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Re-figuring Federalism: Nation and State in Health Reform's Next Round



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Most Western nations treat health policy (especially, but not only, issues of coverage) as a national responsibility in which subnational governments or regions may be granted a more or less prominent role. The United States, by contrast, has never adopted a national health policy, nor agreed that it ought to do so. In consequence the 50 states have played three roles: partners with the feds in some very important programs (for instance Medicaid and the State Children's Health Insurance Program), sources of pressure on Washington for a redivision of labor in health affairs, and sources of innovation in health policy in default of national leadership.

This role trilogy was a potent political force in the run-up to the Clinton health reform plan of 1993-94. In the late 1980s, state spending on Medicaid shot up for several reasons, including the costs of treating people with AIDS/HIV, new federal coverage mandates, the states' own Medicaid maximization strategies, the impact of general medical inflation, and a growing number of uninsured residents. The administration of President George H.W. Bush was disinclined toward bold national measures, and a cadre of states resolved to install systems that would achieve or approach universal coverage and contain costs, mainly via managed care, to boot. In 1988 Massachusetts passed legislation that aimed at universal coverage via a play or pay approach. Oregon's famous rationing plan (aka "prioritization") earmarked savings imputed to the elimination of insufficiently cost effective services in Medicaid for an expansion of eligibility in that program. In legislation of 1993 Washington State coupled an employer mandate with managed competition. Other states—New York, California, Colorado, Vermont, and Florida, for example—deliberated at length on reform but after various and sundry detours came up short. These real and attempted innovations boosted the conviction that health reform was not only imperative but also at long last doable and thereby pushed reform higher on the national agenda. When Bill Clinton prominently advertised his commitment to health reform in his successful presidential campaign of 1992, few doubted that the idea's time had finally come.

By 1994 national reform and most of the states' handwork were dead. Massachusetts deferred implementation of its plan and then repealed most of it. Oregon added about 100,000 residents to Medicaid and then, failing to find big savings by rationing or otherwise, struggled with the program's costs. Washington State gutted most of its 1993 reform bill in 1995. To be sure, not all was lost. Minnesota, for instance, quietly layered federal and state programs without employer mandates or managed competition and brought its rate of uninsurance below 10 percent. The enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 gave the federal government a larger role in regulating private health insurance, which heretofore had been left largely to the states. The creation of SCHIP in 1997 put "catalytic federalism" (Brown and Sparer, 2001) on display: drawing both on Medicaid and on innovative programs of child coverage in states such as New York, Massachusetts, and Florida, the feds designed a new template that entailed new funding and challenges for the 50 states. On the whole, however, misadventures at both levels of government reaffirmed a sour truth that would-be leaders denied at their peril: health reform initiatives tend to generate much more antagonism among threatened interest groups (especially business, providers, and insurers) than gratitude within the electorate and are therefore a poor investment of political capital. For a decade thereafter the reform "movement" fell mute while states fine tuned their "partner" role in Medicaid waivers, the implementation of SCHIP, and other variations on incrementalist themes.

Around 2005, however, history began to repeat itself. The national number of uninsured, rising by roughly one million per year, hit 45 million. As in the late 1980s, relentless media attention to the issue powerfully intimated that the status quo was doomed. Meanwhile, growth in Medicaid and SCHIP had lowered the number of uninsured children by about five million. By enacting a program to cover all its children, Illinois showed that state health reform was afoot again, and Maine and Vermont passed laws that aimed at universal coverage. For a time the media mostly recorded lagging enrollment in Maine's plan, but then the eyes of reformers everywhere were drawn to Massachusetts which, Rip Van Winkle-like, rose to reprise the quest for reform that had gone awry a decade earlier.

Even as the exogenous shock of soaring Medicaid spending had galvanized states in the late 1980s, the proverbial prospect of being hanged the next day by waiver-meisters in the federal Centers for Medicare and Medicaid Services concentrated the minds of Massachusetts's leaders on how best to meet Washington's conditions for renewing roughly half a billion dollars in waiver funds, namely, that the state spend less on the safety net and more on coverage for the uninsured. In 2006 Massachusetts passed legislation that combined an individual mandate (all residents are legally obliged to buy "affordable" coverage if it is available), very modest financial penalties for employers who fail to offer coverage, expansion of Medicaid, new income-related subsidies for those who do not qualify for Medicaid, and assorted administrative innovations that would help residents to find and enroll in affordable health plans. As before, New York State wondered if it should do something similar, and California too soon joined the (small) crowd. In 2008, as had been the case fifteen years earlier, innovations within the federal "laboratory" signaled to the American public and the presidential contenders seeking their votes that a plausible plan for national health reform was a precondition for political success. And now, as then, federalism is sometimes said to be a positive, perhaps indeed invaluable, element in the strategic design. (For example, then: Tallon and Nathan, 1992; now: Aaron and Butler, 2004).

Mandates, Medicaid, Models, and More

States as stimuli to and models for federal policy are one thing; states as partners and participants in federal policies are another. Whereas the Clinton plan of 1993-94 gave the states a major role in organizing and overseeing regional health alliances (which vanished into oblivion with the rest of the blueprint), the main Democratic presidential contenders in 2008 are rather more laconic on federalism. (The main allusion to the states in Hillary Clinton's plan allows them "the option of banding together" to offer regional versions of her Health Choices Menu. Barack Obama would permit "flexibility for state plans . . . provided they meet the minimum standards of the national plan.") The state of the art of health reform on the Republican side, meanwhile, is pretty well captured by the repudiation by (failed) presidential aspirant Mitt Romney of the plan for universal coverage he had promoted while governor of Massachusetts.

