

The Form and Context of Federalism: Meanings for Health Care Financing

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Abstract This article examines the meaning of federalism for health care financing (HCF) and is based on two considerations. First, federal institutions are embedded in their national context and interact with them. The design and performance of HCF policy will be influenced by contexts, the workings of the federal institutions, and the interactions of these institutions with different elements of the context. This article unravels these influences. Second, there is no unique model of federalism, and so we have to specify the particular form to which we refer. The examination of the influence of federalism and its context on HCF policy is facilitated by using a transnational comparative approach, and this article examines four mature federations: the United States, Australia, Canada, and Germany. The relatively poor performance of the U.S. HCF system seems associated with the fact that it operates in a context markedly less benign than those of the other national HCF systems. Heterogeneity of context appears also to have contributed to important differences between the United States and the other countries in the design of HCF policies. An analysis of how federalism works in practice suggests that, while U.S. federalism may be overall less favorable to the development of well-functioning HCF policies, the inferior performance of these policies is to be principally attributed to context.

Federalism is a system of government in which “sovereignty is constitutionally split between at least two territorial levels so that units at each level have final authority and can act independently of the others in some

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area" (*Stanford Encyclopedia of Philosophy* 2006). This article explores the implications of this split in authority in the United States in the area of health care policy and, more specifically, the arrangements that the United States uses to finance health care. Paul Pierson (1995), in discussing the significance of federalism for social policy, observes that federal institutions are embedded in their contexts and will be influenced in their workings by those contexts. If we fail to take explicit account of this, we risk attributing to federalism effects that are, in reality, the product of context or the result of context and federalism interacting. There is no unique form of federalism; there are, so to speak, different "national brands." Pierson suggests that it may be possible to isolate the impact on policy of a given national form of federalism by comparing how it works with how other national forms of federalism work. If it is agreed that context is important, this means that we also have to compare the different national contexts.

The study of federalism and health care financing (HCF) in these terms is complicated. This article uses a simplified approach. It places the United States at center stage and systematically compares it with other mature federations—Australia, Canada, and Germany. It looks at the performance of HCF arrangements in the four countries using four common criteria: universality of coverage, comprehensiveness of the health care package provided, financial accessibility to entitlements, and portability of entitlements. The article then examines the contexts in which the different federal systems and, by extension, national HCF policies operate. Context is assumed to have three principal dimensions: the nature of the sentiments of social solidarity held by the national citizenry, the form of constitutional and statutory rights to health care in place in a country, and the magnitude and complexity of HCF arrangements. Basically, we are interested in how these contextual dimensions condition HCF performance. The article goes on to address the question of how federalism in the United States and the three comparator federations may influence HCF performance. The working of the different forms of federalism and their possible significance—positive or negative—for HCF performance is explored in terms of four further dimensions: how responsibilities for health care (and for HCF) are allocated between different levels of government, how the federal power of the purse is used to influence states' behavior in the HCF sector, what the extent and character of intergovernmental cooperation and negotiation are, and what the internal politics of the federation are. The article concludes by gauging—albeit very tentatively—the relative importance of federalism and context for the performance of HCF in the United States and the other three federations. Since

U.S. readers may not be familiar with the comparator countries' HCF systems, the article begins with a brief description of these, indicating how they differ significantly from the U.S. system.

The Accidental System

The U.S. health insurance system has been described as “accidental” in that, unlike many other countries' systems, the origins for its HCF arrangements cannot be traced back to a single or even a few legislative events (Gabel 1999). Germany applied the principle of statutorily mandated social insurance to health care as far back as 1883. The current system in that country is largely governed by a single statutory instrument, the *Sozialgesetzbuch V* (*Social Codebook V*). The Australian system is based on principles contained in the Health Benefit Act of 1946, the National Health Act of 1953, and the Medicare Act of 1984. The Canada Health Act of 1984 consolidated previous legislation of 1948, 1957, and 1977 and set down basic principles that still govern the health care system of that country. In contrast, the U.S. system grew incrementally over time, scheme being added to scheme.

The three comparator federations rely on a small number of public or quasi-public programs for financing the health care of the vast majority of the population irrespective of age, state of health, income, or labor-market status. In Australia, all citizens have access to most health care regardless of their ability to pay. There are two national schemes—Medicare for medical services and the Pharmaceutical Benefits Scheme—plus publicly financed hospital care; all three are financed by federal and state grants funded by tax revenues (including a compulsory Medicare levy on individual income). There are also small programs for the native population and for certain federal employees (like police and military personnel). Roughly 70 percent of total health expenditure is publicly financed; of the remainder, over one-half is out-of-pocket. Over 40 percent of the population has private health insurance, but this accounts for only about 7 percent of total health expenditure (Hilless and Healy 2001).

Canada has one principal public scheme, Medicare, a nationwide network of provincial health insurance programs financed by federal grants to the provinces and by provincial tax revenues. There are also relatively minor supplementary schemes funded entirely by the provinces that cover services not included in Medicare. Also, Canada has small programs for native populations and for certain categories of federal employees. Private insurance is relatively unimportant for the share of total health expendi-

ture (11.2 percent) it represents. Until recently, by law, it could only cover services not provided under Medicare (Marchildon 2005).

The German system is rather more complex. It consists of almost three hundred nonprofit social health insurance funds, financed with obligatory contributions by employees and employers and by private insurers. However, there is considerable uniformity. All employees with income under a certain level must enroll with a fund of his or her choice. These funds offer broadly similar benefits but levy different contributions, and all are subject to the same regulatory framework. Persons with higher incomes can opt to remain with a social health insurance fund or to insure themselves privately. Most choose the first option. Mandatory social insurance covers 74 percent of the population, and voluntary social insurance covers 14 percent. Private insurance covers 9 percent of the population, including higher-income persons opting out of the funds, self-employed persons, and active and retired public employees (including police and military personnel), whose health care costs are reimbursed by the federal government or *länder* (state) governments. Private health insurance accounts for 12.5 percent of total health expenditure. The contributions of the unemployed are paid by another branch of the social insurance system, the employment insurance funds (Wörz and Busse 2005).

In the United States, responsibility for financing health care is spread over numerous schemes. Employer-based health insurance (EBI) is by far the most important in terms of enrollees, covering just over 60 percent of the nonelderly population in 2005. Directly purchased private insurance protects another 6 percent or 7 percent. Another 17 percent is covered by an array of government programs—Medicare for the elderly (42 million) and for the permanently disabled (5 million), means-tested Medicaid for low-income persons (50 million, including aged and permanently disabled dual eligibles), the State Children's Health Insurance Program (SCHIP) for low-income working families (4 million), TRICARE for career military (9 million), and Veterans Health Administration (VHA) for non-career veterans (7 million). There are also minor federal schemes such as the Indian Health Service (1.5 million) and programs financed entirely by the states. The relative importance of the schemes changes if we look at expenditure, because EBI accounts for only one-third of total health spending, with most of the remainder borne by government. Despite this array of programs, the three-year (2002–2004) average of persons without insurance for an entire year was 45.8 million (U.S. Census Bureau 2005). These uninsured persons largely depend on safety-net providers. It is estimated that over 80 percent of the cost of uncompensated care is met

by federal, state, and local governments (mainly federal) “through a maze of grants, direct provision programs, tax appropriations, and Medicare and Medicaid payment add-ons” (Hadley and Holahan 2003: 78). Finally, tax expenditure represents the public dimension of EBI; tax deductibility of expenditure by employers for employee health insurance coverage is estimated to have cost the federal treasury \$188.5 billion in 2004 (Sheils and Haught 2004).

How the Health Care Financing Systems Perform

Comparison of the performance of HCF arrangements in the four federations requires common criteria. Four are used here, borrowed (somewhat modified) from the 1984 Canada Health Act, which specifies the conditions that the provinces have to meet in order to receive federal funds for health care (Health Canada 2004). “Universality” requires that all residents of a province, state, or *land* be entitled to public health insurance coverage. “Comprehensiveness” requires that all medically necessary services provided by hospitals and doctors be covered under the health care insurance program. “Accessibility” requires reasonable access, unimpeded by financial barriers, to medically necessary hospital and physician services. “Portability” requires that insurance coverage be maintained when a person moves geographically or changes or loses a job. This article adopts a minimalist approach in measuring performance. Ideally, over and above guaranteeing that all have access to a wide range of health care services regardless of income or geographical location, we would probably also like to assure timely, good-quality, and appropriate care, and some countries have, in fact, made legislative provisions for this. Moreover, a minimalist approach ignores the fact that a population’s state of health is a function of many factors in addition to the availability of care. However, the jury is still out on how to get internationally comparable measures for these concerns. Perhaps a more telling criticism of the approach used here is that in the United States many might not agree that an “ideal” system is one that satisfies these four criteria, and for that matter, not all the criteria command universal support in the comparator countries. Nevertheless, even if many oppose or are wary of national health insurance, the debate on HCF in the United States does seem to look with favor on or at least does not preclude policies that could bring the overall system to much greater respect for these criteria, for example, the widespread concern with the large and growing numbers of uninsured (universalism

and continuity or portability of coverage) or the strong popular support for Medicaid for the aged to help them meet Medicare co-payments (financial accessibility). The criterion of comprehensiveness attracts less support but is by no means shunned. In any case, the four criteria are proposed here as a reference framework, not as policy imperatives. The fragmented and heterogeneous character of the U.S. HCF system means that judgments on its overall performance make little sense unless accompanied by appraisals of the performance of the individual schemes. This, however, makes the process of comparison even more complicated. Table 1 is intended to serve as a kind of road map to help the reader navigate the appraisal of HCF performance. Naturally, like any map, it represents a highly simplified picture of reality.

