How the pace of change affects the scope of reform: Pharmaceutical insurance in Canada, Australia and the UK

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Abstract

When policy change is considered, what determines its success or failure? Why do plans for broad reforms often fall short, and why do certain types of change become more difficult over time? This article addresses these questions by examining health policy development in Canada, Australia and the UK – specifically, why Canada alone failed to adopt nation-wide, public pharmaceutical insurance. It demonstrates that the pace of change has significant implications for the scope of policy development. It provides new mechanisms to explain why incremental reforms stall based on the reciprocal relationship between elite ideas and public expectations, and suggests that similar factors can explain how barriers to policy change develop and the conditions under which barriers may be overcome.

Introduction

A variety of factors can prompt consideration of new health policies, but significant changes are proposed more often than they are adopted. 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 welfare states. This article asks how the *approach* to policy development, particularly the pace of change, affects the scope of reform. It distinguishes between radical "big bang" versus incremental change. If a country takes an incremental approach and initially adopts only one element of a health program, can additional services eventually be implemented? What barriers arise to the adoption of additional services over time? These questions are prompted by an empirical puzzle: although Canada initially considered public health insurance that included pharmaceuticals in the late 1940s (as did similar welfare states), and there have been a number proposals for 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

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experience of similar welfare states like the UK and Australia. Existing literature on 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 article 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 different approaches to health policy development.[1] The UK took a radical approach and introduced the National Health Service in 1946, with 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 federal government first proposed universal health insurance in 1945 and nation-wide hospital and medical insurance programs were adopted in 1957 and 1966, respectively. No additional services were adopted: the article discusses the failure of a final federal proposal for universal pharmaceutical insurance in 1972.

Canada, Australia and the UK all experienced a similar "welfare moment" at the end of World War II that motivated governments to take some action on health policy (Hacker 1998: 81; Lynch 2006: 56), but they made very different choices about how to proceed. This article asks why the approach to policy development varies, and how it affects policy outcomes.

A theory of policy development and change

The national health insurance literature does not consider variation in pharmaceutical programs specifically, but given that much of this literature emphasizes the importance of timing and sequence to policy development (Hacker 1998; Maioni 1998; Tuohy 1999), we might expect more general historical theories of policymaking 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

1. I focus on policymaking at the national level. In Canada, provinces only began to offer pharmaceutical programs to limited populations in the 1970s, and in Australia a 1946 constitutional amendment gave the Commonwealth government jurisdiction over pharmaceutical benefits. Health policymaking in Britain was synonymous with policymaking in the UK until devolution in 1997, when Scotland and Wales began pursuing independent pharmaceutical programs.

dynamics that make them increasingly difficult to change, 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 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). 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 (political institutions) (Baumgartner and Jones 1991).

While these literatures provide strong explanations for stability, they have more difficulty accounting for change, in part because there is ambiguity about the nature of major and minor change, and about specific mechanisms for stability and change. How much minor adjustment might we expect in 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 mechanisms by which barriers to policy change develop and to theorize scenarios under which these barriers can be overcome. This article addresses a restricted time period (1940s to 1970s) and focuses on the first question about the development of barriers, but I suggest in the conclusion that similar mechanisms may also help explain how barriers to change can be overcome.

To address limitations in these existing approaches, I offer a more precise definition of policy change. I measure the degree of 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 discrete components, such as the public provision of various health services. To determine the significance of change, I examine initial plans for policy development and ask whether policymakers go forward with all elements of the plan at once (a radical change), or break the plan into incremental steps. Taking an incremental approach to policy development is significant because even if two jurisdictions start with similar goals, an incremental approach limits elite and public expectations about the policy area. Over time, "next steps" that perhaps were not radical when they were considered at the beginning of a policy process *become* radical as expectations adapt to a more limited understanding of

the policy area. Ultimately, a slower pace of change means adopting the entire program is less likely: incremental policy development stalls in predictable ways after the adoption of first priorities.

When does the politics of radical, "big bang" policy development win out over incrementalism? Agenda-setting literature, particularly on the role of "windows of opportunity", provides important lessons about the process of initiating major policy change (Kingdon 1995). There is debate about how to identify windows of opportunity or critical junctures (Mahoney 2000; Thelen 1999), but I conceptualize them as points in time when certain conditions for policy change coincide. There may be parallel critical moments for policy change across countries, in response to exogenous world-historical events. However, conditions for change during these critical moments will vary slightly between countries, and uncovering these variations helps explain different policy outcomes.

One of the most valuable contributions in this regard is Tuohy's 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 I interpret as a combination of ideational and electoral motivations (Tuohy 1999). I hypothesize that there are three factors that 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 these 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

I hypothesize that countries with institutions that centralize authority are more likely to take a radical approach to policy than countries where institutional authority over that policy is fragmented: more veto players means more opportunities to block radical change, while incremental change provides more opportunities for bargains and tradeoffs between multiple veto players. The main institutional difference discussed here is federal versus unitary government. However, it is expected that a similar dynamic applies 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) and can thus veto unilateral action by the national government in a particular policy area. 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 national 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 that provides broad guidelines for policy action. Tuohy 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: 12)

A radical approach requires that significant policymakers support policy adoption for principled reasons, although this does not preclude strategic motivations, as discussed below. This means 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 Berman (1998) calls "programmatic beliefs". These are ideas in a mid-range of generality between ideologies and policy positions, which "provide guidelines for practical activity and for the formulation of solutions to everyday problems…[and] a relatively clear and distinctive connection between theory and praxis" (Berman 1998: 21). Thus, by "principled ideas," I mean principled attachment to guidelines relevant to a broad policy area (health) that provide solutions for how theory (e.g. socialism) should be applied to particular problems (e.g. government involvement in health services). These ideas may still be high-level: in this way

they are distinguished from specific policy instruments dictating the role of various organizations in the provision of services, the determination of eligibility for benefits, or mechanisms for controlling costs and measuring cost efficiency. However, they provide a cohesive response to a policy problem and therefore a specific motivation for radical action. Policy development is still possible in the absence of principled ideas, but the pace of change will likely be slower, and subsequent policy changes will be influenced by the more limited ideas that grow up around practice, rather than broad guiding principles that are present in a radical process.