In the Clinton episode an employer mandate, regional health alliances, and managed competition were the centerpieces of a model that was expected to wed left and right, government and market, regulation and competition into an acceptable reform package. Today's

model du jour features individual and employer mandates, expansion of Medicaid, new public subsidies geared to income, and savings from information technology, prevention, and much more on lists notable for the absence of managed care from center stage. Whereas the Clinton concoction came out of whole theoretical cloth, the latter-day stratagems derive from flesh and blood legislation that has already inspired emulation in important states and could conceivably become a serviceable national model.

The generalizability (upward to Washington or outward across the states) of this or other approaches probably turns less on analytical merit than on goodness of political fit. The Massachusetts plan is arguably highly context-dependent. The law of 2006 was not (merely) the product of superior political enlightenment but rather a response to a sharp stimulus—possible loss of sizable Medicaid funds in a waiver under renegotiation with the feds. The plan supposedly advanced the presidential fortunes of then-governor Romney. Massachusetts couples a high rate of private health care coverage with a generous Medicaid program, and therefore began the exercise with a relatively low percentage of uninsured residents. The state enjoys unusual cohesion and cooperation among health care sectors; this law, like the enactment of 1988, brought hospitals, physicians, business groups, insurers, and academic medical centers together in sustained collaboration rarely found in other states. The continuing federal waiver money, plus new and reprogrammed public funds in a state sometimes caricatured as “Taxachusetts,” cemented a good financial deal for providers (mainly excepting the safety net, whose leaders complained that they won mainly a promise that they would eventually have new paying–insured–customers), for the business community (penalties for not covering workers cost less than buying insurance), and for insurers, who stood to gain new subsidized business. The Massachusetts case directly calls the federalism question: pondering how this or a similar approach might fare in other states, or in a national program in which all states were obliged to participate is a kind of litmus test of the prospects for success of the emerging reform project.

Mississippi is not Massachusetts. States that lack the carrot/stick of big federal waivers on the line, do not have governors eager to use public program-building for the disadvantaged to appeal to a national audience, combine relatively low private-sector coverage with constricted Medicaid eligibility, suffer high rates of uninsurance, house providers, businesses, and insurers with little history of or inclination toward co-operation, and show little taste for crafting new income-related public subsidies for the less affluent may find the emerging reform template distasteful as federal or state policy. At the head of this class of presumed skeptics would be Texas, Oklahoma, New Mexico, Florida, and Arizona (five states in which uninsurance rates run around or above 20 percent and that collectively contain about 40 percent of the U.S. uninsured), and the political economy and health policy tastes of most states probably lie closer to this quintet than to Minnesota, Massachusetts, Maine, and Vermont.

A mandate that all residents of a state (or the nation) buy coverage could be a progressive coup or a regressive affliction—depending on whether Medicaid and public subsidies are generous enough to keep out of pocket payments tolerable. The weaker the requirements for employer participation, the longer the fiscal stretch for public programs. But the firmer the bite on employers, the greater the prospects of political opposition by powerful small (and some large) business lobbies. The broader the role of an expanded Medicaid, the bigger the tax burden to meet state shares of whatever intergovernmental matching formula might be adopted. (As

Nicole Kazee [2008] points out, 70 federal cents on the dollar is objectively a good deal but may not be so perceived by states accustomed to think of themselves as poor and fiscally beleaguered.) The smaller the role for enlarged Medicaid coverage, the greater the funds that must come from consumers and/or employers and/or new public subsidies that will probably mimic the fiscal politics of Medicaid expansions. Equity objectives go hand in hand with tax issues—the need for new taxes to sustain redistributive programs old and new, the case for repealing tax breaks, and so on—that roil the smooth surface of consensus.

The reform approach on display in Massachusetts, and, *mutatis mutandis*, in the proposals of the leading Democratic presidential contenders is less a model than a laundry list of strategies tossed, Lego-like, onto health policy's famous big round table. The five variables in question—individual mandates, employer requirements, Medicaid expansion, public subsidies, and “savings” from various and sundry sources—invite diverse outcomes that extend from fair and affordable universal coverage premised on newfound solidarity among Americans to a cruel charade that compels the less well-off to pay heavily out of pocket to buy costly coverage dubbed affordable by regulatory fiat or for coverage that is affordable but inadequate because insufficiently subsidized, with multiple mixed cases in-between. The new template reformulates the big health reform questions, but does not, *per se*, answer them. The devil, not yet in the details, haunts the design.

In principle the elections of 2008 could launch a universal national health measure that embodies the appeals and virtues of a social insurance-based Medicare program for all or a general-revenue based single payer system. In practice, however, the states now are probably too heavily entrenched in health policy and too powerful and insistent a political presence to be pushed to the sidelines. For this and other reasons, Medicaid may well be a more plausible foundation for reform than is Medicare. (Brown and Sparer, 2003). If so, the central reform challenge is to reconcile subnational variation and discretion with a national set of rules that steers between rigidity and indulgence in ways that are substantively workable and politically acceptable.

Mastering Medicaid

Though it is not the sole focus of federal-state relations in the health sphere, Medicaid is certainly the most prominent one, and it therefore offers an especially helpful entry into the intergovernmental complexities a reformed system will face. Created in 1965 as a program of “welfare medicine” principally for mothers and children on public assistance, Medicaid has steadily added beneficiaries and services and now covers (with the State Children's Health Insurance Program) around 60 million Americans on an annual budget of more than \$350 billion. Boiled down to basics, the federal-state challenges in the program revolve around ten main issues.