Universality of Coverage

In Australia and Canada, health insurance is obligatory and practically the entire population is covered, regardless of labor-market status. Up to a certain (high) level of income, insurance is also obligatory in Germany. Virtually all persons above that level have public or private insurance, however, and only 0.3–0.5 percent of the German population has no health insurance at all (Wörz, Foubister, and Busse 2006: 2). This contrasts with the 15.7 percent of the total U.S. population that was without insurance in 2004 (U.S. Census Bureau 2005: 60). There is wide geographical variation, ranging from 8.5 percent in Minnesota to 25.1 percent in Texas (*ibid.*: 27, table 11). However, to get a real idea of respect for the universality standard, we must look at the single schemes, each of which has its target population. Some schemes provide universal coverage. The military TRICARE guarantees care to all career military personnel in service, virtually all their dependents, and retirees and their survivors. Medicare can be considered to offer virtually universal coverage for the aged: in 2004, only 297,000 persons over sixty-five (0.8 percent) had no health insurance (*ibid.*: 18). Other schemes fall down quite badly for this criterion. Employer-based health insurance is voluntary: employers are not legally obliged to provide health insurance, and employees are not required to accept it. The proportion of workers covered by EBI varies widely between states. In Minnesota, Massachusetts, Wisconsin, and Ohio, it exceeds 80 percent, while in New Mexico and Arizona the figure is 63 percent (Kronick, Gilmer, and Rice 2004). Overall, the coverage offered by EBI is declining quite rapidly, down from 62.6 percent of the population in 2000 to 59.8 percent in 2003, a decline of 3.7 million

Table 1 Performance of Health Care Financing Systems: A Summary

Country	Performance Criteria			
	Universality of Coverage	Comprehensiveness of Care	Financial Accessibility	Portability of Protection
Australia	Complete	Very broad with some cost-effectiveness restrictions	Out-of-pocket expenditure; co-payments with exemptions	Complete
Canada	Virtually complete	Somewhat restricted for some services	Out-of-pocket expenditure	Restrictions in some provinces
Germany	Virtually complete	Very broad	Out-of-pocket expenditure; co-payments with exemptions	Complete
United States				
Employer-based health insurance	60% of population	Excellent to mediocre	80% of employees paid deductibles; sizable co-payments	Limited
Military TRICARE	Complete	Very broad	Deductibles and co-payments for dependents	Complete
Veterans Health Administration (VHA)/Veterans VHA/Civilian Health and Medical Program of Veterans Affairs	Depends on annual Veterans Affairs budget appropriation 3.9 million dependents without insurance but ineligible for VHA care	Very broad	Co-payments with exemptions	Complete
Medicare	Virtually complete	Very limited	High co-payments	Complete
Medicaid	25% of poor uninsured	Broad but excludes long-term care	High co-payments, some paid by Medicaid	Complete
State Children's Health Insurance Program	Over 11% of children uninsured	Broad	Limited co-payments	Very limited
			Limited co-payments	Very limited

persons (U.S. Census Bureau 2005: 60). This fall in coverage by EBI has been, according to the U.S. Census Bureau (2003: 1), the factor "driving the overall decrease in health insurance coverage." For noncareer veterans, the VHA operates a complicated system of eligibility requirements to stay within its annual capped budget. Although this budget and the number of enrollees have increased considerably over the last decade, 1.7 million veterans were estimated to be without either any other form of insurance or health care from the VHA, and 3.9 million members of veterans' families had no health insurance and were ineligible for VHA care (Woolhandler et al.: 2005).

Medicaid also performs badly for this criterion: 13.7 million or 37 percent of nonelderly persons defined as poor had no health insurance in 2002, and 12.3 million or 28 percent of near-poor persons were in the same position (Kaiser Commission on Medicaid and the Uninsured 2004). However, Medicaid coverage has greatly expanded over time, mostly because of the liberalization of mandatory and optional eligibility rules, for example, regarding pregnant women, children, and the aged (Gruber 2000). The number of persons benefiting from Medicaid varies widely geographically, reflecting interstate differences in eligibility rules. A study of thirteen states for 2002 reported, for example, that only 26 percent of low-income parents were eligible in Colorado compared with over 90 percent in Minnesota (Davidoff, Yemane, and Adams 2005). Overall, one-quarter of the total low-income population and one-third of low-income adults are without insurance (Holahan and Pohl 2003). For families with household income below 200 percent of the federal poverty line, SCHIP allows states to extend Medicaid coverage to uninsured children. The Urban Institute estimated that Medicaid and SCHIP together had the potential to cover 98 percent of uninsured children (Kaiser Commission on Medicaid and the Uninsured 2002), but over 11 percent of all children were without health insurance in 2004 (U.S. Census Bureau 2005). Finally, safety-net care does not reach all uninsured persons. In 2003, the percentage of uninsured adults who were unable, for reasons of cost, to see a doctor when needed over the previous eighteen months was 37.7 percent, 43.2 percent, or 43 percent, depending on whether a person was Hispanic, black-non-Hispanic, or white-non-Hispanic; there are also considerable interstate differences (State Health Access 2005: tables 6a, 7a). Another indication that safety-net protection may be inadequate is that expenditure on this by the federal government, the principal source of funding for safety-net provision, has failed to keep up with the increase in the number of uninsured persons. Between 2001 and 2004, the cost of

medical care rose by almost 14 percent, but federal expenditure on the safety net rose in real terms by only 1.3 percent. In the same period, the number of uninsured rose by 11.2 percent. As a result, federal expenditure for safety-net care fell by 8.9 percent from \$546 per uninsured person in 2001 to \$498 in 2004 (Hadley et al. 2005).

Comprehensiveness of the Benefit Package

Australia guarantees a very wide range of services available on uniform terms and conditions throughout the national territory, with the services actually supplied being determined by the availability of public funding and, in the case of drugs, by criteria which limit the prescription of certain drugs for which there are more cost-effective alternatives.

Historically, the federal government in Canada has adopted a rather restrictive definition of comprehensiveness compared with the other federations. Chiropractic services, physiotherapy, dental care, and cosmetic surgery have been excluded, and only since 2004 has some federal financial aid been given to the provinces for covering prescription drugs outside hospitals, long-term care, adult residential-home care, and domiciliary care. All provinces offer supplementary coverage under separate schemes for some or all of these services, but the terms and conditions of this have varied geographically, and some provinces are refusing to cover some services not included in the federal entitlement, such as physiotherapy and chiropractic treatments (*Economist* 2004a).

In Germany, regardless of their social health fund, enrollees have access to a rich and wide catalog of services listed in broad terms in the *Sozialgesetzbuch V*. More detailed lists are contained in the *Rahmenverträge* (framework contracts), which are negotiated at the national level between the self-governing associations. Also, in Germany, there is a growing tendency to limit coverage on the basis of cost and of clinical effectiveness.

In the United States, just as with universality of coverage, respect for the comprehensiveness criterion varies according to the scheme. Enrollees in EBI enjoy widely differing protection. Historically, employees in high-paying industries tend to have had richer protection than their counterparts in low-paying industries; nonunionized companies tend, in general, to have guaranteed a poorer package than unionized ones (Jecker 1993: 660); and larger firms tend to have offered somewhat better benefits than smaller firms (Kaiser Commission on Medicaid and the Uninsured 2002: 7). Employees often have the option to choose between different health care packages with different costs and the lower their wages, the more

inclined they are to opt for less-costly (and less-comprehensive) coverage. Military TRICARE offers a very broad benefit package. Since 1996, all veterans who qualify for enrollment with VHA have access to a supposedly comprehensive and standardized benefits package (Department of Veterans Affairs 2003). Recent research suggests that, judged in terms of process quality, VHA is now superior to commercial insurance, Medicare, and Medicaid (Oliver 2007). Medicare covers hospital services; physician services; outpatient care, including ambulatory surgery, diagnostic tests, and lab services; home health; and since 2006, prescribed drugs; but not long-term care. Considerable interstate differences exist in the average expenditure incurred per Medicare enrollee, ranging from \$3,800 in Hawaii to \$7,200 in Washington, DC. An important expansion in the protection offered by Medicare occurred in 2006 with the introduction of Part D for prescription drugs.

Medicaid provides four distinct benefit packages: one covers most medical needs of families of low-income women and children; another offers the low-income elderly certain kinds of care not available under Medicare; a third protects low-income disabled persons; and a fourth meets the nursing-home expenditures of many of the institutionalized elderly (Gruber 2000). If a state accepts Medicaid funding from the federal government, it must abide by certain minimum federal rules regarding coverage, including that it provide uniform care throughout the state. Federal law also requires that states guarantee a wide range of mandatory services. The state can also cover over thirty optional services and receive federal funds to do so. In addition, the states have considerable discretion in how they define the amount, duration, and scope of services they guarantee. Some states interpret federal standards very liberally; others are less generous, setting a ceiling on the number of prescriptions, doctor visits, inpatient days, and therapies a patient can receive in a month (Weil 2003). States can obtain waivers from the federal government that further extend their discretionary powers, including the power not to provide mandatory services (Mann 2003a). In 2002, about 60 percent of all Medicaid beneficiaries were enrolled in a managed-care scheme, and in some states, this form of provision was almost universal (Hurley and Somers 2003). This probably contributed to create interpersonal differences in benefit packages. Large interstate differences have existed in reimbursement rates for providers, especially for ambulatory care, and this may have contributed to creating geographical differences in availability of services (Sparer 1998). Iglehart (1999: 404) argued that "it is no exaggeration to say that there are . . . more than 50 Medicaid programs." It is held that the Medicaid package

is superior to that offered by Medicare and many EBI plans (e.g., Brown and Sparer 2003).

