this time, cabinet also anticipated opposition from organized interests, saying that the "drug lobby would learn of the interdepartmental studies [of drug insurance], and would react violently against them," and that the inclusion of prescription drugs in health insurance would "only exacerbate" the medical profession's dissatisfaction with the scheme.[39]

On the recommendation of the Minister of Health, John Munro, cabinet focused on a "staged program" that would provide drug coverage to the elderly and eventually expand to cover children and other groups.[40] The result was drug insurance proposals were not debated as a principled extension of medicare, but rather as one of a number of unrelated options under consideration for assisting elderly Canadians.[41] At no time was the proposal debated as a measure to lower drug prices and extend universal and comprehensive health insurance.

DHW attempts to frame pharmaceutical insurance as a tool for price control failed, and this failure is a legacy of politicians' entrenched ideas about the nature of both the drug price and drug insurance problems. A consensus that patents caused high drug prices in Canada had developed over a number of years and through a number of different research efforts. This allowed for strong action in this policy area, but it also made it difficult for politicians to conceptualize the drug price issue in any other way: despite the name of the proposal, in cabinet discussions of the 1972 Drug Price Program the problem of drug prices was not even mentioned by politicians. The efforts of DHW officials to link drug prices to public insurance were unsuccessful, as politicians, including their own Minister, only interpreted the proposals as a potential benefits program that had historically been dismissed for cost reasons.

Adaptive expectations: the public

There is limited evidence with regards to electoral motivations for drug coverage, but the existing evidence suggests there were few opportunities for public expectations to develop. A 1972 cabinet memo arguing for the Drug Price Program notes that federal departments "have received and continue to receive many letters from the public complaining about the high cost of prescription

35. "Measures to lower the unit price of drugs including a drug benefit program," 23 March 1972. LAC. RG 2 Vol 6395 Series A-5-a. It should also be noted that the recession of the mid 1970s had not yet hit and the economy was still reasonably strong at this point (Perry 1989).
36. "Measures to lower the unit price of drugs including a drug benefit program," 30 March 1972. LAC. RG 2 Vol 6395 Series A-5-a.
37. The Drug Price Program, 23 September 1971. LAC. RG 2 Vol 6381 .
38. Ibid.
39. Ibid.
40. "Measures to lower the unit cost of prescription drugs including a drug benefit program," 23 March 1972. RG 2 Vol 6395 Series A-5-a. This is an unpredictable decision that may have had a significant impact on the subsequent policy discussion: it is not clear why the Health Minister chose to disregard the intent of his departmental advisors in taking this approach.
41. "Measures to lower the unit price of drugs including a drug benefit program," 30 March 1972. LAC. RG 2 Vol 6395 Series A-5-a.

drugs and many requests that a drug insurance program similar to Medicare be made available."[42] However, the same memo goes on to discuss strategies for the implementation of a pharmaceutical program and says that since the federal government is not in a position to act unilaterally, it could "wait…for provincial and public pressures to build up," or actively encourage these pressures in hopes of igniting a desire for intergovernmental cooperation on the issue.[43] This suggests that proponents of pharmaceutical insurance recognized the potential for public opinion to aid policy development, but that the necessary pressure did not yet exist.

Furthermore, most provinces did not begin to introduce targeted public drug benefits (for seniors and social assistance recipients) until the early 1970s (Grootendorst 2002), so Canadians' first experience with public insurance for drugs was both late and limited to a relatively small portion of the population. Private insurance was also limited: a 1963 study of prescription drugs in Canada reported that, "insurance against expenditures for prescribed drugs became available in Canada only recently, in a few prototype schemes" (Department of National Health and Welfare (Research and Statistics Division) 1963). Eight years later, the situation remained much the same (Commission on Pharmaceutical Services 1971). Certainly the campaign promises of political parties, and policy agendas of governments, never alluded to pharmaceutical insurance as anything other than a vaguely distant possibility. Thus, although it is possible that the public was beginning to develop expectations about drug insurance based on a perceived "gap" in the now-comprehensive public hospital and medical insurance they enjoyed, there is less evidence for this kind of public pressure than there was for medical insurance in the mid-1960s when governments had a clear sense of having promised insurance, and a need to fulfill those promises for electoral reasons.

