HOW THE PACE OF CHANGE AFFECTS THE OUTCOMES YOU GET:

THE CASE OF PHARMACEUTICAL INSURANCE IN CANADA, THE UK AND AUSTRALIA

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THE PUZZLE

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- Puzzling in light of
  - Similar welfare states and own public hospital and medical insurance
  - Early Canadian plans for health policy
  - Federal "Green Book" proposals in 1945 include pharmaceuticals as a "later stage"

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- Why? Accepted wisdom based on timing of technological change
  - In 1960s (when Medicare was implemented and post-therapeutic revolution), drugs were too expensive
  - Evidence from Canada: cost concerns present earlier; drug programs also considered later

GENERAL RESEARCH PROBLEM

- Changes to health programs proposed more often than adopted
- Why are they implemented in some cases and not in others?
- Why do certain types of change become more difficult over time?

GENERAL RESEARCH PROBLEM

- How does the approach to policy development affect outcomes?

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- How does the approach to policy development affect outcomes?
- Distinguish between radical and incremental approaches
  - Radical: centralized institutions, principled ideas, electoral incentives
  - Incremental: these conditions absent, change still possible…
  - but outcomes are different

GENERAL RESEARCH PROBLEM

- How does the approach to policy development affect outcomes?
- Distinguish between radical and incremental approaches
- Over time, barriers increase: adopting an additional service is more difficult later in process
- New mechanism based on reciprocal relationship between elite ideas and public expectations

OVERVIEW

- Empirical puzzle
- Cases and outcomes
- Analytical problems
  - Why does the pace of change vary?
  - How does the pace of change affect outcomes?
- Main findings
- Contributions and future research

CASES AND OUTCOMES

- Liberal welfare states: Canada, the UK and Australia
- Similar "welfare moment" at the end of WWII
- Pace of policy development different
- Outcomes (comprehensiveness of health system) different

CASES AND OUTCOMES

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- UK: quick, radical change; all health services simultaneously; comprehensive program
- Canada and Australia: slower, incremental change; one service at a time; no comprehensive program
  - Australia: Pharmaceutical Benefits Scheme 1950, no hospital or medical insurance until 1975-1984
  - Canada: Hospital and medical insurance 1957-1966. no pharmaceutical insurance

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1. PACE OF CHANGE: THEORY

- Radical approach when there is:
  - Centralized institutional authority
  - Principled elite ideas
  - Electoral incentives
- These conditions present in the UK but not Canada or Australia

1. PACE OF CHANGE: FINDINGS

UK:

- *Institutions*: Unitary system, centralized parliamentary government
- *Ideas*: New Labour majority government and Beveridge Report; consensus re: comprehensive service
- *Electoral motivation*: Policy popular and salient; 88% of voters in favour

1. PACE OF CHANGE: FINDINGS

Canada

- *Institutions*: Fragmentation key; focus on provincial flexibility
  - 1955: PM St. Laurent wished to avoids "federal interference in matters which are essentially of provincial concern."
- *Ideas*: PMs Mackenzie King and St. Laurent deeply skeptical about public health insurance

1. PACE OF CHANGE: FINDINGS

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Australia

- *Ideas*: 1943, PM John Curtin notes “it is impracticable in war-time to devise and introduce a comprehensive scheme for all these [health] services”
- *Electoral motivation*: Neither Canadian nor Australian politicians prodded by public opinion on health
    - Health policies generally popular but low salience

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- UK adopted all services, including prescription services, with the NHS in 1946
- Canada and Australia took incremental approaches
  - Similar language re: proceeding in "stages" or "steps"
  - Process quickly stalled
  - Predictable: approach to policy development influences the creation of barriers to policy change

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- Why do incremental processes stall; how do barriers to policy change arise?
- Path dependence literature: policies tend to be self-reinforcing
  - Alternative institutional arrangements in the absence of government programs
  - Private actors make investments and create networks that are difficult to displace

2. BARRIERS TO CHANGE: THEORY

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- Public does not develop expectations re: additional services
- Politicians' ideas become more restricted