Under SCHIP, a state can opt to guarantee the Medicaid benefit package, a package provided by a private plan, or a mix of the two. Private plans must guarantee a package equivalent to that available, for example, under the Federal Employees Health Benefits program. If, instead, a state chooses to use Medicaid to meet its SCHIP obligations, it has to guarantee full Medicaid coverage to the children enrolled. Eighteen states and Washington, DC, have chosen the Medicaid option, fifteen have chosen the private plan, and seventeen have chosen a combination of the two. The benefit package that states are obliged to provide under SCHIP is considered to be significantly less generous than that available to children directly helped by Medicaid (Mann and Kenny 2005).

Financial Accessibility

The question of financial accessibility in the comparator federations is somewhat more complicated to treat, and all three perform less well here than on the other HCF performance criteria. In Australia (Hilless and Healy 2001), the health system is funded largely with federal and state tax revenues and a compulsory income-related Medicare levy. Public hospital care is free, as is care delivered by general practitioners and ambulatory specialists, provided that the doctors accept payment of the negotiated fees directly from Medicare (80 percent of doctors). Otherwise, the patient is reimbursed for the negotiated fee and pays the difference as a form of co-payment (on average 15 percent) up to an annual maximum, after which Medicare reimburses the full fee. Prescription drug costs are subsidized for 70 percent, with small co-payments and an annual maximum and exemptions for retirees. In 2000, over 70 percent of health expenditure was funded by taxes, 7 percent was covered by private insurance, and 16 percent was paid for with out-of-pocket expenditure by patients. There has been very little research on the effects of patient-borne costs on accessibility in Australia. Co-payments are uniform throughout the country.

In Canada, health care is mainly funded by tax revenues (around 70 percent) plus, in some provinces, earmarked premiums (Marchildon 2005: 41). The annual premium for British Columbia is C\$648 for a single person and C\$1,296 for a family of three. Ontario has an earmarked income surtax—which is C\$0 for incomes less than C\$20,000 and then increases in steps up to C\$900 for incomes of C\$200,000 and over. Around 12 percent of total expenditure is met with private insurance, and 15 percent

is financed with out-of-pocket payments. Provinces are prohibited from applying co-payments as a condition for federal health care grants. Private insurance mainly complements public insurance and covers services not included in the Medicare entitlement (e.g., 54 percent of drug costs are uncovered). Private insurance pays 34 percent of all drug costs, 22 percent of vision care, and 54 percent of dental care). Private insurance tends to be employer based.

In Germany in 2004, health care was mainly financed with obligatory or voluntary contributions by employees and their employers to nonprofit social health insurance funds (87.8 percent of the population), private insurance (9.7 percent), and schemes for persons in specific categories such as police, military personnel, and the unemployed (1.9 percent) (Wörz and Busse 2005: S144). In 1995, 68.2 percent of total health expenditure was financed with social health insurance, 10 percent with taxes, 6.6 percent with private health insurance, and 10.8 percent with out-of-pocket expenditure (European Observatory 2000: 46). Co-payments have long operated for pharmaceuticals, hospital care, ambulance transportation, and dental care, and in 2004 were extended to cover ambulatory care. Since 2004, co-payments are payable by all patients regardless of income up to an annual maximum of 2 percent of income (1 percent for the chronically sick), with children exempted. Co-payments are uniform nationally. In 2000, 13 percent of insured persons were totally exempt, but research suggests limited knowledge of exemption regulations among the target groups. Little research has been done on the disincentive effects of co-payments. Between 1992 and 2001, co-payments rose from 3.6 percent to 4.3 percent of total social health fund expenditure and now are higher still, but Germany scores well in international comparisons of the financial burden of co-payments (Wörz and Busse 2005: S144).

In the United States, there is substantial heterogeneity between and within health insurance schemes in what enrollees have to pay for services. Thus TRICARE exempts active military personnel from all charges, while their dependents may have to pay fairly high deductibles and co-payments. For example, for those enrolled with TRICARE Extra or TRICARE Standard in 2003, the annual deductible per family was between \$100 and \$300, while the charge for outpatient care was between 15 percent and 20 percent of established fee and for inpatient admission \$11.90 and \$25 per day (Lawhon 2003). Charges tended to be higher for retired personnel and their dependents. The VHA exempts former military personnel with service-related health impairments from payments, but other veterans must share costs and submit to means and net-worth tests. For

inpatient care, they must pay 20 percent of the Medicare deductible for the first ninety days and thereafter 10 percent, plus a co-payment of \$2 or more per day, depending on income. Most outpatient services have co-payments, with the exception of preventive services and some diagnostic tests, which are charged according to income, net worth, disability level, and other factors. With Medicaid, states can impose only nominal co-payments on certain enrollees for certain services, and there are many federal restrictions, including exemption from charges for emergency and family-planning services and an outright ban on cost sharing by children and pregnant women. However, states do have the option of applying a small deductible per outpatient hospital visit, physician visit, drug prescription, and home health care visit. They also can charge up to 50 percent of the amount paid by the state for the first day of hospital care. With nursing-home care, costs can be set against the bulk of beneficiaries' income (Kaiser Commission on Medicaid and the Uninsured 2002: 68–69). As of April 2003, thirty-one states imposed premiums or annual enrollment fees for child health care (\$8 to \$70 per month), and twenty-two required that families with incomes exceeding 150 percent of the federal poverty line pay co-payments for nonpreventive physician visits (\$3 to \$15), emergency-room care (\$5 to \$50), in-hospital care (\$5 to \$100), and/or prescription drugs (\$1 to \$20) (Ross and Cox 2003). States that opt to set up a separate private plan for SCHIP instead of expanding their Medicaid program enjoy additional flexibility regarding cost sharing and can set charges to up to 5 percent of family income (except for preventive services, which are exempt). Of thirty-five states with separate SCHIP programs, thirty-one have introduced some kind of cost sharing, twenty-five require monthly premiums or annual enrollment fees or both, and twenty-one impose co-payments. Most states exempt the poorest families—only eight require premiums for those with incomes less than 150 percent of the federal poverty line. Co-payments are most often required for physician visits (\$2 to \$5), emergency-room visits (\$5 to \$25), and prescription drugs (\$1 to \$5) (Weil and Hill 2003: 302–303).

Other schemes require much heavier cost sharing. This would, of course, be expected with commercial EBI. In 2003, over and above the monthly premium, averaging \$42 for single coverage and \$201 for family coverage, nearly 80 percent of workers paid a deductible. For single coverage the average for all preferred provider plans stood at \$27, but in small firms it was \$492. Over 40 percent of workers face a separate deductible or co-payment for inpatient care (averaging \$200 per admission). Virtually all workers are liable for co-payments for physician office visits

and the vast majority contribute to the cost of drugs. Co-payments are increasing over time (Kaiser Family Foundation 2003a). Medicare also makes considerable use of cost sharing, charging a monthly premium of \$88.50 under Part B (physicians' and outpatient services). It also applies deductibles and co-payments. In 2001, for example (Kaiser Commission on Medicaid and the Uninsured 2002: 71), it set a deductible of \$792 for inpatient stays up to sixty days and \$100 per year for outpatient services. There was no co-payment for inpatient care lasting up to sixty days, but there was a co-payment of \$198 per day from sixty-one to ninety days as well as a 20 percent co-payment for physician services. Until Part D of Medicare was set up, all prescribed drug costs were directly paid by enrollees with private supplementary insurance, by enrollment with a managed-care provider under Part C, or with the help of Medicaid. In 2001, nursing-facility services were free for the first twenty days, \$99 per day for twenty-one to one hundred days, and full price thereafter. Patients had to pay the difference between the charge made by doctors and the fee agreed upon by Medicare out of their own pockets. Medicaid has stepped in to help Medicare enrollees pay co-payments, prescription drug costs, and nursing-home expenses. Under standard coverage of the new Part D, a Medicare beneficiary has to pay an annual deductible of \$250, 20 percent of the costs of drugs from \$251 to \$2,250, and all of the next \$2,850. All additional costs have to be paid by the beneficiary until an annual total cost of \$5,100 has been incurred. Beyond that point, Medicare will pay about 95 percent of the cost of each prescription. Part D is managed by accredited private insurers subsidized by the federal government, and Medicare enrollees have to choose one of these insurers. These insurers must not charge more than envisaged under the standard coverage, but most charge less. Monthly premiums vary significantly.

Portability of Protection

Portability of the entitlement to comprehensive, financially accessible care within the national territory is a feature of the health care systems of the comparator federations. When Germans move for tourism, work, or study to other European Union (EU) countries, they, by virtue of their EU citizenship, have the right to the same range of health care services under the same terms and conditions enjoyed by residents of the country of destination. Some Canadian provinces, especially Quebec, have not respected the portability principle in full, for example, regarding how out-of-province expenditure is reimbursed. Canadians abroad are entitled to reimburse-

ment for services available in their province. Australians are eligible for care in all six states and also abroad if they are in a country with which Australia has signed a reciprocity treaty. In all three countries, health care coverage is unaffected by change of employer or by loss of job because coverage is unrelated to labor market status.