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, politicians will be more likely to support a radical approach to policy development. When 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 radical change, 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 with distributive policies: "good policies" that promote principled commitment in politicians are frequently beneficial to many people, who recognize their potential benefit and in turn provide electoral motivation for politicians to adopt these policies. As discussed below, this research uses a methodological approach designed to distinguish between motivations that are primarily strategic, and those that represent principled commitment to a policy idea.

Barriers to policy change

The choice between radical versus incremental policy development would not be significant if they produced similar outcomes, 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, 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 that allowed for radical change at the beginning of a process.

The path dependence literature sets out a number of features of the policy process that make it self-reinforcing and difficult to change, including large set-up costs, learning and coordination effects, and adaptive expectations (Pierson 2000). We can see these factors at work in the way alternative institutional arrangements for service delivery arise in the absence of government programs. Private actors make investments (pay set-up costs) and create networks (develop expertise and coordinate actors), essentially staking a claim on the service area, making it 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 and one reason that the introduction of public medical insurance in Canada was more difficult than hospital insurance (Hacker 1998; Shillington 1972). However, Canadian pharmaceutical policy presents a challenge to this mechanism, since both public and private policy development was late. Provinces began adopting limited pharmaceutical programs in the 1970s, the same time as private companies began offering commercial drug insurance (Grootendorst 2002; Commission on Pharmaceutical Services 1971). This suggests a need for some new, specific mechanisms to explain why this type of change – the addition of new services, rather than the modification of existing programs – becomes more difficult over time. The mechanism proposed here addresses this need, and 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.[2] Cross-national differences in expectations are driven by differences in the pace of policy change, and there is a particularly strong effect of adaptive expectations when we consider the relationship between elite ideas and public expectations.

Adaptive expectations shape both policymakers' and the public's view of what a policy "should" do. This mechanism is linked to Pierson's insights about the way welfare policies develop "supportive constituencies" of beneficiaries (Pierson 1994), but extends them to include more explicitly the reciprocal causal relationship between principled ideas and

2. I find that domestic policy developments are most influential; see for example the lack of impact the British Beveridge Report had on the Canadian public, compared to the British.

electoral motivations. Early elite expressions of health policy ideas influence public expectations for service by increasing awareness of the potential benefits, and this public awareness in turn promotes 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 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 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). Without an initial principled idea or electoral motivation to take a broader view, 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. New information and ideas may be presented to decision makers – state agencies and bureaucrats are a key source, as Carpenter notes when he examines how regulators and scientists use "conceptual power" to shape understandings of the policy and its goals (Carpenter 2010). However, politicians ultimately decide which items reach the government's action agenda (Kingdon 1995: 30-32). Bureaucrats' ideas may change at a different pace or even in different directions that political elites', since they "have the necessary expertise, the dedication to the principles embodied in their programs" (Kingdon 1995: 30) as well as the time and resources to process the large amounts of disconfirming data necessary for ideational change (Jacobs 2009: 259). There is no guarantee that this ideational change can be translated to political elites, though, and politicians are more likely to accept bureaucratic ideas if they fit with their own existing beliefs about the policy area. As Jacobs argues, "one of the most robust findings in all of cognitive psychology is that individuals display powerful tendencies both to seek and to take into account information confirming prior beliefs, and to avoid and to discount information contradicting them"

(2009: 258). Thus, bureaucrats or agencies may shape change when it occurs, but cannot usually independently get change on the agenda – hence this article's focus on the ideas of political elites.

Method

This theoretical framework poses a methodological challenge: how to distinguish principled ideas from policymakers' strategic or electorally motivated preferences. I address this problem using a process tracing approach, which allows me to "unpack" the different variables in what might otherwise be an indeterminate causal relationship (Hall 2006; George and Bennett 2005). The article builds detailed, chronological accounts of the policy process in each case using archival and published primary documents as well as secondary historical sources. Archival documents are key to distinguishing principled and strategic motivations, as they record both public and private policy discussions and the sequence of different types of ideas in the policy process. Statements of principled ideas may be more common in public fora, such as election manifestos and speeches in parliament. Process tracing allows for a comparison of when these public statements were made, relative to both private statements and the collection of information relevant to electoral incentives, such as 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 that their support for a policy is genuinely motivated by a principled commitment to the idea. As detailed below, the UK is characterized by consistent expression of principled ideas in public and private fora, but this is not the case in Canada or Australia.

The United Kingdom: "something bolder than a mere extension and adaptation of existing services" (Labour Health Minister Aneurin Bevan, 1945)

The National Health Service (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 (Hacker 1998), 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 universal, nationalized service.

