Why Can't We Do What They Do? National Health Reform Abroad

Timothy Stoltzfus Jost
Washington and Lee University School of Law, jostt@wlu.edu

Follow this and additional works at: https://scholarlycommons.law.wlu.edu/wlufac
Part of the Comparative and Foreign Law Commons, and the Health Law and Policy Commons

Recommended Citation

This Article is brought to you for free and open access by the Faculty Scholarship at Washington & Lee University School of Law Scholarly Commons. It has been accepted for inclusion in Scholarly Articles by an authorized administrator of Washington & Lee University School of Law Scholarly Commons. For more information, please contact christensena@wlu.edu.
Why Can’t We Do What They Do?
National Health Reform Abroad

Timothy Stoltzfus Jost

Even Americans who have only a vague knowledge of health policy know that the U.S. is different. We do not have “socialized medicine,” like our European or Canadian neighbors. We believe that health care is not rationed here, and that, unlike citizens of other nations, we do not have to wait in long queues when we need medical care. We believe that U.S. health care is the best in the world.

At the same time, the U.S. spends more on health care—both per capita and as percentage of gross domestic product (GDP)—than other nations do. One in six non-elderly Americans has no health insurance, and voluminous studies show that lack of health insurance has a dramatic effect on both access to care and on health status. Furthermore, on many of the most important indicators of population health, such as infant mortality and life expectancy, the U.S. scores worse than do other nations.

How do we reconcile our beliefs with these facts? Why do other nations have universal health coverage while we do not? What, in fact, do other nations do when it comes to health care? And how do they do it? Why can’t—or don’t or won’t—we do what they do?

This article addresses these questions. It begins with an overview of the public health insurance systems found in countries with economic and political systems similar to our own, exploring the structural and operational underpinnings of these systems and comparing their cost and performance to that found in the U.S. It then considers the legal, political and social factors that account for the profound differences between our system and the systems of other nations.

What Do Other Nations Do, and How Do They Do It?

All other developed nations of the world, including developed countries in Western Europe, Asia, North and South America, and on the Pacific Rim, provide health care for all or most of their residents. Although private health insurance products are available for purchase on a voluntary basis in virtually every country, no other developed country relies on private insurance as does the United States to provide primary coverage for its population. All developed nations have recognized that voluntary private insurance cannot cover everyone, (as it does not in the U.S.) and have developed some form of public health insurance.

Two Basic Models of Health Insurance

Two primary models can be found in the world: social insurance and national health insurance. Each term refers to a specific approach to the task of financing and organizing a nation’s system for providing personal health care. The first, and older, model is social insurance, often called the Bismarck model after the German leader who established the first social health insurance system. The second, more recent, is the national health insurance model, often called the Beveridge model after Lord Beveridge who proposed this approach for the U.K. during World War II.

Chancellor Bismarck established the German social insurance system in 1883 in an attempt to turn back the tide of socialism that he feared would engulf Germany. Under the German system as it has developed, most citizens have an obligation to secure health insurance coverage, which in turn is paid for, usually by a deduction from earnings, on the basis of the insured’s income rather than the insured’s risk status or family size in order to ensure affordability. In Germany the conceptual foundation of health insurance lies in a belief that members of a society have obligations to each other, a concept referred to

Timothy Stoltzfus Jost, J.D., is the Robert L. Willett Family Professor of Law at Washington and Lee University. He has published many books and articles about health care law and comparative health law and policy.
Why do other nations have universal health coverage while we do not? What, in fact, do other nations do when it comes to health care? And how do they do it? Why can't – or don't or won't we do what they do?
developing a full and comprehensive national system of health care finance that would be essential to make such a network of services accessible to all persons. Our own Medicaid program, as well as what we call our veterans', military, and Indian health services, resemble the 'national health insurance' model, in that all use general revenue funds to pay for health services, but they are different in that their coverage is limited to certain narrowly delineated populations, which may even, as with Medicaid, vary from state to state.