1. *Beneficiary Categories.* In the course of a “gradual and relentless extension” (Smith and Moore, 2008, p.181), Medicaid has come to cover not only poor mothers and children but also the aged, blind, and disabled; many of the mentally ill and mentally retarded (the program is the nation's most important payer for mental health services); indigent Medicare beneficiaries

who qualify “dually” for Medicaid ; some of the temporarily unemployed; victims of intermittent disasters (for instance Hurricane Katrina); and , not least important, Americans whose incomes and medical conditions qualify them for long-term care, an extremely costly commitment that the states have at intervals explored “swapping” to the feds in exchange for assuming other functions. Who “deserves” Medicaid coverage has been a continual subject of debate in the program, which has seen ever more organized groups and policy entrepreneurs in and out of Congress seize political opportunities that get benefits for “their” populations ensconced in some corner of the statute.

2. *Income Thresholds.* Medicaid’s enrollment has grown not only by the addition of new groups but also by incremental elevation of income limits on eligibility. In both Medicaid and SCHIP states can opt to exceed federally prescribed income thresholds. What the upper federal limits should be for what groups and how far the feds should agree to match the Medicaid spending of states that want to go farther are contentious issues, as recent skirmishing between President Bush and the Democratic Congress over the latter’s proposed expansions in SCHIP vividly illustrated.

3. *Mandated/Optional Benefits.* One important federal lever for steering Medicaid in the states is to offer them the option of adding new beneficiaries and/or new covered services at their federal matching rate. The feds can also make options mandatory if political conditions are ripe, and a wave of such transitions—the so-called “Waxman two-step”—in the late 1980s triggered protests by governors and their National Governors Association. (Smith and Moore, 2008, pp.177-78).

4. *Delivery Patterns.* Feds and states clash and negotiate over the organizational settings in which the care for which Medicaid pays is delivered. Examples include: the shift from a fee-for-service model to managed care (which now enrolls to more than half of Medicaid beneficiaries nationwide); the push for “least restrictive” care settings for persons with disabilities; the drive to reduce the program’s alleged “institutional bias” by means of home and community based treatment loci; battles over what nursing home variant—“intermediate,” “extended,” “skilled,” and so on—qualifies for payment under what circumstances; and the struggle to formulate and enforce quality standards and patient protections in these and other venues.

5. *Safety Net.* Medicaid, uninsured, or otherwise disadvantaged patients constitute a “disproportionate share” of the patient mix in some hospitals. To ease the fiscal strain, the federal government offers the states (and thence the hospitals) special payments, the amounts and conditions on receipt of which have grown and contracted over the years to the tune of considerable conflict. Some analysts contend that the eternally beleaguered safety net hospitals need all the help they can get. Others view them as relics of a superseded system, ripe for downsizing, and urge that funds be shifted toward community health centers and other sources of primary and outpatient care. Another camp favors shifting dollars from paying for care to supplying or improving coverage.

6. *Fraud and Abuse.* Fear that a nontrivial fraction of Medicaid’s billions goes to providers (or consumers) who cheat the system has inspired congressional inquiries, agency

investigations and closer scrutiny of the financial records of beneficiaries and the billing records of providers. The issue lends itself to (literally) arresting headlines, but the cost-effectiveness of antifraud efforts is unclear, especially given that anti-fraud and abuse systems occasionally succumb to fraud and abuse. (Smith and Moore, 2008, p.141, n. 102)

7. *Matching Formulas.* Since the program's inception, Medicaid has given all states a federal matching percentage of no less than 50 percent, and more (up to 72 percent) for poorer states. Changes in the formula would have large redistributive implications, and so the allocations have stayed pretty much frozen in place. (Smith and Moore, 2008, p.239) States, however, have annoyed the feds with perennial fiscal improvisations to raise their share of the match—for example, by imposing taxes on or securing donations from providers, or contriving “intergovernmental transfers” from localities, which then recoup their “losses” with dividends from the larger federal funds drawn down. At times the feds have proposed to reduce their exposure to “open-ended” matching of state Medicaid spending by converting the program to a block grant or by imposing caps on federal matching, but the states and their allies in Congress and in the advocacy community have thwarted such initiatives.

8. *Compliance Enforcement.* Because Medicaid covers many complex services for a heterogeneous cadre of beneficiaries, feds and states sometimes clash over whether the latter are in fact meeting the program's statutory and regulatory requirements. For example, is the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) reaching out adequately to beneficiaries and offering treatment for the conditions it finds? (Whether such treatment is required when the clinically indicated services are not included in a state's Medicaid plan has been a matter of federal-state contention.) Are substance abuse treatments for adolescents in Medicaid in fact available and accessible?

9. *Flexibility and Innovation.* As states chafed under federal rules but failed to agree on fundamental redesign of the program, governors increasingly argued for greater flexibility to innovate within their states. These pleas, especially after welfare reform in 1996 severed the link between eligibility for public assistance and for Medicaid, persuaded President (and former chafing governor) Bill Clinton to grant more federal waivers that permitted states to make changes in coverage (expansions in some states, reduced benefits in others), financing (including limited cost sharing), delivery (for instance, ventures in community-based care), and other features of the program. President (and former governor) George W. Bush has also been generous with federal waivers, leading some observers to worry that such limited national uniformity as Medicaid has had is fast dissipating into “fifty different Medicaid programs.”

10. *Payment Policies.* Although the states enjoy broad discretion over how much and how they pay providers, the feds sometimes limit their freedom. Contested cases in point include the (now repealed) Boren amendment that mandated higher payments to safety net providers, the “upper payment limit” that links Medicaid payments to those made by Medicare for some services, drug rebates, rules governing payment to nursing homes, and required funding for graduate medical education.