In the United States what happens yet again depends on the scheme. Wholly federal ones—TRICARE, VHA, and Medicare—guarantee virtually complete geographical portability. However, under Medicare Part D, unless enrollees are insured with one of the ten insurance companies operating nationwide, when they change their state of residence, they may have to change their insurer and to accept different (possibly less favorable) conditions. Geographical portability assuredly does not operate under the joint federal-state Medicaid program and SCHIP. Given the substantial interstate differences in eligibility rules and benefit packages under these programs, persons changing state risk seeing their benefit package curtailed, possibly quite drastically, and they could even lose the right to Medicaid completely. Conversely, of course, a move to a more generous state could improve the Medicaid benefit package or even create eligibility where it had not previously existed. A person must be resident in the state to which the request for Medicaid is made and must declare the intention to live there indefinitely, but federal law forbids states from setting minimum residency limits. The most problematic scheme for the portability criterion is, predictably, EBI. The key event here is not a geographical move, but a change in employer or loss of job, in which case employees have no right to remain insured with the same group health plan. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 tries to minimize the risk of discontinuity of coverage accompanying job change or loss. HIPAA requires that insurance plans recognize past coverage and that employees can obtain group insurance provided they have a history of at least eighteen months of group coverage. Persons can be required to wait up to, but no more than, three months before they can join the group plan of a new employer. Federal rules require continuity of coverage for certain services, such as childbirth and mental care, if these were covered previously. Limits are set for the exclusion from coverage of preexisting health conditions, although a waiting period may be applicable if the employee was enrolled in the previous plan for less than twelve months. HIPAA gives powers to the federal Department of Labor to oversee the application of the law by the states and “replaces authority divided between states and federal government . . . with a system in which federal standards undergird all state action” (Ladenheim

1997: 35). Another federal law—the 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA)—protects certain categories of former employees, their dependents, and retirees by giving them the right to temporary continued group coverage. COBRA applies to group plans with twenty or more employees and applies to plans in the private sector and those sponsored by state and local governments but not to federal plans. This type of insurance generally costs more than that for those who are employed, since the beneficiary has paid his or her share of the premium plus the share which would normally be paid by the employer. It is nevertheless cheaper than individual health insurance. Under HIPAA rules, for coverage to be considered continuous, the maximum gap in employment allowed is sixty-two days. COBRA helps employees to avoid costly individual insurance or lack of protection. Despite its apparent advantages, however, many persons fail to use COBRA. For example, during the period 1996–1999, 44.1 percent of all spells without insurance lasted for between two and four months, which is just the kind of gap that COBRA seems designed to fill (U.S. Census Bureau 2003: 12).

The Panorama

A good understanding of HCF performance in the United States is only possible by looking at the individual schemes, and we have to be wary of assessments that only address total system performance. The only scheme performing well for all four criteria is TRICARE for career military. The other schemes have their strengths and weaknesses. The VHA falls down for coverage of its target population, but otherwise it scores well. Medicare covers its entire target population and assures portability, but it is quite weak for the range of services insured and the cost to patients. Medicaid is quite strong on paper for the package of services provided and their cost to enrollees (but both depend a lot on state of residence), however it scores poorly for the coverage and portability criteria. It is impossible to generalize for EBI, because performance rating depends crucially on the employer health plan in question. Many plans are of good quality, and others are weak for all criteria. The evolution of EBI over time has been generally negative, but some public schemes have improved considerably, albeit incrementally, for example, Medicare and VHA for range of services covered and Medicaid and SCHIP for the proportion of target population assisted. Overall, the comparator federations come out looking good, with some reservations for the financial accessibility criterion for Australia and Germany and for comprehensiveness in the case of Canada.

In clear contrast with the United States, the protection citizens enjoy in these countries does not depend on their jobs, their type of job, and how such jobs pay; their age; their parental status; their state of health; and their place of residence. In what ways do these differences between the United States and the other federations depend on the particular context in which federalism operates in each of these countries and on the characteristics of the national brand of federalism operating?

The Context of Federalism and Health Care Financing Policies

The term *context* can encompass many things, but here it is defined in terms of three criteria. One regards the nature of the sentiments of social solidarity that citizens harbor vis-à-vis their fellows. Solidarity is a somewhat abstract notion, but it can be defined as the concept of “mutual help within a group of like-minded people who can bring about a change of circumstances for their benefit by acting as a group” (Graf von Stillfried 1997: 13). Solidarity is about the social protection of social needs and the redistribution of resources. This dimension touches a wide array of issues that have pertinence for HCF policy. Related to social solidarity is the question of whether there are any constitutional or statutory rights to health care. Depending on the form these rights take, they may both impinge upon and reflect HCF policy. A third aspect of context is the size and complexity of the HCF system itself. This factor may affect the capacity of actors in the health domain to understand how the system is working, to design policies aimed at modifying it, and to evaluate these policies *ex ante* and *ex post*. Table 2 summarizes the dimensions of the national contexts that we examine in detail.

Sentiments of Social Solidarity

Historically, social solidarity has tended to be strong in the three comparator federations. Germany has a long institutional tradition in this regard. Busse, Howorth, and Schwartz (1997: 32) argue that in Germany “solidarity, equity and redistribution are interchangeable terms,” citing a federal commission of inquiry on health care reform that affirmed “the importance of a system of solidarity which provides the right of all citizens in Germany to receive a standard of health care that will lead to an equality of national outcomes, irrespective of income, gender, location, etc., underpinning the commitment to equality implicit in the Constitution.”

Table 2 Contexts of National Versions of Federalism: A Summary

Country	Dimensions of Contexts		
	Social Solidarity	Health Care Rights	Size and Complexity of Health Care Financing System
Australia	Very strong	Ill-defined legally but strong in practice	Relatively very small; relatively simple
Canada	Very strong	Ill-defined legally but strong in practice	Quite small; relatively simple
Germany	Very strong	Strong legal basis	Quite large; operation transparent and standardized
United States			
Employer-based health insurance	Very weak	Very limited	Very large; highly complex
Military TRICARE	Very strong	Well defined	Small; relatively simple
Veterans Health Affairs (VHA)/Veterans	Strong	Fairly well defined	Small; complex
VHA/Civilian Health and Medical Program of Veterans Affairs	Seems weak	Ill-defined	Small; complex
Medicare	Quite strong	Quite well defined legally but may be constrained in practice	Large; highly complex
Medicaid	Qualified; varies geographically	Ill-defined	Large; highly complex
State Children's Health Insurance Program	Qualified; varies geographically	Very limited if program separate from Medicaid	Small; quite complex

According to the German Federal Ministry of Health (1994: 28), “Our health system is anchored to the principles of solidarity and subsidiarity.” The solidarity dimension is not as explicit or as formally enunciated in the other two federations, but nevertheless, it seems very present. Two hallmarks of health care reform in Australia are the “preservation of universal tax-financed health care . . . and a continuing commitment to ‘social solidarity’ and equity” (Hilless and Healy 2001: 90). In Canada, “there seems to be overwhelming, continuing support for the baseline values of the Medicare program” (Marmor, Okma, and Latham 2002: 15). Considerable emphasis is given in Canada to the role that social policy plays in defining nationhood and in reinforcing and giving cohesion to the federation (Banting 1995). The national fabric is reinforced by shared values and social programs: for “many Canadians, Medicare is a touchstone of national identity” (*Economist* 2004b).

The question of social solidarity is less clear-cut in the United States. Alesina, Di Tella, and McCulloch (2001: 19) find that “controlling for the personal characteristics of individuals and state/country effects, Americans are not affected by inequality, while there is a well-defined negative effect in Europe.” Expressed somewhat differently, “whereas more Europeans become less happy as inequality in their country rises, the happiness of Americans is unrelated to inequality in their state of residence” (Alesina, Glaeser, and Sacerdote 2001: 238). The *Health Poll Report: Health Care Priorities*, prepared for the Kaiser Family Foundation (2003b), found that health care was not a top priority for citizens. Cited as most important by only 13 percent of respondents, it came after the economy (39 percent) and the war in Iraq (17 percent), was equal with terrorism, but came ahead of tax and budget issues (10 percent), education (9 percent), and crime (5 percent). Robert Blendon and John Benson (2001) report that, in 2000, 63 percent of Americans considered their federal taxes were too high (compared with 46 percent in 1961). Uwe Reinhardt (2003: 384) notes in this regard that already Americans pay relatively low taxes: in 2000, government as a whole in the United States absorbed 29.6 percent of the gross domestic product (GDP) compared with an average of 39.9 percent in Organisation for Economic Co-operation and Development (OECD) European countries. The first George W. Bush administration obtained congressional approval in 2001 for a temporary cut of ten years’ duration in the income tax plus the phased abolition of the estate tax, which benefited less than 2 percent of the population. Plans to make the tax cuts permanent were estimated to cost \$2 trillion through 2012 and \$4 trillion for the decade to follow (Center on Budget and Policy Priorities 2002).

These tax cuts are regressive, benefiting disproportionately, as they do, the higher income groups (Sheils and Haught 2004) and are being made when, in the near future, there will be a need for significantly more resources for Social Security, Medicare, and long-term care under Medicaid, generated by the arrival to retirement age of many baby boomers. Reinhardt (2003: 383), observing that the tax cut consumed the greater part of the budget surplus then existing, argued that the budget legislation containing the tax cut was “the clearest official statement yet of the leadership’s moral sentiment regarding the plight of the uninsured.” However, moral sentiments can change. President George W. Bush’s predecessor, Bill Clinton, declared that “there is a national interest, a national interest in protecting the health care of our children, our seniors, our disabled population. And I believe the American people believe that” (Anton 1997: 707).