In virtually all countries, voluntary private health insurance of the sort sold in the U.S. to both groups and individuals continues to exist, although it serves different functions in different countries. In some, such as Germany and the Netherlands, it covers wealthy people who are not covered by social insurance. In others, such as Canada, it covers services such as pharmaceuticals, which are not universally covered by public insurance. In yet others, such as France, it covers cost-sharing obligations, much like our own Medigap policies. In still others, such as the U.K. or Australia, it allows privately insured persons to jump the queue and get services faster or more conveniently than publicly insured patients.

Coverage and Benefits
Countries that have national health insurance programs cover all of their citizens and long-term residents, although in most countries individuals can choose to carry private insurance and obtain services privately. Some countries with social insurance funds, such as France or Austria, cover their entire populations as well. Others, however, such as Germany and the Netherlands, only require people whose income falls below a certain level to be part of the social insurance program. Although people with higher incomes can choose to be uninsured, few make this choice. In Australia, government subsidies are available that cover 30 percent of the cost of private insurance for hospital care, while tax penalties are imposed on higher income people who choose not to purchase private insurance. This results in about 43 percent of the population being privately insured for hospital care. In several of the southern European nations, many people choose to purchase care privately, even though everyone is covered by national health insurance, because they believe that they will get better care or more attention from their providers.

A number of countries apply means tests for determining coverage for certain services or for determining the applicability or level of cost-sharing. The Irish health care system is partially means tested: only low income holders of medical cards (about a third of the population) have free access to general practitioner services, and higher income people without medical cards must pay a co-payment for hospital and pharmacy services under some circumstances. In the U.K., long-term nursing home care is primarily regarded as a social service, nursing homes are publicly funded only for those who do not have the means to pay privately. Pharmaceutical coverage in the U.K. is also means tested to the extent that the system waives required co-payments for low-income persons, although the government also waives co-payments for children, the elderly, and persons with certain chronic conditions. No developed nation other than the U.S., however, makes access to public health insurance depend totally on economic "medical dependency" (Medicaid), or on age and disability status (Medicare). And no other developed country has nearly as high a proportion of its population uninsured.

Social insurance and national health insurance programs vary somewhat in the benefits they offer. The Canadian health insurance program, for example, only requires the provinces to cover hospital, physician, and surgical dental services, though most provinces also cover pharmaceutical costs for at least some of their residents. Coverage in Australia is limited to hospital, physician, and pharmaceutical care. Most countries do not cover nursing home care or cover it as a social service rather than a health care service. In some countries some benefits that are nominally covered are in fact not generally available because of high cost-sharing obligations, limited coverage, or lack of provider participation.

Delivering Health Care In Other Nations
Though public finance of health care services is quite common in other countries, public provision of health care services is less universal. In most national health insurance countries, many health care services are furnished by private entities and health professionals in private practice. In few countries, for example, does the government directly employ primary care physicians or dentists. Pharmaceuticals and medical devices are generally produced by private manufacturers and sold through private pharmacies or medical equipment suppliers. In most national health insurance countries public hospitals are dominant, but in some private nonprofit or private hospitals also exist. Private hospitals are even more common in social insurance countries.

What Do We Get for Our Money Here, and Why Are Our Costs So Much Higher?
No other country spends as much on health care as does the U.S. As shown on the accompanying table, social insurance countries generally spend more on health care than do countries with national health insurance. The table, derived from a recent study of international health care pricing, illustrates the differences among nations in health care spending as a percentage of GDP and in absolute dollar expenditures. To be sure, some of these differences may be attributable to the fact that nations classify health spending differently; for example, many government-borne costs of long term care, which are classified as health expenditures in this nation, may be treated as social welfare spending in other nations. But even when these differences of classification are taken into account, the U.S. spends more.