There is an excellent scholarly literature explaining why the UK introduced this radical policy change (Hacker 1998; Tuohy 1999; Klein 1995). I look for evidence of centralized institutional authority, principled ideas 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: 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 moved the country from the wartime coalition to a Labour majority government (Jacobs 1993).

The role of centralized authority is apparent in the language of the Ministry of Health. The 1944 White Paper argued 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). Later, the Minister of Health noted that the nationalization of hospitals posed "the risk of losing … the benefits of local interest and local knowledge in day-to-day administration," but the benefits of a single national service outweighed these risks (Minister of Health, 13 December 1945. CAB 129/5. The National Archives, UK (TNA)). 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 opposition and introduce the type of program favored by the central government (Tuohy 1999: 39; Klein 1995: 14). 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 were both strategic and principled reasons for the post-war government to place a high priority on the adoption of the NHS, but the key for pharmaceuticals was that all actors took a comprehensive range of health services for granted: this was one of the overarching guidelines that linked Labour's socialist ideology to the problem of health services. Although

there were controversies over hospital administration and doctors' remuneration, even before Labour took power in 1945 there was 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 and costs managed, not whether they should be included in the scheme or not. For example, a series of Ministry of Health memos from 1943 debate dispensing drugs from central clinics rather than existing chemist shops: one official argued that this would curb "the excessive cost of a practitioner's prescribing habits" in some cases, while another was "doubtful whether it would be convenient or economical to supply drugs through dispensaries attached to the clinics" (Memoranda, March-April 1943. MH 77/120. TNA). In 1944, a ministry memo estimated the potential annual drugs bill to be "somewhere about £10,000,000 and it will, therefore, be worth while to set up some considerable machinery to ensure that we get what we are paying for" in terms of quality products (Memorandum, March 1944. MH 77/120. TNA).

This shared assumption about the appropriate scope of health services was powerfully articulated in the 1942 Beveridge Report. A review of previous health services reports notes that most frequently repeated principles were "that there should be made available to every individual in the community whatever type of medical care and treatment he may need; [and] that the scheme of services should be a fully integrated scheme," so pharmaceuticals would be included along with hospital, medical, and other auxiliary services (Ministry of Health 1944: 76). The Beveridge Report based its recommendations on these principles, and described "comprehensive health and rehabilitation services" as key for its proposed program of social security (Great Britain. Inter-departmental Committee on Social Insurance and Allied Services 1942: 158). Although it did not describe the specific instruments that should be used to achieve these principles, it helped define elite's programmatic beliefs regarding the scope of action required in health policy.

The report was very prominent and broadly supported by the British public. A 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: 113). This high degree of public support provided incentives for government action, and the wartime 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 goal, but disagreement on methods became moot after the 1945 election. 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: 15).

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). The public found these promises more credible than the Conservative health platform (Jacobs 1993: 169), and after Labour came to power there is clear evidence of electoral motivation for bold action. In 1948, a Gallup Poll reported that 61% of Britons felt the new health service was a "good thing" (BIPO/Gallup Poll, 17 May 1948).

There is also evidence of a principled component to Labour's commitment. In 1937, future Prime Minister Clement Attlee discussed the 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, and argued that for Bevan "and for many others," the idea of a free health service "represented the embodiments of a pure Socialist ideal" (Klein 1995: 13; Webster 2002: 13; Ryan 1973: 219). Besides the principled ideas contained 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" (13 December 1945. CAB 129/5. TNA.). Bevan demonstrated his commitment to the NHS' founding principles in 1949 by opposing new legislative powers to impose charges for certain services (Chancellor of the Exchequer, Memorandum EPC(49)111. 14 October 1949. CAB 134/220/34 TNA), 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).

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 services in 1946. This radical approach to health policy meant that pharmaceuticals were just one element of a comprehensive system and were adopted without controversy or fanfare. It also meant that subsequent attempts to limit free services would be very controversial: the simultaneous adoption of a full range of services made it difficult to thwart public expectations with the later introduction of patient charges for prescriptions (Treasury history of prescription charges: S.S. aspects. 24 February 1966 – 31 May 1967. T 227/2522. TNA). In Canada and Australia, conditions did not allow for a radical approach to health policy, and the sequence of policy development had significant implications for pharmaceutical programs.

Canada: Health insurance "capable of being introduced by several stages" (Government of Canada, 1945)

Canada's path to public health insurance was slow and difficult. In the immediate postwar period, Canada lacked the conditions for a radical approach to health policy, and the incremental approach 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 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 (The Drug Price Program, 23 September 1971. RG 2. Library and Archives Canada (LAC); National Forum on Health 1997; Commission on the Future of Health Care in Canada 2002; Senate Standing Committee on Social Affairs, Science & Technology 2002), this component of health insurance has never been adopted. 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 ruled out a radical approach quite early, and once the country embarked on an incremental path it was very difficult to leave it. The 1945 proposals envisaged a comprehensive health program provinces would "have to take, in its entirety, and in a fixed order, within a certain time limit" (Department of National Health and Welfare Memo, 22 December 1949. RG 29. LAC.). 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 report of the Cabinet Working Committee on Health Insurance recommended that further policy development be deferred until provinces provided input (Brooke Claxton fonds. LAC).