Addressing Diversities

Health reform might address these intergovernmental diversities and disparities in one of

three main ways. First, much of the problem would disappear (or be much mitigated) by a single-payer, Medicare-for-all plan that took the states largely out of the action. The system would look something like, say, France—one dominant “sickness fund” operating in a unitary (non-federal) framework. It is sobering to note, however, that roughly 160 million Americans now have health coverage that is a good deal less uniform across work sites, let alone states, than is the coverage of those on Medicaid or SCHIP. And the 47 million uninsured enjoy no uniformity at all. Successful national “standardizing” of this heavily privatized and federalized system would be no mean policy feat, and excluding or much downsizing the roles of employers and the states would be an equally astounding political coup. Some “minimum adequate” scope for disparities (which may or may not constitute objectionable inequities) may be unavoidable.

Second, if Medicare for all is out of reach politically, reformers could push for Medicaid for more, ratcheting up the program’s strong expansionary dynamics. This implies working one’s way down the ten-item list reviewed above to identify opportunities for cost-effective and politically palatable extensions of Medicaid coverage. For instance, Medicaid for all lower-income children and/or for more working, lower income adults? “Lower-income” defined how? What happens to long-term care? Optional coverage for some groups at federal matching rates, or more national mandates? Is managed care to be the, or a, vehicle of choice? Should the feds mandate the use of, and set standards for, electronic medical records and kindred managerial advances? Will more money go to safety net hospitals, community health centers, or perhaps to coverage instead of (directly to) providers of care? How much more fraud and abuse (and efforts to deter and detect them) does Medicaid for more imply? Will the federal matching formula for the states change? Will special programs such as EPSDT be preserved, and if so, on what terms? How much flexibility will be granted to individual states, and on what terms (Waivers? Making the program “more like SCHIP,” as some governors prefer?) How and how much will providers (expected to deliver accessible care of good quality to an expanded Medicaid clientele) be paid? The policy issues and political conflicts that haunt Medicaid today would grow along with the program’s enrollment. More of the same battling within political trenches inside the beltway and state capitols may seem a pitiful and unworthy model of reform, but it may be the best the U.S. system can do, and if perchance it were done in a more liberal political environment after the elections of November 2008, this strategy might make a more than marginal dent in the ranks of the uninsured.

Third, reformers might seek to reconcile national consistency with subnational (and private sector) diversity by taking a cue from Canada and promulgating a set of general standards/principles/criteria the states must meet in order to qualify for their share of federal matching funds. These standards would be broader and less constraining than those of a fully-national system, but they would require no small measure of averaging among current state practices and designing them would be easier said than done.

Pessimists who fear that such a project is beyond the capacity of U.S. government to master may well be right, but before dismissing it as doomed *a priori*, critics might pause to note that other Western nations with federal systems have achieved affordable universal coverage while striking a reasonably serviceable and stable intergovernmental balance that addresses health policy conundrums not so dissimilar from those Americans confront. The workings of federalist improvisations elsewhere might therefore have something to say to U.S. reformers.

Health Policy and Foreign Federalism

Like the United States, most Western societies are perpetually in process of adjusting relations between central and subnational governments or regional units in the health sphere. France, for example, is a unitary, not federal, system, but looks to Regional Hospital Agencies, created a decade ago, to help design and implement changes in local hospital markets. The sharing of authority and spending between the national government in Rome and local and regional “units” and “enterprises” has held center stage in Italy’s health policies since the nation scrapped its social insurance system and adopted a national health service model in 1978. In nations whose constitutions grant formal powers to subnational governments, negotiations between these and the center over which level should do and fund what in the health system are basic parts of the policy furniture.

One European federation—Switzerland—ranks second only to the United States in health spending as a per cent of GDP and per capita. Two others—Canada and Germany—generally vie for third place on the spending charts. That these four federal nations finance health care differently—Canada has a single payer system, Germany a social insurance regime, Switzerland a variant on so-called consumer driven health care, and the United States a hodge-podge of private, public and safety net arrangements—may even suggest, notwithstanding that correlation is not causation, that federalism itself works to push health costs upward. A quick review of the Canadian, German, and Swiss systems pinpoints some challenges and options for U.S. reformers.

Canada

If, as some argue, “most similar” systems are the best sources of useable policy lessons for national counterparts, then Canada, which shares a border, a language, and important historical and institutional similarities with the United States, is the first (and perhaps last and only) place U.S. health reformers ought to canvas. Macro similarities aside, moreover, the Canadian and U.S. health systems exhibit intriguing variations on two key health policy themes. First, whereas the U.S. constitution leaves ambiguous how “states’ rights” may constrain federal health initiatives, Canada’s explicitly assigns health matters to the provinces. Second, the U.S. and Canadian health systems looked very similar for much of the 20th century—until the 1970s (late in the game by cross-national standards), when the adoption of Canada’s version of Medicare put the two nations on divergent strategic paths.

Provincial debates about public health (especially hospital) insurance commenced around the time of World War I and, particularly in British Columbia and Alberta, moved on and off their policy agendas in the 1930s. (Taylor, 1990, chap. 3) Creation of a federal Interdepartmental Advisory Committee on Health Insurance in 1942 centralized and intensified these debates, but negotiations between the central (formerly known as “dominion”) government and the provinces ran aground and adjourned in 1946. The stalemate first broke when Saskatchewan moved in 1947 to create a provincial hospital insurance program. By the end of 1950 four of the ten provinces had broad or near-universal programs of hospital coverage, and

the federal government came under rising pressure to create the fiscal conditions (that is, put up the money) that would induce the remaining provinces to consent to enter a new national program.

