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by

TRACEY SCHRAMM

L.–R.

CLAUDIA KARVAN & PAUL BISHOP

In the Sydney Theatre Company's production of

Brad Fraser's *Poor Super Man.*

Photo Courtesy of the STC.

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ANNE CRICHTON

HEALTH CARE IN CANADA AND AUSTRALIA: THE DEVELOPMENT OF A COMPARATIVE ANALYTICAL FRAMEWORK

Some eighteen years ago I first went to Australia on sabbatical leave from the University of British Columbia, Vancouver. As an immigrant to Canada from Wales I had become interested in the similarities and differences in their health care systems and thought I would like to develop a comparative study of health policies in three countries. This paper describes a process of learning what can and cannot be compared.

When opening a European conference on cooperative social policy research Niessen and Peschar posed these questions: "Why compare? What to compare? How to compare? What to take into account when comparing?" (1976, xvi). An attempt will now be made to answer these questions.

WHY COMPARE?

Social policy analysts often wonder whether their nations have made the best policy choices and look over their shoulders to neighbouring countries. A list developed by Higgins (1981) has set out the main reasons for making international comparisons of social policies. She said that comparative study:

- encourages the making of distinctions between the general and specific;
- is useful in helping to discern larger patterns;

- widens the understanding of the range of policy options by enabling the analyst to examine "rational lists" and possibly to predict outcomes (lesson learning);
- permits evaluation of fashions in social policy, e.g. experiments in participation, positive discrimination, action research, area programs;
- assists in identifying social determinants of policies, in differentiating between culturally specific causes, variables, institutional arrangements and outcomes.

There are, of course, other lists made by other social policy analysts. Much depends on the persons who want to make the comparison, their academic backgrounds, their present pre-occupations and their goals in doing the research.

This list was a useful beginning but it did not tell what to compare, how to compare or what to take into account when comparing. To try to find answers to these questions I set off on a long voyage of discovery.

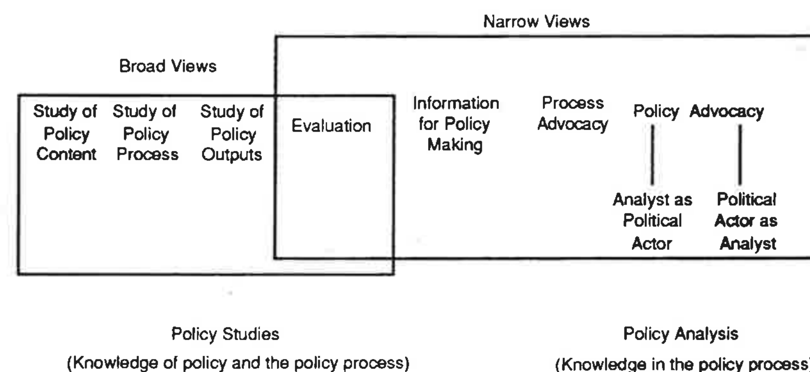
WHAT TO COMPARE

This work was begun naively. It was thought that by choosing what looked like the two most similar colonies of Britain, the three health systems could be set down in parallel without great difficulty. Teune (1978) has argued that comparing "most similar systems" is likely to prove more rewarding. But, it was soon recognised that Britain was the parent country where health care structures and processes had been set up much earlier within a different social and political context. The country was much smaller in extent, it was a unitary political entity, not a federation, and there were many other differences. So I decided to concentrate on examining the Australian and Canadian systems only, although recognising that it would be necessary to look at the British models which these two countries had used in developing particular aspects of their health services.

After I wrote separate historical reviews of health service development in the two countries (Crichton and Hsu, 1990; Crichton, 1990), what stood out were the differences. Though there were many shared ideas about goals, many structures were alike and many processes of decision making were similar, but how could they usefully be compared?

The next step I took was to undertake a selective review of the literature making international health care comparisons. In undertaking this review I found a chart developed by political scientists which distinguished between broader and narrower views of systems or parts of systems.