Subsequent health insurance planning focused on an incremental approach. In 1949, the Department of National Health and Welfare (DHW) was asked "to arrange 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" (Minutes of the Second Meeting of the Interdepartmental Working Committee on Health Insurance, 9 December 1949. RG 29. LAC). When health insurance proposals were discussed at the 1955 Federal-Provincial Conference, the Prime Minister's opening statement demonstrated deference to provincial governments and acceptance 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). Preferences for a slower pace of change varied by province and over time. For example, at the 1955 conference, British Columbia called for the consideration of "health insurance embodying medical, hospital, dental and pharmaceutical services" (Taylor 1987: 209), but in 1964 the province advocated for a program "designed in such a way so as to permit step-by-step implementation" (Statement of Principle advocated by British Columbia Respecting…the Report of the Royal Commission on Health Services, 20-21 July 1964. RG 29. LAC). However, there was never federal-provincial consensus on a radical "big bang" approach to policy development, and standard path dependence accounts of the

process suggest this type of consensus would be increasingly unlikely the further the country travelled down the incremental path (Pierson 2004: 21).[3]

Lack of principled ideas

In Canada, there was no consensus on overarching goals for government involvement in health services. In 1944, Liberal Prime Minister Mackenzie King had been in power for almost a decade, and Liberals had included health insurance in their platform since 1919 (Boychuk 2008: 33). However, Liberal promises on social security, including health insurance, were mainly due to electoral pressure from the Co-operative Commonwealth Federation (CCF), a social democratic party that was gaining power at the provincial and federal levels (Hacker 1998; Maioni 1998: 75). Pressure from the CCF forced the Liberals to act on health insurance, but action was guided by political compromise rather than programmatic beliefs linking ideology and practice. This favored 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 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: 62). 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: 220). 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 (G.D.W. Cameron to Paul Martin, 27 November 1950. RG 29. LAC). After the 1953 election, Martin faced a Liberal cabinet where "most ministers supported voluntary health insurance and opposed government involvement" (Martin 1985: 226).

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3. Federal-provincial coalition building around hospital and then medical insurance was considerably more complex than can be captured in this article. For more on the role of territorial dynamics, see Boychuk (2008).

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: 226).

Hospital and medical insurance are logical first priorities since these are clearly the largest programs, and particularly in the case of hospital care, most likely to impose costs individuals are unable to afford. However, Canadian policymakers explicitly decided to take pharmaceuticals off the agenda, rather than arguing other services were more urgent. When the DHW reconsidered the order of priority for services before the 1950 Federal-Provincial Conference, officials recommended leaving pharmaceuticals off the agenda because, "All the experience to date indicates that it is almost impossible to control the costs in such services" (Health Insurance brief, 7 December 1949. LAC). Although the accepted wisdom often states that pharmaceuticals were simply considered "too late" owing to the pharmaceutical cost escalation of the later 1950s and 1960s, it is important to note that this conclusion was reached *prior to* the pharmaceutical therapeutic revolution. At this time, 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.[4]

Lack of electoral motivation

The lack of cabinet support for a bold health policy reflected the low salience of health insurance among the Canadian public at this time. Since neither federal nor provincial governments outside Saskatchewan provided clear proposals, there was little opportunity for public expectations to develop and therefore no clear electoral motivation for the Liberal government to act radically or quickly. Domestic commissioned reports, such as Leonard Marsh's 1943 *Report on Social Security for Canada*, failed to capture public attention, and the popularity of the Beveridge Report in the UK had not crossed the Atlantic. In 1943, only

4. Why Canadian officials were so pessimistic about the cost 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 here. Australian policymakers focused on designing tools for cost control. Tom Kent, the architect of later Liberal health policy, notes that in the 1960s drugs were seen as more difficult to ration than doctor's visits, and that it was easier to "want too much," and it seems likely that this thinking played a role at this earlier juncture (Author's interview with Tom Kent, Kingston, 11 February 2008).

one in four Canadians could recognize the phrase "the Beveridge Report," (CIPO/Gallup Poll of Canada, 6 February 1943) 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." (CIPO/Gallup Poll of Canada, 6 February 1943).

When Canadians were questioned directly about national public health insurance between 1942 and 1952, they tended to be quite supportive (CIPO/Gallup Poll of Canada, 8 April 1942; 22 May 1943; 8 April 1944; 13 July 1949, June 1952). However, when Canadians were asked variations of a "most important problem" question (a standard measure of salience that provides information on unprompted top-of-mind issues) between 1945 and 1951, health was not an important issue: the top answers were jobs, taxes, prices, housing, or threat of war. Martin reports 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). "Health and hospitalization" were ranked among the top ten problems in 1953, but the percentage of respondents listing health as the most important problem fell well below those concerned about taxation and the economy, the number one problem (CIPO/Gallup Poll of Canada, 1 August 1953; 14 November 1953). No public attention 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.[5]

Barriers to policy change: the 1972 Drug Price Program

Pharmaceutical insurance started and remained low on the Canadian health policy agenda as the slow pace of policy development provided ample time for both elites and the public to adapt their expectations to a limited health program, and entrench attitudes about

5. Although medical and hospital insurance were discussed together, the nine-year gap in adoption resulted in increased opposition from provincial governments and physicians. I argue elsewhere that medical insurance in Canada was adopted through a coincidence of the principled ideas 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).

the unfeasibility of pharmaceutical coverage. A 1955, 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" (Draft Report to the Chairman of the Preparatory Committee for the Federal-Provincial conference 1955. RG 29. LAC). 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" (Meeting 27 March 1963. RG 29. LAC). Despite the very limited discussion of pharmaceutical insurance, however, drugs were not entirely absent from the public agenda. In the early 1960s, drug safety became a major topic of public concern in the wake of the thalidomide tragedy: the drug was banned in Canada in 1962, months after it had been banned in Europe and substantially after Canadian regulators received warnings about its risks to pregnant women (Sjostrom and Nilsson 1972: 140). Additionally, in the late 1950s and throughout the 1960s, Canadian publics and governments became very concerned about the high prices of prescription drugs (*Globe & Mail* 16 December 1955, 6 October 1960, 24 January 1961; Cabinet memos, 2 February 1972 and 24 November 1972. RG 29. LAC). Curiously, this did not lead to a demand for public drug insurance: neither elites nor voters appeared to consider the possibility that government should pay for drugs, as well as control drug prices and regulate their safety.