After 1972, there was a lull in federal efforts towards drug prices or insurance. Compulsory licensing of patents was the key element of federal government pharmaceutical management policies for twenty-five years, until it was repealed as part of the North America Free Trade Agreement Canada signed with the US and Mexico in 1994. Drug insurance was effectively off the agenda until the National Forum on Health recommended universal, first-dollar pharmaceutical insurance in 1997, and this proposal by a body outside of government also failed to produce a change in services

Australia: "a high grade service" that requires "progress step by step"[44]

Like Canada, Australia took an incremental approach to the development of health insurance, but the sequence, and hence outcomes, of its policy development were very different. Australia's first step was to introduce a system of pharmaceutical benefits in 1944, and the federal government intended to follow this with hospital benefits and later comprehensive medical insurance. The implementation of the Pharmaceutical Benefits Scheme (PBS), however, proved unexpectedly difficult, and it did not operate until a new government modified the scheme in 1950. There was no further development of government health insurance in Australia until the 1970s, when a public system of hospital and medical insurance was proposed; it was adopted between 1975 and 1984.

Centralized authority through fiscal means

Australia is a federation and, until 1946, state governments had constitutional authority over all aspects of health save quarantine. Theory predicts that fragmented authority should have been a major barrier to a radical approach to health policy in Australia. However, there is compelling evidence that federalism did not actually act as a barrier in Australia, suggesting that the analyst must

42. Memorandum to Cabinet: "Measures to lower the unit cost of prescription drugs including a drug benefit program [*Pharmacare*]," 8 February 1972. LAC. RG 2 Vol 6397 File 145-72.
43. Ibid.
44 Treasury Memorandum, January 1944. National Archives of Australia (Hereafter cited as "NAA"). A571, 1943/4513.

be alert to both formal constitutional divisions of authority and functional financial capacity. Furthermore, Australia demonstrates that it is often more helpful to look for evidence of the *mechanisms* by which fragmented authority affects the approach to policy development (such as the inclusion of subnational governments in policy deliberations) rather than simply identifying a correlation between the institutions of federalism and the outcome of an incremental approach.

The Labor government in power at the national level during WWII did not consider federalism a significant barrier to broader social services: they simply planned to request a constitutional amendment to provide them with the necessary jurisdiction, unlike the federal government in Canada which was very conscious of a need to negotiate with provincial governments.[45] Although in constitutional terms the Commonwealth government *should* have accounted for the needs and preferences of state governments when considering options for health policy, there is a lack of evidence that they *did* account for states. The unexpectedly minor impact of federalism in Australia's choice of policy approach is explained mainly by the weak fiscal position of Australian states vis-à-vis the Commonwealth government. In 1942, the federal government took over the income tax field in return for fixed grants that provided a lower level of revenue, and unlike Canada, Australian states never regained this tax room, making them highly dependent on federal grants and loans (Matthews and Jay 1972). Although the states retained constitutional jurisdiction over health, they lacked fiscal resources, and were constrained by the Commonwealth government's "unfettered grants power" (Matthews and Jay 1972) that allows the Commonwealth to "grant financial assistance to any State on such terms and conditions as the Parliament thinks fit," (Australia 2003, Sec 51 xxiiiA). This meant states were not in a strong position to turn down federal assistance health programs. This can be contrasted with the Canadian provinces' more effective veto over health policy, owing to a stronger fiscal position[46] and certain contextual factors, such as the way Quebec's unique place in the Canadian federation emphasized fragmented authority.

Lack of principled ideas

The primary barrier to the "big bang" development of hospital, medical and pharmaceutical programs in the early 1940s was the lack of principled ideas about health policy, specifically, in the Australian Labor Party (ALP). I argue that because the government lacked a cohesive and galvanizing idea about how health services should work and because the ALP had a fairly pragmatic ideology at this time, a radical approach to health policy was never seriously considered.