- Lack of elite ideas and public expectations reinforce one another over time to restrict the policy agenda

2. BARRIERS TO CHANGE: FINDINGS

Canada

- Pharmaceuticals low priority by 1950: "all experience to date indicates that it is almost impossible to control the cost in such services"
- Idea was persistent and stifled further discussion

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Canada

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2. BARRIERS TO CHANGE: FINDINGS

Canada

- 1972: DHW proposes national pharmacare but politicians' ideas are limited by previous consensus on drugs
- Lack of electoral pressure: Canadians have no experience with drug insurance and no public discussion of issue
- Barriers to the late adoption of an additional service too high

2. BARRIERS TO CHANGE: FINDINGS

Australia

- First priority service was pharmaceuticals: an option that "will not involve any significant additional drain on professional man power"
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- 1949: new government elected, opposes broad public health insurance

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- Legislation passed by Labour government in 1944 but BMA refused to cooperate

- Liberal government chose to implement in 1949 despite general opposition to government insurance or benefits

2. BARRIERS TO CHANGE: FINDINGS

Australia

- Early 1946: Constitutional challenge, PBS legislation struck down
- Late 1946: Constitutional referendum and amendment to give federal government power over pharmaceutical benefits
- 1947: New legislation, still not implemented
- 1949: Second constitutional challenge

2. BARRIERS TO CHANGE: FINDINGS

Australia

- High profile conflict affected voters' expectations for free medicines
- Change in expectations fed back into electoral motivations
- Even before policy implementation, reciprocal relationship between ideas and expectations allowed for unexpected outcome

SUMMARY OF FINDINGS

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- Institutional, ideational and electoral factors produced incremental approach to health policy
- Pharmaceuticals' low place on the policy agenda was self-reinforcing because of restriction of elite ideas and therefore public expectations over time
- Similar dynamic helps explain why Australia only had pharmaceutical benefits for so long

SUMMARY OF FINDINGS

- Relationship between elite ideas and public expectations also suggests how barriers are (sometimes) overcome
- Small changes take on characteristics of radical reforms as barriers to change increase
- Require centralized institutional authority, principled ideas and electoral motivation to reach agenda and overcome barriers

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CONTRIBUTIONS

- **Approach to policy development matters**
- Even if they start with similar goals, incremental versus radical approach will produce different outcomes
- Dynamics of different approaches help conceptualize the barriers to policy change we expect to see

CONTRIBUTIONS

- **Reciprocal relationship between elite ideas and public expectations help explain policy stability and change**
- Elites tend to develop "blind spots" about a policy over time
- This also affects the way the public thinks about the policy area

FUTURE RESEARCH

- What does this mean for current health policy?

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- Implications for the adoption of additional services
- Predict will require three conditions for radical change
- Preliminary evidence to support: Australian hospital and medical insurance 1975-1984

FUTURE RESEARCH

- How does the initial pace of change influence opportunities to reform existing services?

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- Motivated by convergence and divergence of pharmaceutical programs in Canada, the UK and Australia
  - Canada is still an outlier, but coverage has expanded through provincial programs
  - UK and Australia applied different types of solutions to similar cost pressures