What does the U.S. get in return for its higher expenditures? Certainly not better health status. Life expectancy for males at birth is

<table>
<thead>
<tr>
<th>Personal Health Care Spending: U.S. and Selected Countries, 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>U.S.</td>
</tr>
<tr>
<td>U.K.</td>
</tr>
<tr>
<td>Germany</td>
</tr>
<tr>
<td>Sweden</td>
</tr>
<tr>
<td>Spain</td>
</tr>
<tr>
<td>Netherlands</td>
</tr>
<tr>
<td>France</td>
</tr>
<tr>
<td>Italy</td>
</tr>
</tbody>
</table>


75.7 in the U.K., 77.6 in Sweden, 75.6 in Germany, 75.8 in the Netherlands, but only 74.8 in the U.S. Infant mortality rates stand at 5.5 deaths per one thousand live births in the U.K., and 3.7 and 4.3 respectively in Sweden and Germany; the comparable figure for the U.S. is 6.5.

Health status, of course, depends on diet, housing conditions and societal inequality, and not just on health care. But it would also appear that far higher spending on health care in the U.S. fails to assure residents better or more accessible health care. Indeed, by some measures we get less actual health care than do residents of other countries, although by other measures, we receive the same or slightly more. During the year 2000, for example, the U.K. had 151 hospital admissions per 1000 population, Germany had 205, and the U.S. had only 118. The U.K. had .9 acute care hospital days per capita, Ger-
Symposium

The average physician salary in the U.S. is nearly twice that of Germany, and nearly four times that of the U.K. We also, of course, spend far more on the administration of our health care system. Our highly fragmented health insurance system requires health care institutions and professionals to hire numerous personnel for billing who are unnecessary in unitary systems. Private insurance also costs far more than public insurance. Public systems do not spend the money spent by private insurance companies on marketing, underwriting, and profit. The U.S. pays a very high price for maintaining a market-based health care system, and much of the money we spend does not produce health care goods or services.

Another major difference can be seen in U.S. spending on health care technology. For example, in 2000, the U.S. maintained 8.1 MRI units per million inhabitants, compared to 3.9 in the U.K. and 6.2 in Germany. We had 13.6 CT scanners per million compared to 6.5 per million in the U.K. and 8.2 per million in Canada; on the other hand, Germany had 17.1 per million. Technology that would only be available in regional medical centers in some countries is available not only in community hospitals but in clinics and even physicians' offices in the U.S. While this means that these technologies are immediately available to Americans, it also means that they are used more often in the U.S. In 1999 U.S. physicians performed 388.1 coronary angioplasties per 100,000 population compared to 51 in the U.K. and 165.7 in Germany. Kidney dialysis rates were 86.5 per 100,000 compared to 27 in the U.K. and 64 in Germany.

For all of our technology, however, there is little evidence that the quality of care is better in the U.S. than in other countries. A recent study comparing the performance of the U.S. health care system with those of four other countries using nineteen process and outcome indicators (such as cancer or transplant survival rates or vaccination rates), found that the U.S. scored best on three indicators, worst on two, and somewhere in the middle on the others.

There is also little evidence that the quality of care is better in the U.S. than in other countries. A recent five-country survey of "sicker adults," for example, found that 44 percent of U.S. respondents were dissatisfied with their care, compared to 31 percent of U.K. respondents, and 36 percent of Canadians; while 23 percent of U.S. respondents believed that a mistake had been made in their medical care in the past 2 years, compared to 20 percent of Canadian and 13 percent of U.K. respondents. Fifty-eight percent of U.S. respondents rated their doctors as excellent or very good on diagnosing their medical problem, compared to 52 percent of Canadian respondents and 57 percent of U.K. respondents; while 40 percent of U.S. respondents reported difficulty in seeing a specialist when needed, compared to 33 percent of Canadian respondents and 38 percent of U.K. respondents. In a 2001 survey of citizens' views of access to and quality of care, 57 percent of U.S., 53 percent of U.K. and 54 percent of Canadian respondents rated overall medical care as excellent or very good, while of respondents who had either themselves been hospitalized or had a family member hospitalized in the past 2 years, 50 percent of U.S., 54 percent of Canadian, and 48 percent of U.K. respondents rated care as excellent or very good.