Public health benefits do fit Labor's "belief that there should be freedom from want for all our people" (Chifley election speech 1946, quoted in McAllister and Moore 1991, 27), but when the government began considering the expansion of social policies in the early 1940s there were significant war-time restrictions on the resources available to do so. In 1943, Labor Prime Minister John Curtin proposed a National Welfare Scheme and mentioned health as a subject which "embraces many items such as medical, hospital and dental services, and children and maternal welfare," but went on to say that, "[i]t is impracticable in war-time to devise and introduce a comprehensive scheme for all these services…" (quoted in Crowley 1973).

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45. Unlike Canada, Australia had a constitutional amending formula at this time, and amendments were much more common. To date, there have been forty-four attempts to amend the Australian constitution, eight of them successful. In contrast, there were three changes to the division of federal and provincial powers in Canada's *British North America Act, 1867* before the constitution was repatriated in 1982. After this time there have been a number of successful amendments that apply to only one province, but both attempts at major, national constitutional change have failed.

46. War time tax rental agreements ended in 1947 and provinces regained some powers of direct taxation (Bélanger 2001)

One option would have been to wait until the war ended and undertake radical policy change then – the route followed in the UK. However, Labor did wish to begin implementing new social security measures during the war, perhaps to take advantage of the "elastic" properties of the wartime defence powers under Section 51 (vi) of the Australian constitution, which beginning in World War I expanded beyond purely military matters to social and economic powers for the Commonwealth government as well (Gilbert 1980, 316). Chifley argued that if the government did not begin on cash benefit programs during the war "all sorts of excuses will be found when the War ends for not passing them," (quoted in Gray 1991). The introduction of a single service was clearly seen as the first step in an incremental process that would eventually result in a broad scheme of social protections,[47] but it was not accompanied by a clear and cohesive idea about the value and importance of universal and comprehensive services, such as the idea provided by the Beveridge report in the UK.

Others have discussed the less ideological character of the ALP, particularly compared to socialist ideals of the British Labour party (Beilharz 1994, 58; Johnson 1989, 16, 6). McMullin argues that in the interwar period, the ALP was a party "well and truly in the doldrums," and that the party's "most glaring weakness – in sharp contrast with the British Labour Party – was the ALP's intellectual bankruptcy…intellectuals were distrusted as flighty and unreliable" (McMullin 1991). Roskam points out "that Australia did not have anything like the 1942 *Beveridge Report* on social insurance in the United Kingdom, the basis for creation of the British welfare state, could be cited as evidence of a lack of policy development on both the Coalition and Labor sides of politics in Australia" (2001, 279). He goes on to argue that "Australian governments of both persuasions were a great deal more practical," than the British Labour government with its embrace of the comprehensive and expensive Beveridge proposals (Roskam 2001, 279). However, I argue that it was precisely this lack of a cohesive idea about the value of a comprehensive program, and the inherent pragmatism of the ALP, that prevented the adoption of a radical, simultaneous approach to health policy development in the 1940s.

The lack of a principled idea about health policy can be seen in Labor's manifestos and election speeches, which even after the introduction of pharmaceutical benefits legislation do not place a high priority on health policy (McAllister and Moore 1991, 27, 37). Indeed, it has been argued that health was only incidental to these broader plans for social security after the war (Gillespie 1991). However, the government's desire to implement new policies, amidst its concerns about the availability of resources to do so, helps explain the Curtin government's decision to bypass existing, internally conflicted health planning bodies and give Treasury the responsibility for health proposals (Gillespie 1991). It was the federal Treasury, rather than the Department of Health or any of the preexisting health planning bodies, which made the decision to proceed incrementally and begin with pharmaceuticals, and is further evidence of the lack of principled, programmatic ideas with regards to health policy development in Australia at this time. This was one major reason for an incremental approach to policy development; a second was the lack of obvious electoral incentives to take radical action.