Federal investigation of drug prices began in 1958 with a report by the body responsible for investigating monopolies, which was prompted by "informal complaints about the high cost of drugs" (Director of Investigations and Research 1961), and likely influenced by the high profile Kefauver Committee investigations occurring the US Senate, whose evidence the report cites. Between 1958 and 1969, drug prices were the subject of at least four more government inquiries, both internal and public.[6] The problem was identified as drug patents, which produced a monopoly situation and high prices, and the solution was a series of

6. Reports where authored by the Restrictive Trade Practices Commission (Report Concerning the Manufacture, Distribution and Sale of Drugs, 1963); the Interdepartmental Committee on Drugs (1964); the Royal Commission on Health Services (Hall Commission, 1964); Special Committee of the House of Commons on Drug Costs and Prices (Harley Commission 1966/1967). These reports also recommended drug quality and safety regulations, and the Canada Food and Drug Act was amended to match more stringent US regulations in 1963 (Lexchin 1984: 183).

changes to patent law and tariffs. 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 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

Despite significant changes to patent laws in 1969, concerns about high drug prices persisted (Lang 1974: 248). 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 (The Drug Price Program, 23 September 1971. RG 2. LAC). The bureaucratic authors of the proposals, mainly from the DHW, clearly saw them as a principled policy choice that would not only reduce drug prices, but also fill a gap in the provision of health care and rationalize the use of existing public services. A undated draft memo from the DHW 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 [afford the medicine]" ("DRAFT – Some Social Reasons for Pharmacare" and "Arguments for Pharmacare." RG 29. LAC). They recommended benefits be introduced on a universal basis, as the federal government must be the single purchaser of drugs in order have a bargaining advantage for prices (Memorandum to Cabinet, 2 February 1972. RG 29. LAC).

Bureaucrats' ideas about the importance of pharmaceutical insurance as a way to lower the *social* cost of pharmaceuticals contrast with the position of cabinet ministers, who seemed most concerned with containing the cost of pharmaceuticals *to the government.* This disjuncture in ideas likely contributed to the fact that cabinet did not even consider the

department's recommendation for a universal program or the implications of the program for controlling drug prices.

When the proposal was discussed in cabinet, 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" (The Drug Price Program, 23 September 1971. RG 2. LAC). 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" (Memorandum to Cabinet: "Measures to lower the unit cost of prescription drugs including a drug benefit program [*Pharmacare*]," 8 February 1972. RG 2. LAC). However, various ministers thought pharmaceutical insurance should be avoided because "the government's first priority should be to restore public confidence in its economic policies" (and pharmacare would detract from this priority) ("Measures…" 23 March 1972. RG 2. LAC),[7] 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" (Measures …" 30 March 1972. RG 2. LAC). On the recommendation of the Minister of Health, cabinet focused on a "staged program" that would provide drug coverage to the elderly and eventually expand to cover children and other groups. 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 for assisting elderly Canadians ("Measures …" 23 March 1972; 30 March 1972. RG 2. LAC).

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. Elites had developed a consensus that patents caused high drug prices. 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. 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.

7. The recession of the mid-1970s had not yet hit and the economy was still reasonably strong at this point (Perry 1989: 14, 16).

Adaptive expectations: the public

There is limited evidence regarding electoral motivations for drug coverage, perhaps because there were few opportunities for public expectations to develop. A 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 drugs and many requests that a drug insurance program similar to Medicare be made available" (Memorandum to Cabinet: "Measures …" 8 February 1972. RG 2. LAC). However, the same memo goes on to discuss strategies for implementing a 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. 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, so Canadians' first experience with public insurance for drugs was both late and restricted to a relatively small portion of the population (Grootendorst 2002). Private insurance was also limited. A 1963 study of prescription drugs in Canada reported that private drug insurance had only recently become available, and eight years later, private coverage was still limited (Commission on Pharmaceutical Services 1971; Department of National Health and Welfare (Research and Statistics Division) 1963). 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. 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 little evidence for this kind of public pressure.

After 1972, there was a lull in federal efforts towards drug prices or insurance. Compulsory licensing of patents was the key element of federal pharmaceutical management policies for twenty-five years, until it was repealed as part of the North America Free Trade Agreement 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 also failed to produce a policy change.

Australia: "a high grade service" that requires "progress step by step" (Treasury Memorandum, 1944)

Like Canada, Australia took an incremental approach to health insurance, but the sequence and outcomes of its process were very different. Australia introduced pharmaceutical benefits in 1944, and 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 public hospital and medical insurance were proposed; they were adopted between 1975 and 1984.