FUTURE RESEARCH

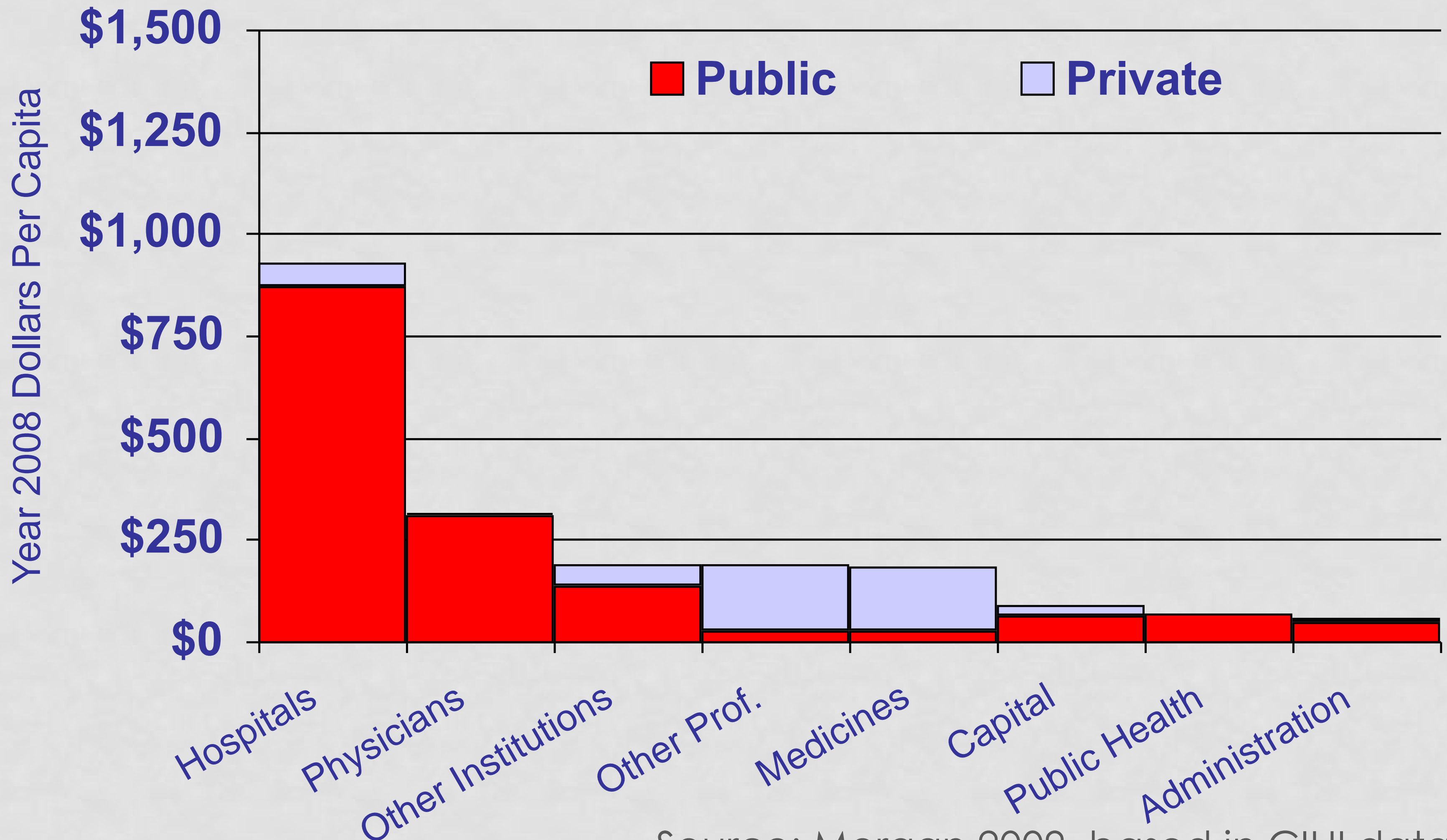
- How does the initial pace of change influence opportunities to reform services?
- Expect conditions that produce a radical pace of change initially would also make services more difficult to retrench
- Preliminary evidence to support: attempts to introduce patient charges for prescriptions in the UK and Australia

THANK YOU!