Figure 1 Types of Study of Public Policy Making



Source: Hogwood and Gunn (1981).

This chart arranged policy studies along a continuum and the accompanying narrative explains the distinction between those researches which were designed to increase understanding of the whole system and those which were aimed at providing lessons for others on organising parts of it (see Figure 1).

The items on the left are concerned with increasing understanding of policies as a whole while the items on the right are concerned with the smaller bites, with the learning of lessons about particular aspects of a system. Many comparative health policy studies take a small bite at the issues. For example, there are comparisons of doctors' payment systems (Glaser, 1970; Marmor and Thomas, 1971), and medical malpractice control (Rosenthal, 1987); others take a larger bite, such as Gray's study (1990) of federal involvement in Canada and Australia or Stephanie Short's study (1991) of the medical profession in the United Kingdom and Australia. Few tackle the comparative discussion of health care systems as a whole except in descriptive terms (for example, Roemer, 1993 and Raffel, 1984).

This approach has been criticised. Wessen (1987), a medical sociologist, thought that there was insufficient use of theory in Raffel's study and that a more solid disciplinary base was needed. But what should be that base? A review of historical, sociological, economic and social welfare disciplinary approaches seemed to emphasise one aspect of the systems only.

As I wanted to increase understanding of the two systems I put "lesson learning" activities to one side and decided that since no one disciplinary approach would satisfy me I would work on developing two case studies on a multidisciplinary basis.

LIMITING THE COMPARISON

Meanwhile I was engaged in some other studies of the Canadian health care system which enabled me to see that I should set some boundaries relating to system goals. In making a study of community care literature in Canada, I had become aware of the major change which had occurred when the country had made its commitment to public health insurance. In the years after the second world war most countries decided to establish welfare states in which health care systems were developed as part of the transformation from individualistic medical care provision to a state funded and organised system of care. Among those countries were Australia and Canada. It was decided that this transformation in distributive goals and the successes and failures of this reform should be the main theme of this comparative study. This gave me a specific area for examination. In reading the literature for the community care study I found that organisation theorists predicted that new organisations would develop in similar ways — first, they would aim to rationalise their services to meet their objectives, then they would review their missions and restate their objectives.

So far as health services in countries which became committed to collectivism (or welfare states) were concerned, this theory seemed to fit. They had to set up new public service organisations to implement the new collectivist objectives and these seemed to go through the two stages of development outlined above: that is, first, rationalising by gap filling and streamlining and then, later, reviewing their missions.

In both Canada and Australia the first objective was to provide universal *access* to medical and hospital services. Both countries had to work on gap filling: financial, geographic and cultural, and they addressed this first. Then, much later, they turned to streamlining when cost pressures began to bite.

They had hardly begun this when questions began to be raised about the mission — the use of the biomedical model of care. Would access to medical and hospital care really result in better health *outcomes*? In 1970 the Deputy Minister of Health for Canada set up a task force to look at the determinants of health, a study which resulted in the report *A New Perspective on the Health of Canadians* (Canada, Lalonde, 1974). This emphasised lifestyle, environment and biological risk factors and

downplayed medical interventions. (The group was influenced by McKeown's suggestion [1971] that only 10% of better health outcomes could be attributed to medical care.)

It took twelve years for this shift in mission to be examined and developed (with WHO backing) in the Health Promotion Conferences in Ottawa in 1986, and Adelaide in 1988. Both Canada and Australia have refocussed their attention away from access as the main issue, to exploration of the determinants of health, and how to improve health outcomes through better health promotion — a much broader concept than biomedical intervention alone.

HOW TO COMPARE

I continued to struggle with the questions "how to compare" and "what to take into account when comparing". I wrote up a comparative study but I still had not found the framework for increasing understanding of how to compare.