Centralized authority through fiscal means

Australia is a federation and, until 1946, state governments had constitutional authority over most aspects of health. Fragmented authority could have been a major barrier to a radical approach to health policy, but there is compelling evidence that this was not the case. The national Labor government during WWII did not consider federalism a significant obstacle to broader social services: they simply planned to request a constitutional amendment to provide the necessary jurisdiction.[8] Although in constitutional terms the Commonwealth government *should* have accounted for the 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 on Australia's approach to policy development is explained mainly by the weak fiscal position of Australian states vis-à-vis the Commonwealth government. In 1942, the Commonwealth 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: 170, 174). Although the states retained constitutional jurisdiction over health, they lacked fiscal resources, and were constrained by the Commonwealth government's ability to "grant financial assistance to any State on such terms and conditions as the Parliament thinks fit" (Matthews and Jay 1972: 188; Australia 2003, Sec 51 xxiiiA).

8. Unlike Canada, Australia had a constitutional amending formula at this time, and amendments were much more common.

Lack of principled ideas

The primary barrier to the radical development of a comprehensive health program was the lack of principled ideas about health policy in the Australian Labor Party (ALP). The ALP was a left party that aimed to achieve "freedom from want for all our people," (McAllister and Moore 1991: 27) but others have found the party to be significantly less ideological than its British Labour counterpart (Beilharz 1994: 58; McMullin 1991: 186). Furthermore, the ALP's overarching socialist goals were not accompanied by programmatic beliefs linking these goals to health policy in the postwar period. Roskam (2001) points out "that Australia did not have anything like the 1942 *Beveridge Report*…" and argues that "Australian governments of both persuasions were a great deal more practical," than the British Labour government (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 a radical approach to health policy in the 1940s.

The lack of principled ideas about health 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 broader plans for social security after the war (Gillespie 1991: 131). However, the Labor government wished 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 (Gilbert 1980: 316). Then-finance minister Ben 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." (Gray 1991: 69). In 1943, Prime Minister John Curtin proposed a National Welfare Scheme including a variety of health services but argued, "[i]t is impracticable in war-time to devise and introduce a comprehensive scheme for all these services" (Crowley 1973: 79) The government decided to bypass existing, internally conflicted health-planning bodies and give Treasury the responsibility for health proposals (Gillespie 1991: 157). This delegation of planning authority fits with political elites' emphasis on resource constraints and their lack of programmatic beliefs about what a health system "should" do. It was the federal Treasury, rather than the Department of Health, which made the decision to proceed incrementally and begin with pharmaceuticals. The introduction of this single service was clearly seen as the first step in an incremental process

that would eventually result in a broad scheme of social protections,[9] but it was not accompanied by a cohesive idea about the value and importance of universal and comprehensive health service or a clear strategy for achieving it.

Lack of electoral motivations

The lack of a cohesive, prominent idea about health also meant there was no rallying point for public opinion. There was little opinion polling in Australia on the importance or even popularity of health insurance, which is perhaps 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 measures of public attention and support. Polls from 1943 to 1948 include questions about the financing of social services including medical care, and they indicate that while there was occasionally a majority of voters supportive of free health services (Gallup Polls October 1943 and March 1947), there was also consistent support for contributory health insurance and voters generally prioritized tax cuts over social service expansion (Gallup Polls July 1944, December 1944-January 1945, November 1945, and September 1946; Gallup Polls May 1945, and February-March 1948).

Another indicator of the lack of electoral incentives for radical action is the surprising fact that during the study period, health policies only appealed to decided Labor voters. In 1945, Gallup questioned voters about the benefits 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 (Gallup Polls December 1945-January 1946). 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" (Gallup Poll May 1948). A breakdown by voting intention indicates that 70 percent of interviewees who planned to vote for Labor in the next election were in favor of the PBS, while only 28 percent of conservative Liberal-Country Party voters were in favor. This split is repeated in later polls on the PBS and other health

9. The government planned "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," but noted, "These measures … require progress step by step" (Memorandum, January 1944. A571. NAA).

policies (Gallup Poll February-March 1949, May-June 1949, and March-May 1969), 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. The fact that free services were actually unpopular with a significant portion of the electorate likely made it less tempting for politicians to tackle.

Barriers to policy change

In Canada, health policy development stalled after the introduction of hospital and medical insurance, despite the Liberal party remaining 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, and the challenge is to explain the new, conservative government's decision to offer pharmaceutical benefits.

Choosing pharmaceuticals as a first priority in 1943 was pragmatic. An unusually high proportion of Australian doctors were overseas during the war (Crowley 1973: 100), 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 would be part of a comprehensive health scheme eventually, but since they would "not involve any significant additional drain on professional man power" they could be introduced before the end of the war (Memorandum, January 1944. A571. National Archives of Australia (NAA)). Another undated 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" (Social Security in Australia memorandum. A571. NAA.).