Perhaps the single most important factor underlying lower overall and per capita health care spending in countries with national health services is that most funds for health care flow through a single, central budget. The health budgets of nations with tax-financed national health services are visible and public and must compete with other funding priorities, such as education or defense. Furthermore, it is hard to grow a publicly accountable health budget, because

If the social insurance model was adopted by conservative governments to suppress the growth of socialism in the late 19th and early 20th century, the national health insurance model emerged from the triumph of socialism in Europe after World War II.
No other country spends as much on health care as does the United States of America.

Why Don't We Do It The Way Other Countries Do?

If other countries can have universal or near universal coverage of their populations and spend less on health care than we do, without obvious sacrifices in quality, why can't we do the same? Why does it seem to be our fate to have the most expensive health care system in the world and still have over 43 million uninsured persons?

Volumes have been written on the topic of American exceptionalism in health policy, and only the briefest survey of this literature is possible here. Explanations tend to focus on five factors, each of which seems to play a role, though commentators disagree on their relative importance: U.S. political institutions; the U.S. social culture and character; a weak left and the limited strength of unions in the U.S.; the political power of provider and insurer interest groups; and the strength of path dependency.

U.S. Political Institutions

First, the unusual character of American political institutions makes radical innovation very difficult. A U.S. President is the leader of his party, but not necessarily of the government in the same sense as a British prime minister is head of the government. It is possible in the U.S. for Presidents to confront Congresses of different parties, with the result that efforts at reform get hopelessly mired in partisan politics. Even when one party controls the presidency and both Houses, as was the case during 1993 and 1994 when President Clinton's national health reform plan collapsed in spectacular failure, the minority may be large enough, and their ability to use the arcane rules of debate strong enough, to defeat even a popular measure. The factiousness of the majority can, of course, achieve the same result.

Most European nations have parliamentary governments, in which the executive and legislative branches are controlled by the same political party or governing coalition. Party discipline is stronger than in the U.S., and when it really matters, party leadership can force back-benchers to tow the line. Of course, few countries have two party governments, as we do in the U.S., and coalition governments bring their own problems and complications, but in most European countries it is possible for ruling parties to enact and implement health reform legislation. Thus, for example, Germany adopted major health care reforms in 1988, 1992, 1997, and 1999, while Britain made significant changes in its health care system during the Thatcher administration and again when Labor returned to power.

By contrast, the governing institutions of the U.S. were in fact designed to block radical change. The current situation in which both houses of Congress and the Presidency are controlled by the same political party is a marked deviation from the norm of divided government that has prevailed in the United States over the past half century. Members of Congress are not, in general, dependent on the President for their jobs, and are relatively free to pursue their own course on health policy. Senators often have their own power bases and shape their policy to reflect the ideology and the special interests of their own states. Most House members currently run unopposed or with token opposition, and are relatively free to pursue their own course on health policy. Senators often have their own power bases and shape their policy to reflect the ideology and the special interests of their own states. Most House members currently run unopposed or with token opposition, and are relatively free to pursue their own course on health policy.
The French spend more on food than we do, the British more on housing. Despite being reasonably affluent, well insured, and able to get the ear of politicians, rationing.

Though a number of countries that have universal health care systems are also federal states, social welfare programs tend to be weaker in such countries. Throughout the nineteenth century and into the 1930s, it was generally believed in the United States that responsibility for social welfare resided in the states, and that the U.S. federal government lacked the constitutional authority to enact universal health insurance. When the federal government enacted public assistance programs in the 1930s, it acted through the states. The Medicaid program was built on this model in the 1960s, and there still seems to be strong support for the notion that providing health coverage through Medicaid-like state programs.