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47. A 1944 memorandum notes that "The Treasury has announced that the Government intends to deal progressively with the provision of a high grade service under which the public can, at the public cost, obtain all necessary medicines, a hospital service…and ultimately, the introduction of a system under which medical services…also will be available to every citizen at the public expense," and also that "These measures for their full practical application *require progress step by step*…(emphasis added) (Memorandum, January 1944. NAA. A571, 1943/4513.) In 1944, the Minister for Labour and National Service, E.J. Holloway, called the Pharmaceutical Benefits legislation "a further installment of the complete plan of social welfare services promised by the Treasurer (Mr. Chifley) last year, when he introduced the National Welfare Fund Bill" (quoted in Crowley 1973, 100).

Lack of electoral motivations

The lack of a single, prominent report or idea on health policy also meant there was no real rallying point for public opinion on health policy. During this time, there was very little public opinion polling in Australia on the importance or even popularity of health insurance with voters, which is perhaps itself an indicator of the issue's low place on the public agenda. Since health was not included in polls that asked respondents to rank the "most important problem" facing the country, it is necessary to rely on less direct indicators of public attention and support. However, polls from 1943 to 1948 that include questions about the financing of social services, including medical care indicate that while there was occasionally a majority of voters that was supportive of the idea of free health services,[48] there was also consistent support for contributory health insurance[49] and voters generally prioritized tax cuts over social service expansion.[50] Therefore, it appears that even after the Labor government's attempts to implement the PBS were well underway, social services were not a high priority for voters.

Another indicator of the lack of electoral incentives for radical action is the curious fact that during the study period in Australia, health policies only appealed to decided Labor voters. This stands in striking contrast to the UK, where both major political parties supported the concept of a free, universal and comprehensive public health service and British polling from the time indicates that the principles of the NHS were both important to and popular with a large majority of the *entire* electorate, not a particular partisan group (Jacobs 1993, 113; Craig 1982). However, in Australia, compulsory public health services were the exclusive policy domain of the Labor party, and tended not to elicit high levels of support from conservative Liberal-Country Party voters. In 1945, Gallup questioned voters about the benefits that the Commonwealth Government should provide, and while overall 64 percent were in favor of the Commonwealth government providing free medicines, this represented about 75 percent of Labor voters and only 50 percent of non-Labor.[51] This partisan division continued in May 1948, when voters were asked if they favored or opposed the government's plan for free medicines. Gallup reported that "Public opinion is unsettled…a bare majority of 51 percent is in favor, 33 percent opposed, and 16 percent undecided."[52] However, a breakdown by voting intention indicates that 70 percent of interviewees who planned to vote for Labor in the next election were in favour of the free medicines scheme, while only 28 percent of Liberal-CP voters were in favor. This split is repeated in later polls on the PBS and other health policies,[53] which suggests that even though these policies might appeal to existing Labor voters, they did not have the broad public appeal necessary to motivate radical action by the government, and the fact that free services were actually unpopular with a significant portion of the electorate likely made it less tempting for politicians to tackle.

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48. Gallup Poll, October 1943, Polls 153-161, "Support for National Medical Service"; Gallup Poll, March 1947, Poll 416-425, "Big change in opinion of financing social services".
49. Gallup Poll, July 1944, Polls 205-212, "Public wants medical service contributory"; Gallup Polls, December 1944-January 1945, Polls 241-248, "Social Benefits Should be On Contributory Basis;" November 1945, Polls 304-313, "Australians in Poll Insist on Contributory Social Services Scheme;" and September 1946, Polls 382-397, "Contributory Social Services Wanted."
50. Gallup Poll, May 1945, Polls 264-271, "Present Taxes Too Heavy for social services." 53 percent of Australians opposed maintaining the current level of taxation after the war. Gallup Poll, February-March 1948, Polls 487-491, "Lower taxes preferred to more social services".
51. Gallup Poll, December 1945-January 1946, Polls 314-326, "Federal Social Services Approved."
52. Gallup Poll, May 1948, Polls 511-528, "Public uncertainty about free medicines"
53. Gallup Poll, February-March 1949, Polls 569-578, "Medical & Dental Plan"; May-June 1949, Polls 590-599, "Public still wants free medicine, but opposition grows"; March-May 1969, Polls 2105-2118, "Keep medical funds voluntary".