The Canadian debate of 1956-57 rings familiarly to American ears fifty years later:

It was too much, it was too little, it was too soon, it was overdue, it drained the federal treasury, it did not offer enough to the provinces, it was the road to socialism, it was the beginning of a new day, it would not represent any additional expenditure, it would bankrupt the nation. (Taylor, 1990, 92)

Then, in a decidedly un-American denouement, Canada's parliament set aside opposition by the insurance industry and chambers of commerce and the lack of endorsement of the Canadian Medical Association and passed the Hospital Insurance Act unanimously in both houses in 1957. (Taylor, 1990, 92-93) A parliamentary political structure evidently does matter: national and provincial prime ministers weighed their options and took their time before endorsing health insurance breakthroughs in their bailiwicks, but once they resolved to make them happen party unity carried the day.

Four years later, Saskatchewan launched a bigger battle by adding provincial coverage for physician services, an innovation that triggered a bitter (and finally unsuccessful) physicians' strike, but also caught the eye of other provinces which (again) adopted similar measures and sought national funds to help pay for them. This prospect called in question the economic future of existing private, voluntary and medical society-sponsored insurance plans, so insurance and physician organizations lobbied hard for means-tested benefits in any national plan and urged that a national commission be formed to explore the issue and (presumably) confirm the wisdom of their wishes. As it happened the report of the Royal Commission on Health Services "astounded" (Tuohy, 1999, 53) this coalition in 1964 by recommending that public (provincial and central) funds should go directly to pay for care, not for income-scaled subsidies to help citizens meet the cost of private health insurance premiums. This decision, which seems to have gone down politically with remarkable ease, reflected both a principled distaste for private insurance and fiscal pragmatism— income-related subsidies not only introduced an inequitable two-tieredness into the system but also were costly and administratively cumbersome. (Taylor 1990, 139; Tuohy, 1999, 55) After the Medical Care Insurance Act passed in 1966 private insurers could not sell coverage that duplicated the contents of the "single payer" program and were thus consigned to offering extra ("supplementary") benefits— outpatient prescription drugs and long-term care, for example. (In Canada supplementary coverage is largely employer based, while funding for the public plan comes mainly from personal, sales, and corporate taxes at the national level and in combinations and at rates that vary among provinces.)

Despite the singularity of public payment in Canada, the system is often characterized as ten provincial (and three territorial) systems that differ on many counts. What keeps order amid this potential chaos is a list of five "criteria" (also sometimes called "principles," "conditions," and "standards") the national government requires the provinces to honor as a condition of receipt of its money. (As a constitutional matter, it lacks the power to mandate them outright but

can attach them as strings to grants.)As set out in the Canada Health Act of 1984, the criteria declare that provincial health programs must secure: comprehensiveness (medically necessary physician and hospital services must be covered); universality (the whole provincial population must be covered); accessibility (physicians may not engage in extra billing and hospitals may not impose user charges); portability (Canadians moving to or traveling in other provinces must be covered by their province of residence); and public administration (provinces cannot delegate management of their health plans to for- profit entities).

Contemplation of 13 subnational health systems bonded serenely by five general principles embodied in eight pages of national legislation may sooth the frayed sensibilities of U.S. reformers, but the evolution of the Canadian system has been conspicuously conflictual all along the way. As noted above, hospital insurance was decades in the making, and the addition of coverage for physicians' services sparked quite a brawl. Once Canada's version of Medicare was intact, the provincial and central governments began (and have continued) to clash earnestly and often over which levels will pay how much and how for the health system. Initial arrangements, which had the central government sharing a percentage of provincial health costs left the former upset about its growing share of provincial "overruns" and the latter fuming about nitpicking federal audits and rulings. In 1977 cost sharing gave way to "Established Program Financing," which entailed block grants and the yielding of federal "tax points" in combinations that complicated the disentangling of provincial from federal funding streams. Through much of the 1990s economic growth slowed and the feds retrenched. In 1990-91, federal transfers amounted to 33 percent of provincial/territorial health spending, but by 1999/2000 the shares had shifted to 28 percent and 72 percent respectively (Marchildon, 2005, 45.)The provinces bewailed betrayal, the providers deplored under investment in the health sector, and the public's satisfaction with the system, hitherto among the highest in Western nations, began to erode. Political leaders got the message, and when the economy revived, so too did federal health care contributions, which in 2005-2006 stood at 35 percent federal and 64 percent provincial/territorial. (Marchildon,2005, 45). Not all was forgiven, however. The renewed federal largesse in 2000 and after generated "considerable irritation from provincial governments who saw it [the federal government] as trying to gain credit for re-entering an area from which it had withdrawn in an antisocial manner." (Greer, 2004, 218) A survey of 2003 found that only 42 percent of respondents affirmed that the feds and provinces worked well together. (France, 2005, 40) And throughout this fiscal fracas the provinces have been devolving authority in the hospital sector to new regional and community boards that could admirably fuse planning with local control or could, as Jonathan Lomas (1997,821) observes, become "sponges for local discontent."

All the same, by contrast to the U.S., Great Britain, and various Continental nations that perpetually ponder "systemic" reforms, the Canadian system has been and remains, as Carolyn Tuohy notes, impressively stable. Evidently intergovernmental marriages, like the nongovernmental kind, can be, as Greer (2005, 220) writes of the Canadian system, "petty in the moment," but "productive overall." The frictions the system faces are, however, surely more than momentary and arguably more than petty. Allegations by American critics that the Canadian system is one long waiting list widely miss the mark, but such lists (sometimes called the system's "Achilles heel") do sometimes accumulate in some provinces for some services,

leading providers, the media, and consumer groups to complain that the system so egregiously under invests in health care facilities and personnel that citizens are sometimes driven to distraction—or over the U.S. border for care! Indeed a recent court decision in Quebec that excessive waiting jeopardizes the accessible care the system promises could open the door to the private competition Canada has so far refused to admit .Meanwhile, even as the right deplores the absence of private competitors in the public insurance plan, the left denounces the advent of groups of private physicians (some with corporate ties in the United States) on the supply side. And of course the absence of a national requirement that provincial plans fund outpatient prescription drugs and home health care (among other omissions) continues to vex critics who point out the rising (and often out of pocket) costs of such services to the public and the disparities that ensue when coverage is left to provincial discretion.