The Brookings Institution paper “Why Doesn’t the United States Have a European-Style Welfare State?” points to a values system stressing self-reliance and linking effort with success, which grew out of the United States’ particular history and geography (Alesina, Glaeser, and Sacerdote 2001). Americans, according to polls, are more likely to think that poverty is the fault of the poor, whereas Europeans are more inclined to consider the poor to be just unfortunate. A root cause of the United States’ tendency to redistribute less is, according to the paper, its much greater racial and ethnic heterogeneity. Related to this is the disproportionate representation of ethnic minorities among the poor and welfare beneficiaries (Hodgson 2004: chapter 7). It is not, of course, that Americans do not hold sentiments of social solidarity. The difference with the comparator federations seems to be that U.S. social solidarity is qualified, that is, selective or discriminating. This may have important implications for HCF policy. The stronger and less ambivalent social solidarity felt by citizens in comparator countries probably helps to explain the reliance in those countries on one or a few major health insurance schemes that treat all beneficiaries more or less equally. Instead, qualified solidarity in the United States is reflected concretely in the fragmentation of the HCF system and its heavy reliance on EBI. It also translates into more generous protection being given by public health insurance programs to so-called deserving persons (the aged and permanently disabled and poor pregnant women and children) compared to that given to “undeserving” persons (chiefly poor adults of working age without children). Thomas Anton (1997) points to the billions of dollars that go to middle-upper- and middle-income persons under public health insurance programs and to nursing-home residents who were once middle income but who may now be medically poor—all

persons with a good public image and all deserving. Qualified solidarity may also help explain why even deserving persons are treated differently according to presumed merit (e.g., the civilian aged and permanently disabled tend to be treated better than the non-aged, career military in active service or retired are treated better than noncareer veterans, and poor veterans are treated better than poor civilians) or why legal immigrants have no entitlement to Medicaid (except for emergency care and care for the aged and disabled) until they have lived in the country for at least five years or, in some states, until they become citizens. The way veterans and immigrants have been treated in U.S. society over time provides an interesting case study of how notions of what it means to be deserving or not develop (Schneider and Ingram 2005).

The fragmentation of HCF arrangements probably also reflects something which has been a constant feature of health care reform processes in the United States. During the Depression, a form of health care financing was created whereby public providers created health insurance plans (Blue Cross and Blue Shield) for the local community, and these sold insurance on a voluntary basis to local employers. These plans were originally non-profit, but over time commercial insurers entered the field. This approach seemed to work well, and the American Medical Association, insurers, and even the labor unions claimed there was no need for a national health insurance system. The role of government was, and still is, seen as one of filling the gaps. Thus, only if a group is not covered by EBI (which is driven by the market) and only if it is deserving is government legitimized to make public health insurance provision for it, and as a rule, this is accepted, if at all, only after a struggle. This has been the screenplay for Medicare, Medicaid, and SCHIP. Two thresholds have therefore been faced by government in the United States in its attempt to address health care inequalities: the private sector must have shown itself to be incapable to fill a gap and the intended beneficiaries must be deserving. This has made the U.S. context very different from that in other countries, and it still prevails (Brown 2005).

Social solidarity is probably tempered by selfishness and self-interest in any country, but this seems especially the case in the United States. For example, VHA beneficiaries protested vociferously and effectively against a 1992 proposal by the White House to admit nonveteran Medicaid patients to underutilized VHA facilities, insisting: "VHA for vets only" (Bauman 1994: 4), an interesting result of the fragmentation of the U.S. HCF system. And sentiments of solidarity may be limited even for beneficiaries of the same program. The Catastrophic Coverage Act was

passed in 1988 with wide bipartisan support in Congress. This law provided supplementary insurance coverage under Medicare for serious and costly illness and paid for it with an extra, highly progressive premium; the less affluent thus benefited at the expense of the more affluent who, however, tended to have private supplementary insurance already. The latter protested vehemently, and the act was abolished after a year (Marmor 2000: 112–113; Brown and Sparer 2003: 35). The Health Poll Report cited above found that 74 percent polled believed it was urgent to pass a law for the uninsured, but not at the price of drastically modifying EBI. Moreover, 81 percent of respondents supported increased expenditure to tackle the uninsurance problem even if this meant forgoing tax cuts, but less than 50 percent supported higher taxes for this purpose. Public Agenda, a nonpartisan public-opinion research body, reports opinion surveys in which as many as two-thirds of those polled want the federal government to guarantee universal insurance coverage, but many renege on their good intentions if this were to be funded with higher taxes (Public Agenda 2008a).

Social solidarity in the United States, of course, has its geographic dimension. Classifying states in terms of the depth of their Medicaid coverage (expenditure per enrollee) and its breadth (enrollment as a percentage of the total poor population), one study found that only fifteen states were identified as offering both broad and deep coverage. Those states, mostly in the Northeast and Midwest, tended to have higher income per capita, lower poverty levels, and pride about being more liberal than the nation on average (Boyd 1998). Two interesting studies looked at geographical variations in the percentage of the population covered by EBI. One suggested that such variations might be due to cultural factors that induced some communities to have greater health insurance coverage. An analysis of sixty-six U.S. cities, towns, and counties found that some of these had a “culture of offering” and others did not (Cunningham and Ginsburg 2001). Another (Kronick, Gilmer, and Rice 2004) looked instead at all fifty states and found that the probability that a worker in a given state had EBI depended not only on the worker’s own demographic and employment characteristics but also on those of other workers living in the state. It concluded that there was a strong contextual effect on EBI coverage rates and poetically called this “the kindness of strangers” (*ibid.*). The data given above on the performance of HCF arrangements show that U.S. states vary widely in how they administer Medicaid and SCHIP, presumably in part because of geographical differences in social solidarity. The

most recent demonstration of such differences are the initiatives taken by a limited number of states to introduce universal health insurance.

Transnational comparisons have to be made with care. Would the majority of citizens in the other federations still opt for universal and comprehensive health care with limited cost sharing if they had to make the decision today? Health care approximately fifty years ago (when decisions were being made about the future shape of these countries' health systems) was relatively much less sophisticated than it is today, and the age composition of the population was younger. Public health expenditure was, therefore, much lower, absorbing, in 1960, 2.0 percent of the GDP in Australia, 2.3 percent in Canada, and 1.2 percent in the United States, compared with 6.2 percent, 6.9 percent, and 6.8 percent respectively in 2003 (OECD 2006). The cost to more affluent persons of supporting a strongly solidaristic health care system was lower, probably less obvious, and therefore less painful than it would be today.

Rights to Health Care

Timothy Jost argues that a constitutional right to health care, even if it is vaguely specified, reflects a national aspiration to protect citizens in this sphere (Jost 2003a). It is a concrete expression of social solidarity. The three comparator federations differ regarding the degree of specificity with which citizens' rights to health care are enunciated.

There is a uniquely German rights-based approach to health care (Busse, Howorth, and Schwartz 1997). The German Constitution states that the Federal Republic is both democratic and social and that living conditions should be equal throughout the country. The *Sozialgesetzbuch V* regulates the health insurance funds and sets out the rights of enrollees. Citizens can go to court if they are refused a service by their health insurance fund and can, in theory, arrive at the Supreme Court. Social courts operate at the local, regional, and federal levels and are entirely devoted to social insurance issues, including health insurance. Decisions made by health insurance funds and government regulations can be challenged before these courts. However, the health insurance funds have tended to accord doctors and hospitals considerable discretion in deciding what services to deliver, although this may be changing as concern mounts over the need to contain costs (Wörz and Busse 2005).

There is no constitutional right to health care in Australia. However, all states have consumer rights and complaints procedures and, under the

Health Care Agreements between the states and the federal government, are obliged to set up patients' hospital charters. All the states have created ombudsmen or health care commissioners to administer grievance procedures for all aspects of the health system (Hilless and Healy 2001: 87; Healy 2002).

Canadian residents are entitled to public health insurance coverage as defined in the Canada Health Act, but constitutional jurisprudence has, in general, been reluctant to recognize a general right to health care. There has been a debate on whether the Charter of Rights and Freedoms, section 7, adopted in 1982, includes a right to health care, and there have been some recent sentences that hold that such a right exists (Jackman 2002). However, even if the federal government were disposed to recognize and enforce such a right, it is suggested that it "would probably intrude on the constitutional responsibility of the provinces to administer and deliver health care" (Marchildon 2005: 37). The Canadian Constitution does establish that all provinces should have sufficient resources to provide citizens with reasonably comparable levels of public services for reasonably comparable levels of taxation, and this looks suspiciously like a quasi-constitutional right to health care. The Canadian federal government is, moreover, said to have the duty of upholding the "sacred trust" of preserving the key principles of the health insurance program (Smith 1995), which opinion polls show to be enormously popular (Marchildon 2005: 129).

The link between social solidarity and the right to care therefore is most evident in Germany. It is more tenuous in Canada and Australia, where, although social solidarity is strong, either the societies seem not to have felt the need to translate this into a formal expression of the right to care or there are constitutional problems with doing so. Nevertheless, in these countries, rights are seen to exist, seem to be strong, undergird HCF arrangements, and are common for all permanent residents.