The adoption of the Pharmaceutical Benefits Scheme

Beginning with pharmaceutical benefits is not intuitive: they are not the most obviously important or costly service, and this decision has been something of a puzzle in Australian health policy. However, archival records indicate that, in keeping with the government's concerns about the lack of resources to implement social security measures, the decision to begin with pharmaceuticals was a pragmatic one. An unusually high proportion of Australian doctors were overseas during the war (Crowley 1973), and the government did not believe there would be sufficient medical personnel for any health services besides pharmaceutical benefits until after the war. A 1944 Treasury memorandum explained that pharmaceutical benefits were meant to be part of a comprehensive health scheme eventually, but alone, these services "will not involve any significant additional drain on professional man power and it is this feature which enables the introduction of the scheme before the end of the war."[54] Another Treasury document reiterates that the government was considering medical benefits but "owing to the absence in the fighting services of a substantial proportion of medical men, it is expected that it will not be possible to introduce a scheme of free medical services until after the war."[55]

Although this suggests that the choice of pharmaceuticals as a first priority was dependent on fairly idiosyncratic factors, the Australian government's response to these particular resource constraints is consistent with what we would expect from a government motivated by a pragmatic desire to implement some policy change, without guidance from principled policy preferences. The choice of priorities was also supported by compliant state governments and the federal government's expectation that pharmaceutical benefits would be less controversial with the medical profession (Gillespie 1991). However, the government did not predict that the BMA would view the PBS as the wedge towards socialized medicine and would oppose it "with a furor and effectiveness which decided its fate" (Hunter 1965, 412).

The BMA lobbied against the introduction of the PBS and, once it was passed, prevented the scheme from functioning by simply refusing to use the government prescription forms necessary for patients to obtain free drugs at the pharmacy. The doctors' most overt objection was to the proposed Commonwealth Formulary, or list of subsidized drugs. However, these concerns overlaid a more basic fear of major changes to the medical profession and the introduction of "socialized" or "nationalized" medical services. [56] The BMA fought the PBS in private meetings with the Minister,[57] and in public, with newspaper statements[58] and published pamphlets.[59] The BMA was able to prevent the implementation of this first priority for five years. In 1949 there was a change in government that allowed for a compromise with the BMA and the implementation of a slightly modified PBS, but also ended further health policy development for almost twenty years.

Barriers to policy change

54. Memorandum, January 1944. NAA. A571, 1943/4513.
55. Social Security in Australia memorandum. NAA. A571, 1943/4513.
56. "Objections to Free Medicine: bad for patients," Argus, 8 June 1945. NAA. A571 1943/1812 Part 1. See also the speech by Liberal member of parliament and BMA champion Sir Earle Page on the first reading of the PBS bill in 1944 (quoted in Crowley 1973).
57. Transcript of meeting, Minister and BMA, 21April 1947. NAA. A571 1943/1812 Part 2. "Social Services in Australia – Pharmaceutical Benefits. 1946-1947;" Transcript of meeting, Minister and BMA, 2 July 1948. NAA. A571 1943/1812 Part 3. "Social Services in Australia – Pharmacy Benefits. 1948-1947."
58. BMA statement, 10 August 1944. NAA. A1928 781/4 Section 2. "Pharmacists and Pharmacy – Pharmaceutical Benefits Act – General. 1944."
59. BMA pamphlet to hospital patients, 1945. NAA. A571 1943/1812 Part 1.