Another camp of critics complains that the system’s accommodative and “collegial” (Tuohy, 1999) catering to private practitioners (mostly independent and paid fee for service, which constitutes 83 percent of physician revenue) and hospitals (mainly private, non-profit and paid by global budgets) generates excessive use of services, forecloses opportunities for integration and coordination, and deserves a heavy dose of the managed care (and/or managed competition) in which Canada has to date shown little interest. These aggravations all flow in some measure from the system’s costs, which though well below those of the U.S., stand high enough and rise fast enough perpetually to distress Canadian leaders.

What insights might the U.S. take from the success (for so it is on any reasonable definition or measure) of Canada’s system? It is tantalizing to picture a federal “compact” in which the U.S. states, like the Canadian provinces, agree to a fund-sharing formula accompanied by five (or however many) criteria that assure to all citizens accessible, comprehensive, portable, properly managed health services. The Canadian case also shines light on some possible mine fields along the way, however. In the political run up to Medicare, Canadian employers did not cling on principle to health insurance as a fringe benefit for workers or ideologically bash a “big government takeover” of the health sector. Canadian physicians remain independent private practitioners subject to little clinical monitoring or interference, but “collegiality” is not capitulation by the State: they agree collectively to negotiate their fees with provincial ministries of health and, overall, earn less than U.S. counterparts. And, perhaps most important, Canada’s federal authorities gave private insurers a swift shove to the sidelines of the system and have (so far) insisted that they stay there. For all the grumbling about the distasteful features of the US health insurance industry it is not easy to picture US policymakers doing something comparable.

Germany

The German health care system, quite the opposite of single payer, has been since its creation by Otto von Bismark in 1883 a social insurance model, reliant in 1910 on 23,354 occupation-based sickness funds (Leichter, 1979, 124), a universe that declined to about 1,000 by 1990, and that now contains roughly 250 funds, competing and open to all customers, wherever employed. The system draws funds mainly from payroll taxes shared half and half by

worker and employer. This financing method has much-noticed limitations: it allegedly discourages the formation and expansion of businesses, is at the mercy of the dependency ratio (given Germany's low birth rates a shrinking number of workers must sustain benefits for a growing number of beneficiaries over time), and it fails to tap "modern" sources of wealth such as real estate and stock holdings. Germany, therefore, has very recently begun emulating France by infusing more general revenues into the health accounts, thus blurring the distinction between Beveridge and Bismarck models. The latest round of German reforms also aims to fill a small but important gap in the fabric of universal coverage--200,000 self-employed residents who were not hitherto eligible for the statutory regime.

The German constitution (Basic Law of 1949) assigns to Germany's federal government responsibility for designing the benefits, eligibility, funding, and payment rules for the public health insurance system. The Länder (states), which since unification in 1990 number 16, are in charge of planning, building, licensing, and monitoring hospitals. (About half of Germany's acute care beds are in public hospitals owned by the Länder; roughly 35 percent are in nonprofit hospitals often run by religious orders; and 15 percent are in for profit facilities. Hospital physicians are generally salaried, whereas their community counterparts are paid mostly fee for service.) The hospitals of course depend on funds from the public insurance system, so the federal and land levels share authority for determining hospitals rates and payments. (Altenstetter, 1999, 66)

German health care policy honors what Altenstetter and Busse (2005,125,138) call the three S's: solidarity, subsidiarity, and self-governance. Solidarity—universal and equitable coverage and the cross-subsidies required to sustain these goals—falls largely to national policy. Subsidiarity—the making and running of policy should be entrusted to local units insofar as possible—honors the turf of the Länder, which themselves embody strong regional identities that antedate the creation of the German nation in 1871 and have by no means disappeared. (Altenstetter, 1999, 54, 81, n.3) Self-governance adds a distinctively German element to the equation—delegation (within a framework of federal and Land rules) of many decisions to national and regional (Land-based) associations of sickness funds and associations of sickness fund physicians, which bargain over matters of mutual interest, especially the monetary coefficients of medical procedures listed in fee schedules. The result, wrote William Glaser (1978, 110, 109) some years ago, is "national uniformity with provincial flexibility," a model for Americans of how "government can enact the rules and then leave the doctors and sick funds to carry out the program with little government interference." More recently, Altenstetter and Busse (2005, 124-125) characterize the German state (presumably both the federal and Land levels) as "regulator, facilitator, and enabler to the parties in corporate self-governance."

Admirers of the German system laud its "cooperative federalism," under which the national government makes policy and the lander and the national and land-based corporatist associations of sickness funds and providers implement it. Critics of German federalism complain, however, that it can make the price of cooperation unacceptably high. The lander have a large hand in making as well as implementing policy because they are constituent units of the upper house of the German parliament, the Bundesrat. Legislative proposals go first for debate to this body, which can withhold approval from some statutory categories. A majority party at the head of the federal government may encounter an opposition majority (or no clear party

majority) in the Bundesrat, which can stymie legislation and occasionally oblige federal ministers to make policy via “federal ordinances.”