There is no generalized right to health care in either the U.S. Constitution or in federal law. It has been suggested that the constitutional jurisprudence has been too narrow, focusing as it has tended to on negative rights: namely, that citizens have only the right to be protected from government (Parmet 1993). The position taken by the U.S. jurisprudence has generally been that it is inappropriate to create rights that are not explicitly contained in the Constitution and that, if it is considered that there should be a right to health care, this should be determined via the political process. The Supreme Court and the federal courts have tended to interpret federal laws very narrowly, declining to recognize that there may be rights

implicit in the concept of the modern welfare state (Jacobson and Selvin 2005), and some justices of the Supreme Court have in recent years tended to adopt a fundamentalist position in their (literal) interpretation of the Constitution, which, if followed by a majority of the Court, would risk emasculating federal welfare programs (Sunstein 2005). For example, the Court might take the position that the Medicaid law does not create a legally enforceable right of individuals to health care but just a guarantee of federal funding to the states. The lower courts have issued conflicting sentences in this regard (Finegold 2005: 177). Failure by the United States to express such an aspiration constitutionally may not have prevented the creation of specific rights or entitlements to health care, but it has made such entitlements more vulnerable (Jost 2003a).

The interesting thing about the United States is that health care entitlements quite closely mirror the qualified character of social solidarity: the strength and enforceability of rights depend on which insurance scheme people are enrolled with. Jost (2003a: 46) holds that, relatively speaking, the weakest rights are probably those enjoyed by those with EBI. Under the Employee Retirement Income Security Act (ERISA) of 1974, those covered by private employer-sponsored health insurance plans, including the self-insured, are precluded from suing their plan in state court to remedy wrongful denial of health care services; they must go instead to federal court. All others, including government employees and those purchasing individual insurance, can turn to the state courts. Federal courts, however, have been heavily constrained by Supreme Court jurisprudence in granting compensation for damages caused (generally limited to the cost of the service denied) compared with the state courts (compensation for injuries caused by negligent denial of services) (Jost 2004). SCHIP carries no entitlement whatsoever for the children enrolled, if that program is administered independently from Medicaid. Jost (2003b: 146) argues that, although it “was obviously intended to create rights for recipients,” the law establishing Medicaid does not explicitly create any right for individuals to sue to enforce such a right nor — very important — does it establish federal court jurisdiction over suits regarding aid under this program. The Supreme Court has recognized the enforceability of these rights in federal courts, but Congress has so far not embodied this in the Medicaid statute, hence what Jost calls “the tenuous nature of the Medicaid entitlement.” He concludes that to transfer large sums of money to the states for Medicaid and, at the same time, deny federal rights to Medicaid beneficiaries “seems not only unjust but also stupid” (*ibid.*: 152). For what regards safety-net care, a 1986 federal law (the Emergency Medical Treat-

ment and Active Labor Act) establishes that hospitals and other providers must guarantee health care to persons unable to pay for it, but this right has been interpreted very narrowly in the jurisprudence (Jacobson and Selvin 2005). For what regards federal programs, the TRICARE entitlement is very strong. The entitlement under the VHA has been reinforced since the late 1990s, but it is still conditioned by the fact that the VHA has a fixed annual budget, meaning, as we have seen, that large numbers of veterans and their dependents are excluded. Since Medicare is a federal entitlement program, aged and disabled people have the right to go to a federal court to seek protection of their entitlement to be enrolled with it and to receive its services. The principal problem here is that the right to sue has, in practice, been limited by the fact that the courts have preferred that legal action be preceded by recourse to administrative appeal procedures available to enrollees who allege to have been unfairly treated (Mello 2002).

However, this is only part of the picture. Polls register strong resistance by the public to making beneficiaries pay a larger share of Medicare costs—in a 2006 poll, 73 percent of respondents were opposed (Public Agenda 2008b). Those against probably included not only current beneficiaries but also their families in their dual role of children (with the moral responsibility to assist parents) and future beneficiaries. An indirect indicator of the popularity of Medicaid is the demonstrated reluctance of the states to incur the political costs involved with cutting back on optional eligibility groups and optional services during periods of budgetary difficulty, quite apart from these states not wanting to lose federal funds (Holahan and Weil 2003). Jost (2003a: 51) argues, “Ultimately, it is not the Constitution, not even the courts, but the polls that offer the most solid protection to our health-care entitlements.” But protection also comes from organized interest groups. For example, Veterans Affairs (VA) and, therefore, the VHA are sheltered by organizations “whose Washington lobbying and election day clout is legendary” (Bauman 1994: 3). The powerful AARP is prominent among the lobbies promoting Medicare. Medicaid is a vital source of revenues for many providers: it is the single largest source of funding for nursing-home care, with 70 percent of nursing-home residents dependent on it; it pays for 40 percent of all births; and it generates revenues upon which pharmacies, community clinics, AIDS facilities, safety-net providers, and many physicians all rely heavily (Mann 2003a; Park et al. 2003).

For sentiments of solidarity to exert a strong influence on HCF policy, the federal government must be able and willing to act as an agent to promote and protect rights—in Canadian terms, to accept the role of the

repository of the sacred trust. Jost (2003a: 51) seems to allude to such a trust when he argues that “three and a half decades of legislative action, administrative implementation, beneficiary and provider reliance and judicial interpretation have woven Medicare and Medicaid rights *deeply into the fabric of the American state*” (our emphasis). Thomas Anton (1997: 706) thinks the same: “The idea that (social programs) are ‘national’ responsibilities, available to all citizens regardless of where they live, is an important component of our sense of citizenship and is unlikely to be abandoned by either politicians or beneficiaries.” However, public mistrust of the federal government has often coincided with the reluctance of or refusal by the federal executive branch, for political or ideological reasons, to assume a proactive role as protector or promoter of public health care entitlements, emboldening members of Congress to propose drastic modifications of public health insurance programs or major reductions in their funding levels, often veiled in the rhetoric of efficiency or federal budget solvency. In the other federations, this would be tantamount to political suicide. In the United States, only attacks on TRICARE and the VHA are taboo: “Few in Congress have ever voted against a VA appropriation and survived” (Bauman 1994: 9).

Size and Complexity of the Health Care Financing System

The U.S. HCF system is far larger and more complex than those of the other federations (country data from OECD 2006). In 2003, total health expenditure for the United States, expressed in terms of GDP purchasing power parities, was \$1.4 trillion. This was 6.6 times the figure recorded for Germany, the largest of the other federations, 17.1 times that of Canada, and 30.9 times that of Australia. U.S. health expenditure was 4.1 times as great as the sum of that in all three countries. Perhaps even more striking, Medicare and Medicaid both spend more than each of the three countries (expressed this time in crude currency exchange rate terms). The military system (TRICARE plus VHA) spends more on health care than Australia, and VHA alone spends around two-thirds of the total for that country. Spending by some states is also relatively very large. For example, New York, excluding federal transfers, spends more than one-half as much as Australia. There are also marked differences between the U.S. health system and some of its component parts and the other countries for population and enrollees. A single U.S. managed care organization, WellPoint, has almost as many enrollees as Canada has citizens (WellPoint n.d.).

Magnitudes of this nature would seem guaranteed to hinder a good understanding by citizens, politicians, and policy makers of how the U.S. HCF system functions. This system is intrinsically very complex, compared with those of the other countries, in part due to its fragmentation. Schemes are linked and interact. For example, unemployment and loss of EBI create new clients for public insurance schemes and/or safety-net providers. In addition, there is what might be described as the “Wal-Mart effect,” namely increased demand for public health insurance because of firms offering inadequate or no EBI coverage or low wages that make EBI seem like an unaffordable luxury. Changes in services covered or in cost sharing under VHA or Medicare may affect demand for Medicaid, while waivers allowing states to tighten eligibility rules or to limit benefits may increase use of safety-net providers. Finally, relaxation of eligibility rules for Medicaid may discourage persons from taking out private health insurance.

In addition, the operation of individual programs can be awesomely complicated. The Medicare Payment Advisory Commission reported to Congress in 2001 that the Medicare statute accounted for over six hundred pages of the U.S. Federal Law Code and took up two volumes of the Code of Federal Regulations; in one case, one hundred pages were dedicated to explaining three pages of new regulations for providers (Medicare Payment Advisory Commission 2001: 5). The same report noted that the Balanced Budget Act of 1997 contained seven hundred specific directives for what was then the Health Care Finance Administration, a number increased by further legislation in 1999 and 2000 (*ibid.*: 14). Medicare processes 900 million claims by over seven hundred thousand providers annually (*ibid.*: 18). There is a “vast array of regulators and administrators,” and the Centers for Medicare and Medicaid Services (CMS) needs the help of 127 private contractors to administer, regulate, and monitor the program (*ibid.*: 15). Henry Aaron (2003: 802; cited in Reinhardt 2005: 84) describes the U.S. HCF system as “an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird.” There are over fifty state and territorial Medicaid programs, which operate within the framework of federal standards but with considerable discretion in setting rules and regulations. Considering federal rules only, there is a bewildering number of so-called eligibility pathways, which aspiring Medicaid beneficiaries can follow: in 2001, there were fifteen for low-income children,

eleven for disabled children, three for mothers, four for low-income parents, seven for disabled adults, and nine for the aged, and these were only the *principal* pathways for these groups (Kaiser Commission on Medicaid and the Uninsured 2002). States may differ greatly in the number and kind of waivers obtained from CMS and how they use these.