CASES: FEDERALISM

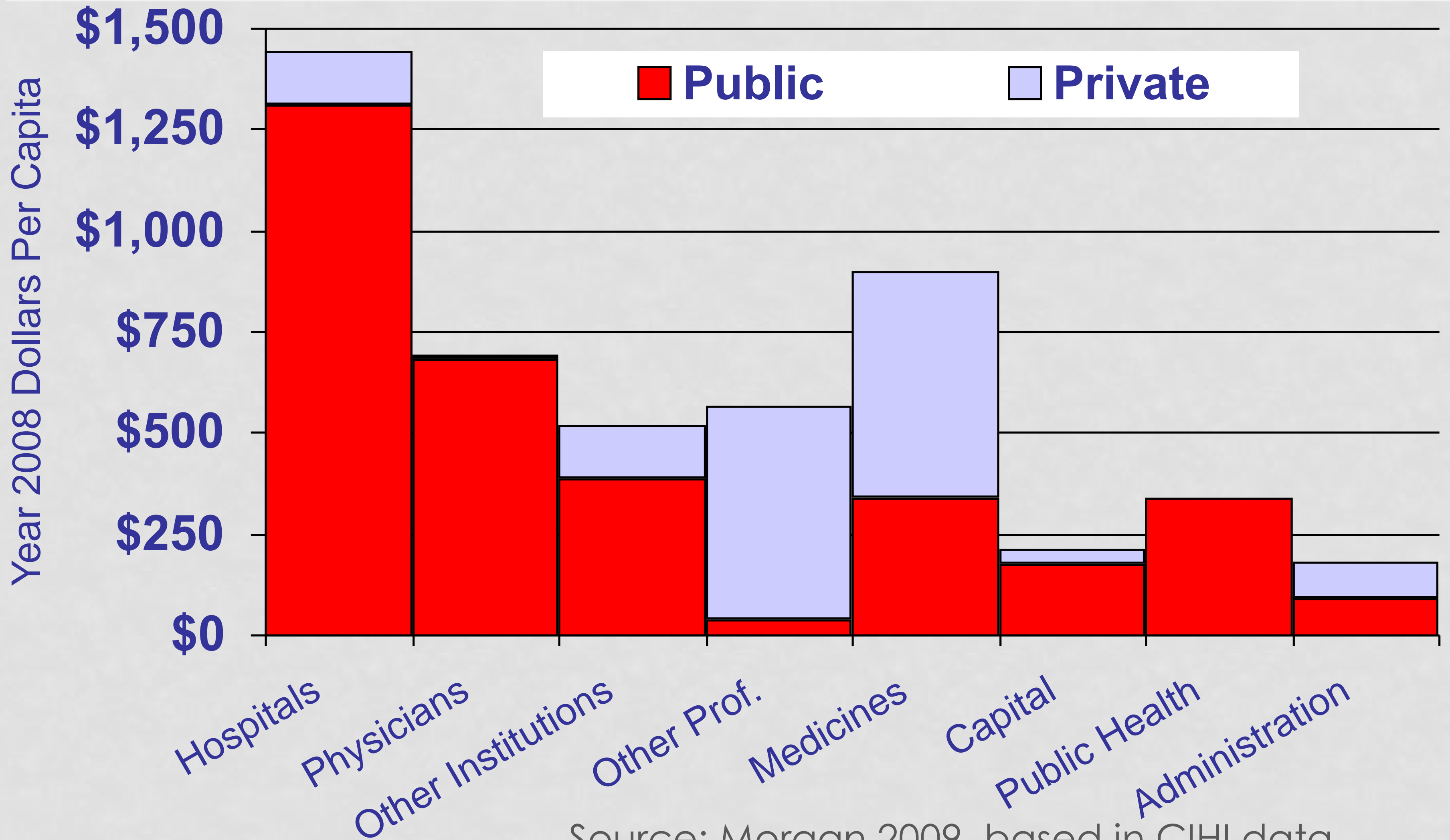
- Institutional fragmentation should lead to a slower pace of change and radical outcomes
- Does it provide a full explanation?
- Centralized authority: what a government **can** do but not what it **does**
- Also consider role of ideas and electoral motivations to explain process of policy development