In 1994, however, there was a great increase in the number of publications about two or more health care systems because the President of the United States was endeavouring to reform the health insurance schemes in that country and was looking over the borders — particularly to Canada and Germany — for models which could be used in the United States. Among these publications was a short paper by Tuohy (1994) who explained why the Clinton administration would have difficulties in using Canadian models of health care. She quoted a study by Day and Klein (1992) which had been conducted in Britain. This broke down the analysis of policy decisions into their distributional and constitutional dimensions.

Tuohy, a Canadian political scientist, has explained the distinctions between the distributional and constitutional concepts in these terms: "The 'distributional' dimension of policy relates to the allotment of tangible benefits across various interests in society. The 'constitutional' dimension relates to the allocation of positions of influence in the making and implementation of policy" (Tuohy, 1994, 249).

When Tuohy focussed on constitutional policy change, she said:

> [It] almost always results from exogenous factors — and particularly from partisan factors in the broader political system. Because they are generated by external factors, episodes of constitutional change arise independently of policy ideas about health care delivery. But the effect of these episodes is likely to be shaped very much by the prevailing climate of policy ideas. To put it another way, the "window of opportunity" for constitutional change in the health care arena may be created and opened by factors in the

> broader political system. But that window will open onto a landscape of policy ideas about health care that is in a constant state of evolution. The particular constitutional changes that result will depend in large part upon that landscape. They will also depend upon the way prevailing policy ideas are absorbed and translated within the existing constitutional structure....
>
> The relatively stable process of government distributional changes within an existing constitutional structure is inherently easier to understand and predict than is the episodic intersection of factors that result in major constitutional change. (249–50)

In comparing the way in which the British National Health Service and the Canadian National Health Insurance systems evolved she drew attention to the postponement of decision making about the introduction of Canadian health insurance in 1945–46 by forces outside the health care arena (i.e. provincial governments concerned about preserving their constitutional rights). This postponement resulted in the development of private insurance schemes and various provincial government health insurance plans. It was not until the 1960s that federal government was able to come back with its "cooperative federalism" (i.e. welfare state plans) and to open up another "window of opportunity". But the context was different. Tuohy said that, by then,

> a substantial proportion of the population had become accustomed to a relatively generous and comprehensive coverage under private insurance plans. Furthermore, opinion within the medical profession had come to favour government subsidisation and supplementation of private plans.... The medical profession presented a relatively united front and could establish a political price for its participation in the program. The price was essentially, maintenance of the delivery system and governmental underwriting of its costs on relatively generous terms. The buoyant economic conditions of the time, moreover, placed few constraints on such a design. The system was launched on an economic and political base favourable to more generous financing and a greater degree of medical influence than had been the case in Britain two decades earlier. (251–52)

Her analysis provides a good framework for explaining why the British and Canadian health care systems are similar yet different. The similar aims of the distributional systems are affected by the different constitutional dimensions of policy making.

What to Take into Account when Comparing

Thus it appears to be vital to try to identify what are the constitutional dimensions impinging on distributional aims. Contextual material already collected on geography, settlement, economic development, social organisation, the constitution and the political parties would have

to be used somewhat differently. It would also be necessary to examine why some of the windows of opportunity for improving distribution of services were lost through power plays, the moving political situation and so on, such as medical resistance to the new collectivist approach to organisation, workforce unrest in the larger health care system, and the strengths and weaknesses of the new administrative bureaucracies with formal power. There are many complexities in the formal power structures, including federal and state divisions of authority, the public-private mix, and the extent of decentralisation. But the use of power was not all negative. There were many positive moves towards the goal of providing universal health care and better health status outcomes.

Is the Making of Comparisons Worthwhile?