These structural arrangements give voice to the lander: the views of land-level political leaders and bureaucrats are “known from the very beginning of the federal legislative process.” They also prompt critics to lament that the lander are a “cartel” and a “decision trap.” (Altenstetter and Busse, 2005, 129-30; Altenstetter, 1999, 70-71) The Länder successfully “vetoed” plans to put tougher controls on spending for drugs and physician salaries in 1999 (Altenstetter and Busse, 2005, 132), have been slow to advance national policies favoring closer integration between the community and hospitals sectors of care (Altenstetter, 1999, 61) and, seeking to maintain a “regionalized landscape” of sickness funds, have lately resisted proposals to consolidate and thus reduce the number of funds. (Bode, 2006, 202)

Since enacting in 1993 the legislation that gave its population a choice among sickness funds, Germany has flirted with managed competition, a development that piqued the interest of U.S. would-be reformers in the Clinton years. The advent of competition ushered in predictable protections—funds, for example, cannot turn away applicants or tailor premiums to health conditions and are compensated for the risk profiles with which they end up by risk-adjusted payments determined by a federal formula— and equally predictable debates— for instance, do the risk adjustment mechanisms “work”? Do the competing sickness funds think they work fairly? Might the new competitive ethos not insidiously undercut solidarity in practice? (For an excellent and uncommonly full discussion of techniques of informal risk selection, see Bode, 2006, pages 193-194.) Moreover, although the (limited) price competition the scheme permits has triggered some (limited) switching among funds, the system’s de facto unwillingness to break the longstanding norm that any German physician can treat any member of the statutory plan leaves the selective contracting that is now officially permissible little practiced, at least to date. In Germany, then, managed competition comes unaccompanied by “managed care”— the reverse of the American picture. (Brown and Amelung, 1999)

The German system holds several “lessons” for the U.S. First, if U.S. employers were to accept mandatory contributions to the coverage of workers and citizens more broadly—a very big “if”—one would expect vigorous complaining by them and their ideological allies about damage to economic growth and the unfitness of social insurance financing in modern times. This implies that a Medicare program continually alleged to teeter near bankruptcy may be hard to expand “for all” and that general revenues (and the taxes that supply them) will be a crucial and growing component of universal coverage. Second, although German physicians (fee-for service in the ambulatory sector, salaried in hospitals) retain wide clinical freedom, the collective bargaining with associations of sickness funds that determine their incomes has led to discontent and, of late, strikes, unheard of in the past. Third, the U.S. too could avert the “big government” inherent in a single payer system—so long as its health insurance firms morphed into health insurance institutions (private bodies with a public charter, as the Germans have it) competition among which would be governed by firm rules that, among other things, proscribe preferred risk selection. Fourth, a pervading and sometimes messy federalism can obstruct health reform in Germany, as in the U.S., but is less likely to do so if, as in Germany, universal and equitable health coverage is an undisputed duty of the national government and the values of subsidiarity (“government close to the people”) and self-governance are not allowed to trump solidarity. The

uses and limits of federalism in health policy are, in short, mightily context dependent.

Switzerland

The Swiss system is insurance based (unlike Canada), but the insurance is funded not from the payrolls of workers and firms (as in Germany) but rather from the checkbooks of individual citizen/consumers, who since 1996 have been mandated to buy coverage. The Swiss constitution, like Canada's, officially vests power over health affairs mainly in subnational units, and like Canada's, the Swiss system is highly decentralized. This nation roughly the size of Maryland is sometimes said to have 26 different (cantonal) health systems. Like the United States, the Swiss political system bristles with veto points— in this case, requirements that major legislation be approved in popular referenda. (A fine account of Swiss health politics through the late 1980s is Immergut, 1992, chap. 4.) These high hurdles for system “overhauls,” breached only in 1911 and 1996, have, as in the U.S., brought down promising reform proposals, which then linger on the agenda awaiting another try on a better day.

Until very recently scholarly accounts of cross-national health policy seldom took note of Switzerland. That system is now enjoying at least 15 minutes of fame because it combines three features of great interest to American reformers, namely, an individual mandate, “consumer driven” insurance (Herzlinger and Parsa-Parsi, 2004), and not inconsiderable discretion for and diversity among the cantons. Less frequently remarked is the framework of national rules that govern the system. Before 1996, health insurers were allowed to tailor premiums to risks, but now, in an explicit affirmation of solidarity, the national government requires all insurers to offer a basic package of benefits, to set community rates, and to take all applicants. (Medical exams and differential premiums are allowed, however, in supplemental insurance contracts.) That government proscribes for-profit insurance firms, mandates and defines a risk adjustment formula to level the playing field among insurers, reviews the compliance of insurers with national law, and audits (and can reduce) their proposed rates (European Observatory on Health Care Systems, 2000, 29). It also requires that the cantons define eligibility and levels for related premiums for consumers who could not otherwise afford what is offered in their canton (about a third of the population is subsidized, and cantonal policies vary considerably), precludes selective contracting among providers by insurers (except by managed care plans), and sets national fee schedules for payments to providers, the monetary value of which is negotiated in each canton by associations of insurers and associations of physicians and “endorsed” by the cantonal government. (European Observatory on Health Care Systems, 2000, 15) Swiss citizens do indeed get to choose among insurance plans that compete on price (premiums, size of deductibles, and copayments), choice of provider (HMO and other managed care variants are available, though their penetration is low so far), and service amenities (administrative efficiency, quick handling of queries on the telephone, and so on). But, as noted above, the public—national—rules of the insurance game are many and stringent.

Official cantonal duties, as in Germany, center mainly on the construction, running, and (partial) funding of hospitals (249 of which were publically owned or subsidized and 143 private in 1999) (Herzlinger and Parsa-Parsi, 2004, 1215); planning and delivering public health

services; and overseeing negotiations on prices between insurers and physicians. The number and type of insurance plans differs among cantons, as also of course does the distribution of physicians, hospitals, and other resources.