The Australian government's choice of priorities was supported by compliant state governments and the federal government's expectation that pharmaceutical benefits would be less controversial with the medical profession (Gillespie 1991: 210). However, the government did not predict that the Australian branch of the British Medical Association (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 refusing to use the government prescription forms necessary to obtain free drugs. The doctors' most overt objection was to the proposed

Commonwealth Formulary, or list of subsidized drugs: they preferred either no list (so every prescription would be subsidized) or a very limited list (so government would only subsidize and therefore control a small number of expensive drugs) (Cabinet memorandum, 24 September 1947. A27000. NAA). Both options preserve doctors' autonomy: if the PBS subsidized a reasonably comprehensive but still finite list, as the Labour government proposed, doctors would be under pressure to prescribe mainly from the list, and accept government guidelines regarding amounts and frequency of prescriptions.[10] These concerns, however, overlaid a more basic fear of the introduction of "socialized" or "nationalized" medical services ("Objections to Free Medicine" *Argus*, 8 June 1945. A571. NAA). The BMA fought the PBS in private meetings with the Minister and in a broad public campaign (Minister meets BMA, 21 April 1947 and 2 July 1948. A571. NAA; BMA statement, 10 August 1944. A1928; BMA pamphlet, 1945. A571. NAA), and was able to prevent the implementation of this first priority for five years. A Liberal-Country Party coalition government was elected in 1949, and although it reached a compromise with the BMA and implemented a modified version of the PBS, it also halted further development of public health programs in favor of expanding private health insurance.

The Liberal Party under Prime Minister Robert Menzies not only lacked principled ideas *supporting* comprehensive and universal health policy: it 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 calls for contributory social security and makes no mention of health, and his speech in 1949 calls for preventative health programs rather than "the making of monetary payments to citizens through the Treasury" (McAllister and Moore 1991: 165, 171).

In 1950, the party in power was opposed to public health benefits, and BMA had expended considerable resources fighting the PBS, although they were prepared to be

10. Doctors' preference for a limited list was framed in terms of retaining autonomy over medicines compounded by pharmacists according to individual doctors' instructions, but interestingly, pharmacists do not appear to have shared this concern. The pharmacy profession cooperated in the design and implementation of the PBS, and their main concern was limiting dispensing from Friendly Societies versus independent chemist shops, as these mutual aid groups undercut their prices (Federated Pharmaceutical Service Guild of Australia to Prime Minister Chifley, 14 October 1945, A432. NAA).

mollified by a Liberal government that was more in tune with their interests. Thus, the lack of further health policy development is expected, and the puzzle is the Liberal decision to implement a modified PBS.

Implementing the PBS: Elite ideas and public expectations

The Liberal government implemented the PBS with a restricted formulary that appeased doctors and allowed for claims that, in contrast to Labor's comprehensive list of covered medicines, the new scheme was "comparatively simple and safeguards against extravagant waste of drugs" (Cabinet submission 22 June 1950. A1658. NAA). But given that the party was otherwise opposed to broad public health benefits, why implement the PBS at all? This decision demonstrates 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.

Although the initial impetus for the PBS was pragmatic rather than principled, five years of high-profile controversy 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 fed back into electoral incentives to act. However, the slow pace of policy development meant early promises and ensuing controversy were restricted to a single service, and thus 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 been the subject of two High Court cases (one only a year previous) and a successful constitutional referendum 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 was supportive of a public pharmaceutical program. In March 1950, when the Liberal's scheme for a less generous PBS was first introduced, Gallup asked whether people favored a scheme where all medicines were free (the original PBS), a scheme were only expensive medicines were free (proposed by the 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, but crucially, only 15 percent of respondents overall favored "no free medicines," suggesting a new set of expectations based on government's policy promises (Gallup Poll March-April

1950). A few months later, this dropped to only 11 percent of respondents preferring no free medicines (Gallup Poll June-July 1950), so taking some sort of action on pharmaceuticals was clearly an electoral winner across party lines.

Although the Liberals criticized the Pharmaceutical Benefits Act when it was introduced in 1944 (Crowley 1973: 101), this changed once the scheme was nominally in place, reflecting the difficulty of removing an existing benefit outright (Pierson 1994). 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" (Roskam 2001: 278). The turning point came in 1948, when the Liberals changed their platform to call for "the free provision of certain specific drugs" (White 1978) and members of Parliament gave speeches deploring the fact that citizens were paying taxes for free medicines that they were not receiving (Mr. Harrison, Hansard, 17 June 1948. A571. NAA). 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 implementation of the PBS when they took power.

Conclusion

Change is sometimes an all-or-nothing proposition, but frequently a more nuanced view is necessary. This article has argued that we must be attentive to the pace of change and its effect on adaptive expectations. A radical approach to change, where all elements of a comprehensive plan are adopted simultaneously, is not equivalent to an incremental approach, where a similar plan is designed to be adopted in steps or stages. Over time, adaptive expectations contribute to increased barriers to change and later stages in an incremental process take on the characteristics of radical (and therefore rare) reforms.

The pace of change is thus significant, and it is predictable based on the institutional, ideational and electoral conditions present during critical moments for change. Centralized institutions means fewer veto players to block radical change. This is a prerequisite for radical policy development, but it is not the sole determinant of the approach to change. It is necessary to consider how institutions work with reference to a specific policy area, and the presence or absence of ideational and electoral factors that support radical change. For example, in Australia's federal system, fragmented authority could have been a barrier to radical change. In fact, the centralization of fiscal authority meant that fragmented

constitutional authority was less meaningful. Instead, ideational and electoral conditions prevented a radical approach, even in the absence of opposition from institutional veto players.