There is no doubt that other countries wrestle with the same sort of problems in health services distribution as do Canada and Australia and that lessons can be learnt. Leonie Short (1992) has listed ten areas where, she suggested, comparisons between the two countries could be made:

1. overspending by hospitals,
2. the costs of the fee-for-service system of paying doctors,
3. whether the training of doctors is satisfactory,
4. whether there is an oversupply of doctors,
5. the need to review the provision of dental services because there may be overemphasis on treatment rather than prevention,
6. whether nursing education is satisfactory,
7. whether there should be more emphasis on a social model of care in order to prevent ill health,
8. whether too much money is spent on technologies for screening rather than on preventive services,
9. whether medical care organisation should be changed,
10. whether there should be more emphasis on reforming hospital-community care structures.

As Leonie Short pointed out, Ham, *et al.* (1990), and others have shown that there are no easy solutions. Marmor (1990) thought that the remedies proposed by Rachlis and Kushner (1989) for the problems of Canada's health care system were inadequate because they picked out parts which were not working well and proposed using American models to remedy these parts, but did not discuss whether these models would fit the whole. One part cannot just be transferred holus bolus from one culture to another and expected to work immediately. Each country has to pilot new innovations and what may work in Ontario may not work in British Columbia, or reforms in New South Wales may not fit in Victoria.

Similarities and Differences

I have been trying to make sense of the similarities and differences. There are great similarities in the distributional dimension because the basic structures derived from Britain are very much alike though somewhat different because of responses to patterns of settlements. Both countries have put strong emphasis on *access* to medical care and have now moved on to developing a new concern for *outcomes*. Yet even in this respect there are some differences. Outcome models in both countries are hardly developed yet but Canada seems to be as much concerned with reviewing the determinants of health (lifestyle, environment and biological risk factors) as well as focussing on clinical outcomes of medical treatment. It appears to put more emphasis on a social rather than a biomedical model of health care. So far as health promotion is concerned, Canada seems as much interested in the idea of reducing social inequities and enhancing coping than in directly preventing disease, which is the primary concern of health promotion programs in Australia.

And so we come back to the *constitutional* dimension. This has set up major differences which have interfered with the development of the *distributional* aims. Exploring these "constitutional" differences necessitated going back into the early history of the two countries to identify the social and political development of structures and processes of decision making. Australia began as a country of cities, Canada as a land of rural settlement. This led to major differences in the construction of the constitution, political decision making (Gray, 1990) and in the development of physical structures, such as hospitals where services are delivered, and social structures, such as medical professional organisation.

It is these structures which are difficult to change within the broader social organisation and which affect the response to distributional questions such as those posed by Short (1992). For example, overspending by hospitals in Canada has much to do with overbuilding between 1948 and 1969 when it was much more difficult to get about on unpaved roads and there was not yet medical care insurance for treatment in doctors' offices; but, once built, it is almost impossible to close small rural hospitals for political reasons. And resistance to change by doctors has made it difficult to get their cooperation to charge fees for service payments, control supply and distribution and reform practice organisation (Crichton, 1994), although the centralised payment systems of Australia may hold out greater hopes for structural reform than the decentralised collective bargaining of Canada.

Short's questions about the social model of care and the use of technology raise even more complex issues of changing political values about social distribution and how the money for health and social services is spent. What is the continuing commitment to the acceptance of collectivism? How stable is the concept of universal health insurance when the rest of the world is considering greater privatisation of health care? Australia seems more committed to market solutions than Canada which is reluctant to abandon any of its income support and social welfare programs despite the tremendous pressures of the national deficit. From the beginning there were some differences in their approach to welfare state development. The chart developed by Graycar and Jamrozik (1988) in their book, *How Australians Live* has helped us to understand these differences. This chart (see Figure 2) is based on Titmuss' (1958) three divisions in welfare state policies — efforts to increase income security, interest in developing and preserving universal social programs and special support for industrial development activities. Both countries recognise that spending on health care is closely linked to national income and both are concerned about economic development, but I believe that Canada has taken universal health care for granted and is presently more concerned about reforming its income security programs while Australia is still politically divided on the Medicare issue, less interested in social security matters and more concerned with economic advancement policies.