The U.S. Social Culture and Character
Second, there is the cultural aversion of Americans to the use of government to solve problems, and in particular, to the creation of social welfare programs. We like to believe that private know-how and entrepreneurialism can solve all problems, even ones such as health care coverage lapses and excessively high spending levels, which so obviously and consistently defeat the power of even the most creative entrepreneur.

Indeed, it is far from obvious that the American people want their government to adopt universal coverage, or at least that they want it enough to push their lawmakers into doing something about it. European health care systems reflect a deeply rooted belief in the importance of social solidarity, a value that is widely shared across the citizenry. Even though the welfare state lacks the support in Europe that it enjoyed a generation ago, and most European countries have experimented with harnessing market forces in health care delivery and financing, there is still strong support for universal health care and little support for turning health care coverage over to the caprice of markets.

Americans are far more ambivalent about universal coverage. Though a strong majority of Americans believe that legislation should be passed to help the uninsured, consensus evaporates when specific approaches to accomplishing this goal are discussed. There is considerably more support for solutions like expanding state Medicaid programs or increasing employer coverage than for creating a new national health insurance program. The recently adopted Medicare drug benefit plans and pharmaceutical companies, is a classic example of the pork barrel character of American health care politics.

A Weak Left and Limited Government
A third factor is the lack of a strong left wing in American politics, (and the presence of a strong right wing) and also the weakened nature of the American labor movement. The lack of a powerful left wing labor movement in the U.S. has been a particularly important factor in explaining the American rejection of the welfare state. Organized labor has never been as strong here as in Europe and has seen a more precipitous decline in its membership in recent decades. But perhaps even more important, labor has not been the political force in the U.S. that it has been in Europe. We have no labor party or labor-based socialist parties. Though labor unions are traditionally associated with the Democratic Party, they have not historically dominated that party. Most importantly, organized labor has focused traditionally more on private benefits for its members to be gained through collective bargaining than on public welfare benefits to be obtained through political action. Indeed, Samuel Gompers and his AFL played a major role in defeating national health insurance when it was first mooted in the second decade of the twentieth century because he preferred to retain union control over benefit programs.

The weakness of the left in the United States is matched, moreover, with a powerful right wing. Right wing pressure groups like the Christian Coalition played a major role in defeating the Clinton plan. Public relations-savvy conservative think tanks like the Heritage Foundation have managed very successfully to keep the media focused on their market-oriented proposals for health care system organization, and distracted from exploring reform ideas that might actually work here because they have worked elsewhere.

The Power of Special Interest Groups in Opposing Reform
Perhaps an even more important political factor in explaining our peculiar American situation has been the role of special interests that oppose universal health coverage in American politics. As Robert Evans has often pointed out, in health care as elsewhere in the economy, one person's cost is another person's income or profit. We spend currently $1.6 trillion on health care, and millions of individuals have a massive investment in the continuation of the current system. On the other hand, American political campaigns are particularly expensive by international comparison. Special interest groups contribute freely to American politicians, and expect that their interests will be attended to. The recently adopted Medicare bill, loaded with special interest provisions, especially its prohibition against government "interference" with price negotiations between drug benefit plans and pharmaceutical companies, is a classic example of the pork barrel character of American health care politics.

Doctors throughout the world have tended to oppose government involvement in the health care system, at least initially. Not surprisingly, the American Medical Association played a peculiarly important role in opposing the adoption of universal health insurance, particularly in the middle of the twentieth century when it was at the peak of its political power. But provider interests have not been
National Health Reform and America's Uninsured • Fall 2004

alone in this. Business and employer groups have also proved very effective in opposing health care reform. Though the present employment-based system is burdensome to them, it at least gives them control over benefit costs and structures, and gives them a means of attracting workers. They also fear the higher taxes that would accompany a government-run system. Business coalitions played a leading role, for example, in defeating the Clinton plan.