In Canada, policy development stalled after the introduction of medical insurance in 1966, despite the fact the Liberal party remained in office for all but one of the next eighteen years. In Australia, however, a change in government was a decisive factor in blocking further health policy development. The position of the Liberal Party under Prime Minister Robert Menzies can be understood as a significant lack of principled ideas supporting comprehensive and universal health policy: in fact, the party opposed compulsory, non-contributory health insurance on principled grounds. The 1945 Liberal platform called for "the encouragement of supplementary voluntary schemes in addition to government schemes" for social security and stated the party's opposition to "the nationalization of the medical profession and service" (White 1978). Menzies' 1946 election speech again calls for contributory social security and makes no mention of health, while his speech in 1949 calls for preventative health programs, saying "it is a grave error to treat the problem of a national medical health service as if it meant nothing more than the making of monetary payments to citizens through the Treasury" (McAllister and Moore 1991). The Liberal government demonstrated these principles in 1952 by restructuring Labor hospital subsidies to states in a way that created a larger market for private health insurance, although the change initially had limited impact on most patients (1991). After the implementation of the Pharmaceutical Benefits Scheme, there was no further development of public health insurance until 1972, when a Labor government again came to power at the national level. Doctors were clearly opposed to public health benefits of any kind, and the Australian branch of the British Medical Association (BMA) had expended considerable time and resources fighting the PBS, although they were prepared to be mollified by a Liberal government that was much more in tune with their interests. Given these factors, the lack of further health policy development after 1950 is expected, and the real puzzle is to explain the Liberal decision to implement a modified PBS. This decision is an example of how quickly public expectations of service can take hold, a conclusion which is supported by the evidence contradicting any alternative explanations for the PBS's implementation, such as support for the scheme from within government or from a major interest group.

Implementing the PBS: the reciprocal relationship between elite ideas and public expectations

The Liberal government choose to implement the PBS with restrictions to the formulary that allowed the party to appease doctors[60] and to argue that in contrast to Labor's comprehensive list of covered medicines, the new scheme was "comparatively simple and safeguards against extravagant waste of drugs."[61] But given that the party was otherwise opposed to broad public health benefits, why implement the PBS at all? Although the initial impetus for the introduction of the PBS had been pragmatic rather than principled, five years of high-profile controversy over the policy resulted in a new set of conditions for its implementation. Elite promises of pharmaceutical benefits changed public expectations, even in the absence of a functional scheme, and this is turn fed back into Liberal's electoral incentives to act on health policy. As the early promises and ensuing controversy

60. Doctors' preference was for a limited list (see Cabinet memorandum, 24 September 1947. NAA. A27000, 1005C. "Pharmaceutical Benefits Act 1947."), so they could retain complete autonomy over compounded prescriptions: those medicines that chemists mixed in their shops according to the doctor's instructions, rather than manufactured medicines that were mass-produced and shipped in their final form. If a formulary was sufficiently comprehensive, it would provide formulas for most commonly used drug preparations and prevent doctors from prescribing individualized compounds as they saw fit. Essentially, physicians' concerns about the formulary appear to have been grounded in their desire to retain the maximum autonomy over prescribing, whether that was by the government covering any script a physician wrote (even if it was compounded according to individual instructions), or by limiting government prescriptions to a small number of costly manufactured medicines.

61. Earle Page, "Department of Health – Pharmaceutical Benefits," Cabinet submission 22 June 1950. NAA. A1658 813/1/1 Part 1.

were restricted to a single service, however, so was the focus of public attention and support and the incentives for the Liberal party to adjust its policy preferences.

By 1950, the PBS had become a reasonably salient issue: it had been the subject of two High Court cases (one only a year previous) and a successful constitutional referendum in 1946 that gave the Commonwealth government jurisdiction over pharmaceutical benefits and certain other cash benefits (Australia 2003, Sec 51 xxiiiA). Opinion polls demonstrate that the public had become attached to the idea of a public pharmaceutical program. In March 1950, when the Liberal's scheme for a *less* generous PBS was first introduced, Gallup reports that, "at this stage, the public is not keen on the idea."[62] The poll asked whether people favored a scheme where all medicines were free (like the original PBS), a scheme were only expensive medicines were free (as was proposed by the new Liberal government), or if they preferred no free medicines. Overall, 43 percent of respondents favored "all medicines free", and 37 percent preferred that only expensive medicines were free. As expected, there was some difference along party lines, with 57 percent of Labor voters supporting the "all free" scheme, versus 33 percent of Liberal-CP voters. Crucially, however, only 15 percent of respondents overall favored "no free medicines,"[63] suggesting a new set of expectations based on government's policy promises. A few months later, this dropped to only 11 percent of respondents preferring no free medicines,[64] so taking some sort of action on a pharmaceutical program was clearly an electoral winner across party lines.