There are continuing discussions of the meaning of equity (or equitability) in Canada. There is much emphasis on human rights, enhanced citizenship and so on. I have the impression that although there are discussions of these topics in Australia there is less emphasis on rights, probably because this issue was given a very high profile in Canada with the appending of the *Charter of Rights and Freedoms* to the patriated constitution of 1982. And there are other differences in structures and processes to be considered. For example, the Australian federal government has always been anxious to claim more power over the states while Canada has been decentralising steadily since 1970.

These *constitutional* questions and the way in which they are resolved have enormous implications for health service *distributional* issues and how they are tackled within this wider context. They affect the behaviour not only of the politicians and bureaucrats who are responsible for the formal organisation of the system but that of the other power holders such as the doctors (with their technical power) and the consumers/taxpayers who may be brought in as allies of one side

or the other (Alford, 1975). As well, as Tuohy (1994) has pointed out, it is not one or other issue which has to be dealt with at a particular time, it is the whole situation and the determination to use a window of opportunity.

Perhaps one example of using windows of opportunity is what may be called medical manpower planning (even if the term is politically incorrect) . Both countries have struggled with this issue over the years and found that it is easy enough to increase the output of their medical schools and to attract doctors trained elsewhere, but it is very difficult to find how to shut down on what might be considered oversupply. Although Canada was aware of the issue for many years it was not until 1993 that the Health Ministers (spurred on by economic data) adopted a joint policy which is now being implemented. But the window did not open until cost pressures became acute. Australia still struggles with the matter generally (for lack of good data) though it has been able to cut back its medical school intakes with cuts to educational funding.

CONCLUSION

By picking out a series of parts of the system for comparison, Short (1992) has made a useful contribution to focussing attention on deficiencies in the distributional system, but we must always be conscious that the constitutional dimension will exert strong pressures and if we wish to be reformers we shall have to look for the windows of opportunity to bring in changes when we can.

It is useful to compare Australian and Canadian health care systems because of their similarity in distributional goals and their fairly similar determination to cut through the constitutional barriers to reach these goals. Both countries decided to set up welfare states to work towards collectivist objectives (though these welfare states had different emphases); both found that providing access to medical care was only a first stage in working towards better health status of citizens — and have subsequently moved to the new mission of promoting health and focussing upon health status outcomes; and both are very concerned about the distributional issues in health care provision and how best to resolve them. We should continue to look to one another for good ideas about reforming deficiencies but should not expect easy answers.

Figure 2
Public Expenditure (Commonwealth) and its Beneficiaries of Australia

Selective in favour of low income groups	Universal provisions	Selective in favour of high income groups
1. Direct allocations (means tested)		
Unemployment benefits		
Family income supplement		
Invalid pensions		
Supporting parent benefits		
Widows' pensions		
Age pensions		
Public housing		
2. Collective provisions[1]		
	Family allowances	
	Dependent spouse rebate	
	Public transport	
	Public schools	
	Public health system	
	Technical (TAFE) education	
	Early childhood services	
	Employment in public sector	
	Colleges of advanced education (CAEs)	
	Universities	
	Culture, recreation	
	Private health system	
	Private schools	
3. Taxation expenditure (revenue foregone)		
		Superannuation concessions
		Occupational welfare concessions
		Assistance to industry
		Concessions to business
		Tax-free dividends
		"Condoned" tax avoidance[2]
		"Condoned" tax evasion[2]

Source: Graycar, Adam and Adam Jamrozik. 1989. *How Australians Live. Social Policy in Theory and Practice*. Melbourne: Macmillan. p.70.

1 Some of these benefits/provisions entail taxation expenditures but they are not available to recipients on a universal basis, irrespective of income. Some are means tested, most are not.

2 "Condoned" because the complexity of the taxation system enables some people to take advantage of loopholes and minimise, avoid or (illegally) evade payment of tax.

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