Perhaps the most important impediment to universal coverage at the present time, however, is the commercial insurance and managed care lobby. Though private health insurance existed in both Germany in the 1860s and Britain in the 1940s, it was in both instances generally offered by nonprofit fraternal and mutual organizations that did not pose a significant political obstacle to the enactment of a universal system. Countries that use a social insurance approach to coverage, moreover, in general initially co-opted existing private health insurers by permitting them to operate the system. By contrast, health insurance and managed care are important and influential forces in the U.S., as they demonstrated through the "Harry and Louise" commercials. This series of commercials in the early 1990s when the Clinton Health Plan was under debate, which showed a clearly affluent couple expressing their concerns over the dinner table about what the plan would do to them, helped kill it. Similarly, insurers' power in Congress guaranteed that the Medicare prescription drug legislation would include, by the Administration's account, $46 billion dollars in subsidies over the next ten years to entice managed care companies to participate in the Medicare program.

Path Dependency: The Stickiness of What Is

Though each of these accounts of American exceptionalism has explanatory power, in the end, one of the most plausible explanations is the theory of path dependency. This theory has been popularized in the health policy area by Carolyn Tshoo in her book, Accidental Logics, which recognizes that, in a sense, every country is exceptional. The notion of path dependency emphasizes the power of inertia within political institutions. Once nations get into the habit of doing things in a particular way, they tend to keep on doing them that way.

This is not a theory of historical determinism, however. From time to time "critical moments or junctures" appear when a policy a conference of factors in the broader political arena makes major institutional changes in health care systems possible. Thus the German social insurance system was created by a powerful German chancellor faced by a strong socialist challenge in the tumultuous time following German unification in the late 19th century. The British National Health Service was established as the Labor Party, which, receiving a decisive political mandate following the end of World War II, turned its hand to rebuilding a devastated health care system. The Spanish and Portuguese national health services came into being as those countries emerged from long-standing fascist dictatorships. The Dutch social insurance system was imposed by the German occupation during World War II. The greatest change in the American health care system, the creation of Medicare and Medicaid in 1965, resulted from the landslide victory of Lyndon Johnson, which brought into power for the first time in history a working majority of liberal and moderate northern and Midwestern Democrats. There are few examples of situations where national health services simply evolved, though the Scandinavian national health services may represent this possibility.

At this point in time, it appears particularly unlikely that in the U.S. a window of opportunity will open any time soon for health care reform. The conservative Republicans who currently dominate all three branches of the federal government are aggressively hostile to social welfare programs. The tax cuts enacted since 2000, combined with high military spending and subsidies for favored businesses, have resulted, apparently intentionally, in massive budget deficits that make any major new social initiative almost unthinkable. But countries do change. One impressive fact when one reviews the history of universal health coverage throughout the world is how recently many countries have adopted it. Switzerland only established a system of universal coverage in 1996 and Israel in 1995, while the Australian system dates only from 1984. The Spanish and Portuguese national health systems were created in 1986 and 1989 respectively.

One can, just barely, imagine a scenario in which a universal health care system might become politically viable in the U.S. In, for example, our employer-based health insurance system continues to implode, driven on by the risk-segmentation that will result if employers abandon relatively well subsidized defined-benefit health plans (plans that provide employee with a defined set of benefits and relatively well articulated coverage standards) in exchange for poorly subsidized defined-contribution health plans (which offer employees only a limited sum of money to procure coverage), the number of uninsured— and seriously underinsured—Americans will continue to grow. At some point, a critical mass of the uninsured will consist of politically active, middle class Americans, who will demand a response from the government. At some point, moreover, doctors, and perhaps even drug companies will feel the pinch as more and more Americans are priced out of the market for their goods and services. Hospitals, moreover, will face an increasing uncompensated care burden. At the same time, the political pendulum may swing back toward the left, and a majority of Americans may become more comfortable with a larger role for government in the American health care system. Perhaps the opposition of business to national health insurance will soften as employees become ever more dissatisfied with ever more limited health coverage. Perhaps insurers may ultimately conclude that they are better off trying to find a role in a national health insurance system, perhaps as claims processors and fiscal intermediaries, than to chance a fight to the death. Perhaps the day will come when we do health care finance pretty much like other countries do it. We will never do it just like they do it, however, in part because "they" do not do it in any one particular way. The British health care system is different from the German system—which in turn are different from the Canadian or Irish systems. But that is the beauty of it. In the wealth of experience that the world has had with providing universal health insurance, there is a world of ideas for us to draw on—in terms of broad models for carrying out universal coverage, in terms of technical approaches to addressing technical problems, and in even in terms of political strategies for bringing universal coverage into existence. The ideas, the models, even the technology is there. We only have to decide that we want it.