Although the Liberals criticized the Pharmaceutical Benefits Act when it was introduced in 1944 (Crowley 1973), once the scheme was (nominally) in place, there seems to have been a different attitude, reflecting the difficulty of removing outright an existing benefit (Pierson 1994). Roskam notes that, when Menzies became Prime Minister in 1949, he "endorsed the central elements of welfare policies adopted by Labor in the 1940s, and he recognised that first the Great Depression, and then war, had changed community expectations about economic and welfare policies" (2001, 278). The turning point came in 1948, when the Liberals added pharmaceuticals to their party platform: the health section called for "the free provision of certain specific drugs vital to the preservation of life (such as insulin)" (White 1978) and members of Parliament gave speeches speech deploring the fact that citizens were paying taxes for free medicines that they were not receiving.[65] Opposition parties had concluded that some level of pharmaceutical benefits was desirable or at least inevitable and began using rhetoric that would set the stage for the early Liberal implementation of the PBS when they took power.

Overcoming barriers: preliminary evidence

After this time, there was no further development of public health insurance or services for more than two decades. However, in 1975 a new Labor government was able to overcome the barriers to later policy development with the introduction of public medical insurance and free public hospitals, and the program was reintroduced permanently in 1984 after a period of Liberal government retrenchment. Although this research has focused on the issue of pharmaceutical programs, the argument that an incremental approach precluded the development of pharmaceutical insurance in Canada naturally raises a question of why Australia was able to introduce Medibank/Medicare so long after the adoption of the PBS. This development suggests that while incremental policy development makes later steps more difficult, it does not make it impossible, and that major change in health policy can still occur. An initial reading of the literature on the introduction of public

62. Gallup Poll, March-April 1950, Polls 662-676, "Public not keen on Page medical plan"
63. Ibid.
64. Gallup Poll, June-July 1950, Polls 690-699, "Page medicine plan hasn't "caught on"."
65. Mr. Harrison, Hansard, 17 June 1948. A571 1943/1812 Part 3.

medical insurance in Australia[66] suggests that taking these later steps was analogous to the decision to take a radical approach to health policy initially, in that it required a combination of institutional authority, principled ideas, and electoral motivations to overcome barriers to additional services that develop over time.

With regards to centralized authority, in the 1970s the Commonwealth government retained the financial supremacy discussed earlier, and Labor leader and later Prime Minister Gough Whitlam certainly did not see Australia's federal institutions as a barrier to the policy change he wished to introduce. He argued that "In Australia, if a significant function is not financed by the national Government it will be unfairly financed, inadequately financed, or not financed at all" (Whitlam 1985, 3). There is also evidence of new principled ideas about the value and importance of a comprehensive public system. While in opposition, Whitlam was concerned with setting out a clear program of social policy expansion to differentiate the ALP from the government (Whitlam 1985, 4), and he found a specific idea about the shape this expansion should take in the work of two Melbourne University economists. Whitlam records in his memoirs that,

> Although well aware of the inadequacies of the existing health insurance system, I was yet to develop a viable policy alternative on behalf of the ALP. The solution came in 1967 when Cass asked me to his home to meet John Deeble and Dick Scotton of the Institute of Applied Economic and Social Research at Melbourne University…Deeble and Scotton were preparing an alternative health insurance program which built upon the criticisms, identical to my own, that they had developed of the existing system. Medibank was conceived that night" (Whitlam 1985, 335).

In Scotton's own account of that meeting, he recalls that although he and Dr. Deeble had been doing research which "prompted skepticism about the social outcomes of the voluntary [health insurance] system," in 1967 their "ideas were still quite tentative" (Scotton and MacDonald 1993, 21, 24). However, they put them into writing at Whitlam's urging, and their plan joined a number of their published articles "which Whitlam lost no opportunity to cite," in promoting the universal, compulsory alternative (Scotton and MacDonald 1993, 24). Scotton and MacDonald note that in 1968, "the Pandora's box which had contained public debate on health insurance was now well and truly open" (Scotton and MacDonald 1993, 25), and the greater salience of this cohesive, principled idea of how health insurance should work helped fuel electoral incentives for reform – the third important factor for radical change.