People are quite ignorant about important aspects of the system. One survey found, for example, that the majority of respondents felt that the low-income aged and low-income children merited broadly equivalent levels of government funding for health care. Indeed, most interviewees were under the impression that public expenditure on the aged did not greatly exceed that on children, when in fact it was eight times more (Berk et al. 2004). But there is also ignorance about matters much closer to home. For example, a 2003 survey of workers aged forty-five to sixty-four found that only one in seven had an accurate idea of the services covered or not covered by Medicare (Schur et al. 2004). Many were uninformed about the coverage to which they were entitled under EBI, once retired, and there seemed to be a significant mismatch between persons' expectations concerning coverage and what they were actually likely to receive. They tended, for example, to be ignorant of the fact that employers are cutting benefits for retirees and were vague about how they would finance their health care protection in the future. In general, other than knowing that Medicare is aimed at helping the elderly with their medical care costs, "the public is largely uninformed" about the scheme (Marmor and McKissick 2000). The introduction of Part D to help the aged with their expenditure on drugs has further complicated Medicare for its beneficiaries. Some of the ignorance about the U.S. HCF system may not be, however, because of its size or complexity. One study, commenting on the debate on the Clinton health care reform, lists as sources of confusion "cant, hyperbole, and misrepresentation" (Marmor and Oberlander 1994: 496).

To sum up, context is important for HCF policy in all the countries considered, but it appears more benign in the comparator federations than in the United States. Social solidarity, in particular, seems to have had a high-powered positive effect on HCF policy design and performance in the comparator countries. In the United States, this issue is much more problematic. Contrary to what is widely believed at home and abroad, sentiments of social solidarity do seem to play a very important role as a fuel for public health insurance programs. However, the qualified character of these sentiments has contributed to system fragmentation and differential treatment of persons in terms of the four HCF performance criteria. The transformation of sentiments of solidarity into formal, explicitly enunciated

ated constitutional rights to health care has occurred only in Germany; in both Australia and Canada, things are vaguer, but *de facto* rights seem solid nevertheless. In the United States, qualified social solidarity appears to have translated into a hierarchy of differentiated and categorical rights with some people having scarcely any rights at all. Context is even more problematic in the United States by virtue of the much greater size and complexity of the HCF system. This complexity reflects policy legacies and inevitably must hamper attempts to ameliorate HCF performance by rendering the policy process opaque and resistant to public scrutiny, thus providing a smoke screen for those working to hinder change.

National Models of Federalism and Health Care Financing Policies

In trying to get an idea of the specific effect of federalism upon HCF policy, four features of this form of government are singled out for attention. The first is the formal allocation of powers between the federal government and the intermediate level of government—the states, provinces, and *länder*—in the health care sector. The second is how the federal government extends its influence beyond its formal powers to intervene directly in the health sector through the exercise of its spending power. A third is the state of intergovernmental relations. The fourth is the internal politics of the federation. Table 3 summarizes key features of these four dimensions.

Intergovernmental Allocation of Powers

The 1901 Australian Constitution restricted central government responsibility in health care to questions of quarantine, but a constitutional amendment in 1946 gave the federal government power to intervene in a wide range of pensions and benefits, including pharmaceutical care as well as sickness and hospital benefits, and the federal government is considered to have taken on a “leadership role in health policymaking and funding” and regulation (Hilless and Healy 2001: 18). Over time, an *ad hoc* division of responsibilities has emerged: the federal government is directly responsible for funding and organizing physician services, pharmaceutical care, veterans’ care, and nursing-home care and for regulating health insurance, while the individual states have the task of organizing the provision and financing (with federal aid) of hospital care, dental care, mental care, home and community care, prevention services, and public health as well

Table 3 Dimensions of National Versions of Federalism: A Summary

Country	Dimensions of Federalism			
	Intergovernmental Allocation of Powers	Use of Federal Spending Power	State of Inter-governmental Relations	Internal Politics of Federation
Australia	Wide federal powers	Substantial	Tend to be collaborative; good institutional arrangements	Tight federal executive control of legislative process
Canada	Very limited federal powers	Substantial	Tend to be poor; limited institutional arrangements	Tight federal executive control of legislative process
Germany	Increasingly strong federal powers	Very limited	Can be difficult; good institutional arrangements	Tight federal executive control of legislative process
United States	Rather ill-defined but wide federal powers in practice	Substantial but risk of erosion of effectiveness	Can be difficult; limited institutional arrangements; intense bilateral bargaining	Weak federal executive control of legislative process

as regulating health personnel. The fact that the federal government has direct responsibility for certain areas of health care is crucially important, because it means that it is, in large part, free to decide how the services in question are organized, operated, and delivered. However, the confines of the federal power to intervene directly are constitutionally imprecise, and there is some overlap in federal-state responsibilities, which can cause tension at times (ibid.: 18).

In Canada, the only explicit reference to health care in the British North America Act of 1867 (the basis for today's Canadian Constitution) regarded hospital care and psychiatric institutions, responsibility for which was assigned exclusively to the provinces. Constitutional jurisprudence and more general legal sources now support the interpretation that the provinces have primary, but not exclusive, jurisdiction over health care (Marchildon 2005: 25). The federal government has no direct responsibility for the provision of health care except for the native population, armed forces, and prisons, although it is concerned with many aspects of public health, regulation of drugs, and research. Under its general powers contained in the Constitution, however, the federal government has to protect the health and security of Canadians, and the federal government, by means of the Canada Health Act, can and does set and enforce the guiding principles of the HCF system. But it is the provinces that have the responsibility for organizing and running the public health insurance program, financing hospitals, negotiating remuneration rates for physicians, and providing, directly or indirectly, home care, long-term care, and pharmaceutical care. The federal government has very little room to intervene directly.

The allocation of responsibility for health care in Germany is a complex matter. Under the Constitution, responsibility is shared by the federal government, the *länder*, and the so-called corporatist bodies that make up the social insurance system (self-governing associations that represent doctors, hospitals, and insurers). Essentially the state has delegated these associations to negotiate contracts governing what care is provided and how much is paid for it, with the state covering the role of "regulator, facilitator, and enabler" to the associations (Altenstetter and Busse 2005: 124). The federal government has no direct responsibility for financing or providing health care. The *länder* have traditionally been responsible for hospital care, particularly for planning and investment, but over time this function has been revised because of retrenchment in the regional public finances. Since the end of the 1970s, hospital care has increasingly become an integral part of the self-governing bodies' negotiation process, and this negotiation process and resulting contracts have become more national,

less regional and local, and more strictly controlled by the federal government. (Legally, the *länder* also have powers of surveillance over the health insurance funds and the associations of providers.) National health policy used to be primarily concerned with cost containment, but it is now also heavily focused on quality. If federal health legislation impacts on areas of competence of the *länder*, it must be approved by the Bundesrat, the second chamber of the federal parliament, whose members are nominated by the *länder*. Since the Bundesrat may be controlled by parties making up the opposition in the elected Bundestag, the debate at this point becomes a political one, and in any case, this means that health policy is mainly being set at the national level. As a result of these developments, German federalism, as such, may be having less and less to do with health care and HCF policy.

The United States resembles Canada in that its Constitution contains little explicit reference to federal responsibility for health care. Indeed, there is no mention of health care in the powers of the federal government enumerated in article 1, section 8. Formally, under the Tenth Amendment, any power not expressly granted to the federal government by the Constitution is reserved to the states. However, the Constitution states that “the Congress of the United States shall have the power To levy and collect taxes . . . and provide for . . . the general welfare of the United States” (art. 1, sec. 8), and the Supreme Court has tended to interpret this to mean that the federal government has broad powers to spend regardless of whether the areas to which the funds are destined are specified (Watts 1999). This has allowed the United States, like Australia but unlike Canada, to directly fund and administer a number of health insurance programs, most notably Medicare, TRICARE, and the VHA, and the fact that these are managed directly from the center has certainly contributed to what success they have had regarding specific performance criteria—high coverage of the target population in the case of Medicare and TRICARE, complete portability of protection under these two schemes and the VHA, and comprehensiveness of care under TRICARE and the VHA. Unlike Australia, however, direct federal administration of Medicare in the United States has not meant a comprehensive benefit package, and the criterion of financial accessibility is compromised because enrollees have to share a nonmarginal portion of costs. Significant geographical differences exist in utilization of Medicare services, expenditure per enrollee, and the quality of care provided and in how this quality has improved over time (see, e.g., Jencks, Huff, and Cuerdon 2003; Baicker et al. 2004). The reasons for this are not well understood, but in part it seems to be linked to race, levels

of remuneration of providers, availability of providers, and prescribing behavior of providers. However, the Medicare program per se seems to be administered reasonably uniformly throughout the country.