References

1. Institute of Medicine, Care Without Coverage: Too Little, Too Late (Washington, D.C.: National Academy Press, 2003).
4. Id., at 335.
5. Id., at 204.
7. Tariffcheck 24, "Soll ich in der gesetzlichen Krankenversicherung bleiben oder mich privat versichern?" <http://www.tariffcheck24.de/Tariffcheck24-
51. Id.
52. Id.
53. Id., at 101.
55. Moreover, even those of us who are fully insured must sometimes wait for services. I was told recently that I would have to wait six to seven months to see a gynecologist with my plan.
57. Waiting lists also seem to be less of a problem in social insurance countries. See L. Siciliani and J. Hurst, Explaining Waiting Time Variations for Elective Surgery across OECD Countries (Paris: OECD, 2003).
60. Anderson, supra note 46, at 98.
64. Id.
65. Id.
66. Id.
70. Jost, supra note 3, at 216-217.
73. Jost, supra note 3, at 34-45.
74. See note 3, at 208-214.
76. See note 3, at 208-214.
77. Jost, supra note 3, at 34-45.
78. See note 3, at 208-214.
79. See note 3, at 224-25.
83. Jost, supra note 3, at 34-45.
84. See note 3, at 34-45.
85. Steinmo and Watts, supra note 84, at 360, 362.
86. See note 3, at 34-45.
87. See note 3, at 34-45.

89. Jost, supra note 3, at 79–76.
90. Id., at 76.
93. Jost, supra note 3, at 177.
96. Id., at 608–611.
97. Blendon, Benson, and Desroches, supra note 91.
98. Id. It should be noted, however, that the public tends to be more supportive of collective responsibility for health care and less interested in market approaches than current policy elites. See M. Schlesinger, "On Values and Democratic Policy Making: The Deceptively Fragile Consensus around Market-Oriented Medical Care," Journal of Health Politics, Policy and Law 27 (2002): 889–925.
100. Id. at 79–80.
102. Jost, supra note 3, at 190; Blake and Adolino, supra note 78, at 281–284.
104. Id., at 279–280.
105. Id., at 281–284.
106. Ritter, supra note 6, at 5–7, 123.
108. Id. at 199.
111. Id., at 297.
113. N. Laham, supra note 99, at 206.
114. See Steinmo and Watts, supra note 84, at 364.
115. See e.g. Tuohy, supra note 84, at 40 (U.K.); Tuohy, supra note 84, at 53 (Canada).
120. Id., at 72, 205–06.
121. This also happened in the United States when the Medicare program was created in 1965, and private insurers were brought in as carriers and intermediaries to operate the program. Health insurance coverage of the elderly was thin enough at that time, however, to make this strategy possible.
122. Skocpol, supra note 99, at 183–89; Tuohy, supra note 84, at 163.
124. Indeed, an attempt to use Boolean Analysis to test the power of these hypotheses found that all of them seemed to contribute to the explanation, though it found the veto points hypothesis most powerful. It also found, however, that the United States is the only country where all of the obstacles to change discussed above coexist, and also the country in which all but one of these factors was most unfavorable to reform. Blake and Adolino, supra note 78, at 699–707.
125. Tuohy, supra note 84, at 5, 123–124.
126. Id., at 6–7, 123.
127. Id., at 6, 123.
128. Tuohy, supra note 84, at 38–41.
132. Id., at 199.
133. Id., at 123–124.