The electoral motivation to attempt radical health policy reforms developed in a number of ways. First, there was simply the worsening objective condition of the voluntary scheme: "by the mid-1960s the limitations of Australia's voluntary health insurance scheme were starting to be felt. The financial growth of the [private] health insurance funds contrasted with the growing dissatisfaction with rising contributions and gaps in coverage" (Scotton and MacDonald 1993, 19). After universal health insurance was adopted as Labor policy, it "rapidly assumed increasing prominence as an issue" in the 1969 election (Scotton and MacDonald 1993, 32). Labor lost this election, but by September 1972 polls found that "'free medical services' were identified by 46.3 percent of respondents – more than any other item – as the most important single issue" (Scotton and MacDonald 1993, 51, citing Stubbs 1989). Medibank was adopted by the Labor government when it won power in 1975, and although the subsequent Liberal government undertook significant retrenchment, the popularity of the program meant that easily it was reinstated when a Labor government took power again in 1983. According to Whitlam, "Hawke won in March 1983 with a simple one-line undertaking: 'We will

66. See Boothe 2010 for a more detailed overview of this evidence.

restore Medibank'" (Whitlam 1985, 349), demonstrating again how quickly public expectations adapt to elite promises and even short experience with a health benefit.

Conclusion

This research provides an answer to an empirical puzzle: why Canada lacks nation-wide public drug coverage. Pharmaceutical insurance failed to develop in Canada because the institutional, ideational and electoral conditions during the earliest stages of health planning prompted an incremental approach to policy development. Pharmaceuticals were originally on the agenda, albeit as a lower priority. However, the dynamics of an incremental approach meant that there was no opportunity for pharmaceuticals to move up the agenda: over time, adaptive expectations arising from the reciprocal relationship between elite ideas and public expectations increased the barriers to the adoption of additional services and stalled the process of policy development.

The paper also makes two main theoretical contributions. First, it demonstrates that the approach to policy development matters. Even if an incremental process starts with similar goals as a radical approach, they are likely to result in significantly different outcomes. Considering the dynamics of incremental versus radical policy development helps conceptualize different types of reform – are policymakers attempting to go "forward," and add new elements to a program, or "back" by adjusting or retrenchment existing programs? This in turn clarifies the barriers to change we expect to see in different policy processes.

The second main theoretical contribution is an explanation for both policy stability and change that rests on the reciprocal relationship between elite ideas and public expectations. The paper provides more specific mechanisms by which barriers to change increase over time by highlighting the importance of sequencing effects in changing policymakers' fiscal calculations, and the way adaptive expectations work in combination at both the elite and the mass level. It also suggests a explanation for when and how these barriers may be overcome that is logically connected to the original dynamics of policy development, by demonstrating that the conditions for radical change at the beginning of a policy process also apply later in the process, when changes that originally may have been relatively "small steps" face significantly increased barriers to adoption or reform. This framework allows us to develop a complete understanding of policy development that acknowledges the realities of the process – small steps may often be necessary – while providing a theoretically satisfying explanation of why this is the case, and addressing the predictable elements of policy success, failure and change over time.

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Archival institutions are identified in the footnotes using the abbreviations provided. Under each institution, I list the record groups cited.

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CAB: Cabinet office

MH: Ministry of Health

T: Treasury

Library and Archives Canada (LAC)

RG 2: Privy Council Office

RG 29: Department of National Health and Welfare

MG 32-B5: Brooke Claxton fonds

National Archives of Australia (NAA)

A571: Department of the Treasury, Central Office.

A1658 and A1928: Department of Health, Central Office.

A2700: Secretary to Cabinet/Cabinet Secretariat (Curtin, Forde and Chifley Ministries).

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Canadian Institute of Public Opinion/Gallup Poll of Canada, *Public Opinion News Service Release*

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