REAL SPENDING PER CAPITA: 1975



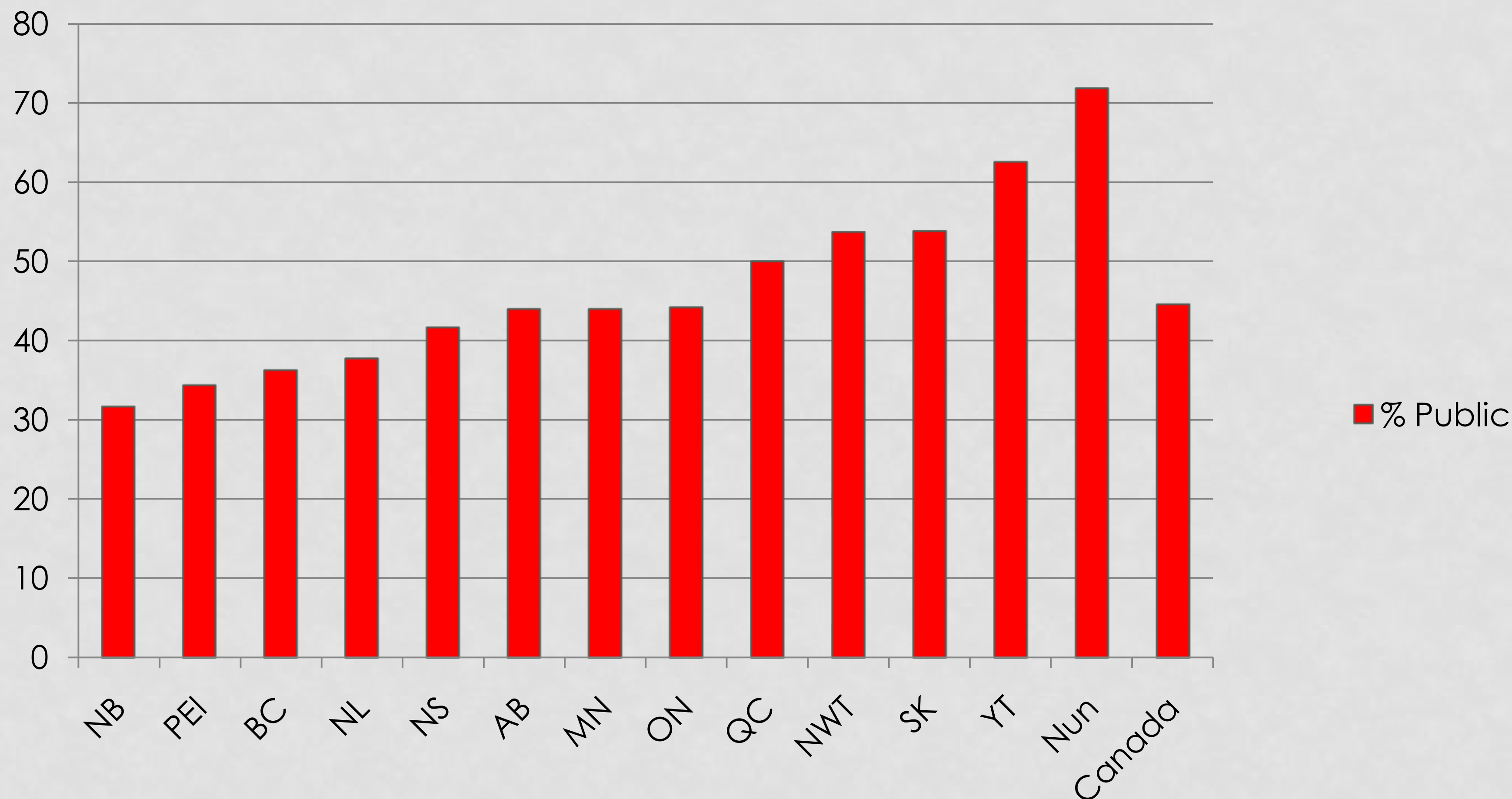
Source: Morgan 2009, based in CIHI data

REAL SPENDING PER CAPITA: 2008



Source: Morgan 2009, based in CIHI data

PRESCRIBED DRUG EXPENDITURE BY PROVINCE: 2008



Source: based on CIHI 2009 data

AUSTRALIA'S SECOND STEP

- Medibank first introduced 1975
- After 25 years of no health policy development, this was a **radical** step, requiring:
  - Centralized authority: Commonwealth government financially if not constitutionally supreme
  - Principled ideas: new Whitlam Labor government and plan by Melbourne Uni economists
  - Electoral motivations: Increasing dissatisfaction with private plans *and* popularity of new proposals