This article provides more specific mechanisms by which barriers to change increase over time by highlighting the way adaptive expectations at the elite and the mass level reinforce one another. Radical change requires principled ideas about the broad outline of the policy area and how theory should be connected to practice. Public discussion of these ideas increases their salience with voters, and if the public is supportive, this feeds back into elite incentives to take bold policy action. However, if there is no principled idea motivating policy change initially, public demand for additional policy development may not arise. This was the case in Canada and Australia, where the initial stage of health policy development was motivated by pressure from a new left political party or a sense that the national government needed to take action to preserve its wartime powers. Public support for the first health service was quick to develop, but without specific public promises for additional services, these received little attention from voters. Over time, further steps in an incremental process become more difficult. Elites develop "blinders" regarding a policy area, as their attention is directed to the problems of existing programs rather than policy expansion. This limits opportunities for public expectations for additional services to develop, and the two factors reinforce one another to keep further policy development low on the agenda.

Change later in the policy process may be difficult, but it is not impossible, and this research also suggests an explanation for when and how barriers to change may be overcome that is logically connected to the original dynamics of policy development. Conditions for radical change at the beginning of a policy process should also apply later in the process, when changes that originally were relatively "small steps" face significantly increased barriers to adoption or reform. Evidence from Australia's late introduction of public hospital and medical insurance supports this suggestion. In Australia, the barriers to the introduction of additional health services were significant: when a public health insurance program, Medibank, was first introduced in 1972, it had been more than two decades since the adoption of the PBS, and in that time, states had developed alternative institutional arrangements for hospital care, private health insurance had flourished, and a continuous period of Liberal government, with its principled preference for

private, voluntary health insurance, had prevented any influential, government-sponsored reports that could provide competing ideas about universal public insurance. However, when the Whitlam Labor government was elected in 1972, after twenty-three years in opposition, ideological and electoral conditions allowed it to clear these barriers, at least temporarily. Although a Liberal government was elected in 1975 and slowly retracted the new system, the original policy prompted sufficient public attention and support that when a new Labor government was elected in 1983, it was able to implement public medical and hospital insurance on a permanent basis.

As in earlier periods, federal institutions were not major barriers to program adoption. The Commonwealth government's lack of exclusive constitutional authority over health meant it required the cooperation of state governments to implement public hospital insurance, but it had the advantage of superior financial resources and an ability to negotiate with more cooperative, co-partisan states first and hence provoke electoral incentives for agreement in other states, since these "Liberal states could be seen to be withholding benefits from citizens" (Gray 1991: 146).

Principled ideas about health policy and electoral motivations both contributed to the adoption of additional services, and were mutually reinforcing. When Gough Whitlam became leader of the ALP in 1967, he felt that Labor needed to become a more programmatic party, and "set out to formulate activist, reformist and thoroughly documented policies on all areas of significance," including health (Scotton and MacDonald 1993: 19). A radical expansion of public health insurance fit with current Labor ideology, since it "provided all Australians with adequate health treatment as a social right, rather than as a function of their income" (Whitlam 1985: 337, 12), and reintroduced free treatment in public hospitals according "with traditional Labor party policy" (Gray 1991: 134). Crucially, Whitlam found a specific idea about the shape this expansion should take in the work of two Melbourne University economists. This idea provided the link between theory and practice that allowed the expansion of health insurance to reach the Labor's immediate policy agenda. Whitlam writes that,

> Although well aware of the inadequacies of the existing health insurance system, I was yet to develop a viable policy alternative.... The solution came in 1967 when [I met] 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).

Health reform was an attractive policy program because it clearly distinguished Labor from existing Liberal policies, fit with party ideology, and involved a clear distribution of benefits to voters. After Scotton and Deeble's ideas for compulsory health insurance helped focus Whitlam's priorities on this topic, health reform assumed increasing salience in the late 1960s and early 1970s. A March 1969 poll found that most voters preferred to keep the existing voluntary insurance system (Gallup Poll, March-May 1969) but by August of that year, Gallup reported that 58 percent of all voters favored a revised proposal for a free medical service with a 1.25 percent levy on taxable income (Gallup Poll, August-September 1969). In a 1972 opinion poll, " '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).

There is further evidence for the electoral motivations involved in universal public health insurance after it was implemented in 1975. A Liberal government was elected in December 1975, following a constitutional crisis where the Liberal Senate refused to pass supply bills and the Governor-General dismissed the Whitlam government. However, the new Fraser government promised to maintain Medibank (Gray 1991: 147), despite the fact that its "members were strongly opposed ideologically to Medibank, and its broad election policy involved a commitment to massive reduction of government expenditure" (Scotton and MacDonald 1993: 235). It appears that the same electoral dynamic that drove the Menzies Liberal government to implement the PBS in 1950 resulted in the Fraser government's promise to maintain Medibank, and its decision to only undertake incremental retrenchment. According to Scotton and MacDonald, "Fraser's position [on Medibank] was a logical response to evidence of the growing popularity of Medibank shown in public opinion polls," (Scotton and MacDonald 1993: 236). Although the compulsory element was removed in 1976 and public benefits were gradually reduced, the popularity of the original scheme is evidenced by how easily it was reinstated when a Labor government took power again in 1983.

Future research is necessary to flesh out this suggestion – what types of reforms are made possible by the coincidence of centralized authority, principled ideas and electoral incentives? What adjustments are possible in their absence? What constraints does an initially radical approach to policy development put on subsequent reforms? This framework

is a starting point for understanding of policy development 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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- June 1952
- 1 August 1953
- 14 November 1953

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- October 1943
- July 1944
- December 1944-January 1945
- May 1945
- November 1945
- December 1945-January 1946
- September 1946
- March 1947
- February-March 1948
- May 1948
- February-March 1949
- May-June 1949
- March-April 1950
- June-July 1950
- March-May 1969
- August-September 1969

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