Some key features of the Swiss system are but a decade old (including the individual mandate and the shift from employer-based to consumer- driven funding), and thoughtful Swiss would remind American enthusiasts that this reformed system remains a work in progress. As in the U.S. (and Canada and Germany) Swiss policymakers are distressed that health costs are so high (according to the latest OECD data, in 2005 the nation spent 11.6 percent of GDP and \$4,177 per capita on health care, second only to the U.S. in relation GDP, and, for per capita spending, third behind the U.S. and Norway). Moreover, out of pocket costs are high (in 2002 in Switzerland these ran to \$1,149 per capita, as contrasted with \$302 in Germany and \$281 in France) (de Jong and Mosca, 2006, 5) and cantonal spending on health services ranges widely— from \$2,452 per capita in the canton of Geneva in 2002 to \$1,103 in Appenzell-Innerrhoden) (deJong and Mosca, 2006, 8)

Analysts round up the usual suspects: Switzerland has the highest hospital density and highest concentration of high-tech equipment in Europe (European Observatory on Health Care Systems, 2000, 35), a high physician-to-population ratio, an abundance of specialists, high expenses for chronic care, restrictions on selective contracting, too little managed care, an expanding list of mandated benefits, and so on. Some critics charge that efforts to boost efficiency are damaging equity. Insurers cannot legally turn away high-risk applicants but they can and allegedly do discourage them informally, partly because the national risk-adjustment formula is widely agreed to need work. The financing system is said to be regressive, inflicting on Swiss citizens very high out of pocket payments that (incidentally and ironically) have demonstrably failed to curb the rise of spending. Consumer choice among competing insurers has triggered “little switching . . . and little price convergence.” Indeed between 1996-2000, rates of switching among insurers, already low, declined further, suggesting that amid so many choices consumers find themselves unable to “make an effective selection.” (De jong and Mosca 2006, 12; quoting Frank and Lamirand) The premium subsidies for the less well-off do not keep pace with the costs of coverage— perhaps because this lag may encourage membership in managed care plans, on which some policymakers pin hopes for cost containment. Finally, planning for the number and distribution of hospitals and physicians and for the prevention of illness and promotion of health are said to suffer from lack of coordination among the cantons.

Could the U.S. “do” the Swiss system? It could indeed IF it were willing to couple an individual mandate with a long list of central constraints on health insurers, craft public subsidies that offset the regressive effects of a shift in funding from employer-based to consumer-driven insurance, create fee schedules as a basis for bargaining with the medical profession over payments, and give states a large say about the size and character of the hospital system, among other reforms. Simply to scan the list is to see that the present and potential goodness of fit between the Swiss and U.S. systems is much more problematic than surface inspection suggests.

Conclusions

The three federal systems scanned here in search of lessons for the U.S. have distinct

financing approaches (single-payer in Canada, social insurance supplemented by general revenues in Germany, “consumer driven” in Switzerland), but all three in their various fashions honor the adage that one must first centralize policy before one can effectively decentralize it. All have achieved universal coverage by including everyone (Canada) or permitting (Germany) or requiring (Switzerland) everyone to join the system. None grants autonomy to business in the offering and funding of coverage: in Canada business supports the health system (and the rest of the public sector’s budget) via general corporate taxes, in Germany employers have long been obliged by federal law to contribute 50/50 with workers into social insurance funds, and Switzerland’s 1996 reform largely took business out of the health financing picture (employer contributions now come only to 6 percent of the funds in the system).

In all three nations physicians are largely independent, fee-for-service “private” practitioners whose fees are set by means of bargaining over nationally- designed fee schedules between their associations and either provincial authorities (Canada) or associations of insurers (Germany and Switzerland) In none are managed care organizations an important source of employment for physicians. In all three subnational discretion applies mostly to hospitals, in the planning, construction and funding of which the provinces, lander, and cantons play large roles. All three complain of excessive (albeit declining) hospital beds, admissions, and lengths of stay; decry lack of integration between the ambulatory and inpatient sectors; and intimate that the power of subnational units over “their” hospitals is an obstacle to integration and streamlining. All three laud the promise of public health and health promotion to improve the health of their populations and (potentially) the fiscal picture of the health systems, and all three offer mea culpas for not doing more on this score. All three say (and may even believe) that advances in information technology, evidence based medicine, and health technology assessment will improve their systems in numberless ways.

One of the three, Canada, contemplated retaining insurance firms whose premiums would be offset by income-related public subsidies, concluded that the financial and administrative costs of doing so were too high, and summarily relegated insurers to a market strictly supplementary to the public single payer plan. The other two have competing sickness funds but constrain their rates, proscribe risk selection, forbid profit making by firms, and mandate benefits. All three (though Canada less so) rehearse the virtues of managed care, but none (yet) shows much taste for selective contracting , which would trigger pitched battles with physicians long accustomed to treating any patient who selects them.

For the U.S. the good news is that well-working (albeit costly) systems of universal coverage are eminently compatible with federal systems of government. The bad (at least disconcerting) news is that emulation of their achievements in the U.S. would require several major departures from its current system. The minimum workable package would include: central rules of the game such as Canada’s five principles that govern fund sharing between the central government and the provinces; the elevation of health coverage from a fringe benefit of employment to an entitlement of citizens, thus telling business in effect to pay its fair share into national and/or state budgets and then butt out; requirements that physicians accept (hence presumably agree to bargain collectively over) fees set by subnational payers, insurance institutions, or some combination of government and insurers; and constraints on or elimination of business practices now central to profit or revenue-maximizing firms in a health insurance

“industry” unique among Western nations. Such provisions make sense if the U.S. decides that universality, equity, and solidarity should be guiding principles of health reform. Within such a context, federalism can be part of orderly arrangements in which subnational units sometimes lead, sometimes follow, and sometimes get out of the way. But refiguring federalism is no reform panacea. The health policy records of other nations have much to say to American reformers, but whether these latter care, and can afford politically, to listen is an open question.

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