What about the future? According to a Brookings Institution study, “where ‘sovereignty’ is or ought to be located in the American political regime, either in general terms or in relation to specific policy, administrative, or budgetary goals, is a matter that the Framers did not clearly answer, and no one else has been able to answer since” (DiIulio and Kettl 1995: 2). The Supreme Court has ruled that conflict of this kind tends ultimately to be a political question and as such must be resolved through the political process. Some observers note, however, that the Court in recent years has been retreating from this position, tending to emphasize states’ sovereignty (Colby 2001: 145; Pickerill and Clayton 2004; Sunstein 2005; Finegold 2005). The real balance of power between the two levels of government has changed over time. For much of the history of the United States, the states were the “paramount actors” in the public sector and the “strong partner” in the federal system (Advisory Commission on Intergovernmental Relations 1985: 385–387). From the mid-1930s until at least the mid-1970s, the federal government was the principal vehicle for pursuing national social goals via, for example, the New Deal, the New Frontier, and the Great Society. The growth of the federal budget reflected this: in 1930, federal revenues were less than 5 percent of the GDP, while state and local government revenues stood at 10 percent; by 1993, federal revenues absorbed 20 percent of the GDP and state and local government revenues absorbed 15 percent (Bovbjerg, Wiener, and Housman 2003: 29). According to one observer, the high point of federal policy making in health was during the Nixon administration, with the National Health Planning and Resources Development Act 1974, which obliged the states to adopt federally approved health planning laws or otherwise lose federal funds for public health (Bovbjerg, Wiener, and Housman 2003). Since then, there has been a gradual flow of authority and resources away from the federal government in the direction of the states (Kellerman 1999: ix). In this respect, the U.S. case contrasts with that of Australia, where there has been a long-term tendency for power to shift upward to the federal level (Hilless and Healy 2001). This suggests that we are unlikely to see any significant expansion of the federal role in the United States in the direct administration of HCF, but, having said that, the recent Medicare Part D reform is a good example of expansion to the benefit of the comprehensiveness criterion.

The Federal Spending Power

We risk understating the potential of the national government in a federation to influence health care policy if we overlook the spending power. This refers to the power to make payments to individuals, institutions, and lower levels of government, even in instances in which the federal government lacks constitutional authority to legislate or take direct action (Watts 1999: 1). Perhaps the best example of this is Canada, where the federal government's lack of direct responsibility for health care has not been a barrier to its exercising a strong influence in the sector. The spending power is not explicitly envisaged in the Canadian Constitution, but as a rule, it has been recognized as legitimate in the constitutional jurisprudence. It is exercised via conditional transfers to the provinces, the logic being that the provinces are free to decide whether or not to accept federal funds, but once they choose to accept them, the federal government can require them to respect prespecified rules of behavior. For years, federal conditions for health transfers in Canada were very detailed, but since 1984, federal aid is conditional on provincial respect for five broad standards contained in the Canada Health Act. These standards have been enforced quite rigorously for universality of coverage and financial accessibility, while comprehensiveness has been given less emphasis.

In Australia, the Constitution states that the federal government can allocate funds "for the purposes of the Commonwealth" and make grants to the states for specific purposes. Central grants for hospital care are conditional on all citizens having access to timely hospital care of good quality, irrespective of their financial resources or geographical location and, by and large, the states have respected this requirement.

In Germany, the federal spending power has been of very little importance for HCF, given that virtually all health care is financed with social health insurance contributions by employees and employers, with public budgets financing about 8 percent of total health care expenditure, excluding social insurance contributions paid by governments in their capacity as employers (Altenstetter and Busse 2005: 124). The limited financial leverage that the *länder* have had over the character of hospital care provided, deriving from their responsibility for funding hospital investment, seems to be in decline due to retrenchment in this sector because of budgetary difficulties and the gradual absorption of hospital care into the self-governing bodies' negotiation process at the national level. In the case of this federal factor, therefore, the importance of federalism for HCF in Germany seems quite marginal.

In the United States, the federal spending power finds its chief justification in the Supreme Court decision *Massachusetts v. Mellon* of 1923. This decision held that the states are free to reject grants with conditions attached (see Finegold 2005: 160–161) and that, therefore, such conditional grants cannot be considered to be an abuse of federal power. The federal spending power in health care is chiefly exercised through the funding of the Medicaid program and SCHIP, financial aid to safety-net providers, and tax expenditure generated by tax deductions for private health expenditure and seems to have produced important results. It is, of course, impossible to know how arrangements for health care financing in the United States would look without Medicaid and SCHIP. The more liberal states might, for example, have set up public health insurance programs aimed at guaranteeing universal coverage and have applied more generous standards for eligibility and services provided. With Medicaid, for example, it has been the states (or at least some of them) that have pressed for making the program more generous and directed at the medically needy as well as at the poor (Grogan and Patashnik 2005). However, the states are more constrained fiscally than the federal government: forty-nine states have constitutional restrictions on budget deficits, and many have limits on spending and/or taxes (Finegold 2005: 151). There are currently over 50 million Medicaid beneficiaries, compared with 4 million enrollees when the program started, no mean achievement by any yardstick. Medicaid protection is almost certainly more uniform in terms of eligibility rules, services covered, and cost sharing than would have been the case had the states operated independently. It provides a richer benefit package than many private schemes and requires a relatively modest financial contribution from enrollees. Moreover, the fact that the formula used to calculate the Medicaid grant takes account of state per capita income has meant a net redistribution of income from the richer to the poorer states, and this is increasing over time (Kaiser Commission on Medicaid and the Uninsured 2002: 88). Another example of the federal spending power are grants to safety-net providers, which ease the financial burden of treating the indigent and encourage them to meet their statutory obligation to provide emergency care. Tax expenditure linked to private health insurance probably ensures that EBI coverage is greater than it would be otherwise.

There is the problem of interstate variation in how enrollees are treated under both Medicaid and SCHIP, in part due to the wide discretion that states enjoy, especially with regard to optional eligibility groups and services. States have also considerable flexibility in interpreting the require-

ment under Title 19 of the Social Security Act that services provided be “sufficient in amount, duration and scope to reasonably achieve its purpose” and in defining what is medical necessity. Probably the greatest source of discretion for the states are waivers that permit them to disregard specific Medicaid requirements. Depending on the type of waiver obtained, states are allowed under specified circumstances to assist populations that would otherwise be ineligible under federal rules and to provide additional services, but they may also be allowed to increase cost sharing and bypass the amount, duration, and scope criteria and other regulations. It was estimated that about 20 percent of Medicaid spending in 2001 went for services provided under waiver (Kaiser Commission on Medicaid and the Uninsured 2002: 97). Waivers are intended to give the states more flexibility, but they carry with them the risk of eroding minimum federal standards. The Bush administration introduced the Health Insurance Flexibility and Accountability Initiative in 2001, which allowed CMS to grant states waivers that permitted benefits to be cut back for optional eligibility groups and to use the savings from this to extend coverage to more people. The states also have the option of limiting the health care thus provided to only primary care or nonspecialist physician services; yet other waivers allow application of higher cost-sharing requirements to optional eligibility groups. The greater the discretion conceded to the states in administering the Medicaid program, the weaker the federal spending power is.

However, it would be still weaker under a block-grant arrangement. With the present arrangement (*ibid.*: chapter 3), the financial burden assumed by the federal government—measured by the federal medical assistance percentages (FMAP)—varies inversely with a state’s per capita income, subject to a statutory minimum equal to 50 percent (for the wealthiest states) and a maximum of 83 percent (for the poorest states). The Medicaid grant is open ended in terms of both aggregate annual program expenditure and the amount that a single state can receive. Total expenditure depends on which optional eligibility groups the states choose to help, which optional services they decide to provide, and the costs of services and their utilization. For every dollar an individual state spends on Medicaid, it receives a federal contribution of between \$1 and \$4, depending on its FMAP. The federal government, therefore, exerts a powerful financial leverage on the states—at least potentially—to induce them to expand both coverage and benefits and to respect minimum federal standards and, indeed, to exceed them. Potential leverage is further enhanced by the states’ practice of so-called Medicaid maximization, aimed at raising their effective

FMAPs above their nominal ones (ibid.: 103–115). Under a block grant, federal financial aid for health care for the poor would not be open ended, but rather it would be a fixed annual amount. At present, the burden of cost expansion of Medicaid is disproportionately borne by the federal government, but with a block grant, all expenditure exceeding the block grant would have to be met entirely by the individual states. This would probably encourage them to be conservative in the coverage they offered. Every dollar of spending in excess of the block grant would cost a state \$1, unlike today when, depending on the FMAP, each dollar of expenditure on Medicaid costs a state between \$0.17 and \$0.50. By the same token, a \$1 cut in a state's spending on the health needs of its poor would reap a saving to a state of \$1 compared with \$0.17 to \$0.50 today (Mann 2003b; Holahan and Weil 2003). Under the 2003 proposal, states would have had considerable flexibility to define the benefit package, to apply cost sharing, and to set maxima on the numbers of enrollees, and optional eligibility groups would no longer have been protected by federal standards.

The federal spending power exercised through Medicaid has probably been eroded by the CMS's inadequate surveillance of how Medicaid funds are spent. The U.S. Government Accountability Office (GAO) has criticized the CMS for poor oversight of the states, emphasizing holes in the data provided by the states. In addition, both the GAO and the Office of Inspector General of the Department of Health and Human Services have highlighted abuses of Medicaid maximization and the failure of the CMS to deal effectively with these abuses (Kaiser Commission on Medicaid and the Uninsured 2002: 108, 114). This phenomenon has been described as placing the integrity of Medicaid's federal-state matching arrangements in doubt (ibid.: 104). Both CMS and the states are criticized for inadequate control of contracted providers working with managed care plans; this is attributed in part to the fact that contracts with providers are formulated in excessively general terms (Mello 2002). In an open letter to "Congress and the Executive," published in 1999 by *Health Affairs*, an authoritative group of observers noted that, when the Health Care Financing Administration (HCFA), the predecessor of the CMS, was set up in 1977, it oversaw Medicare expenditure amounting to \$21.5 billion serving 26 million beneficiaries with a staff of 4,000 full-time equivalents. Two decades later, in 1997, Medicare spending stood at \$207 billion, beneficiaries were 39 million and HCFA responsibilities had vastly expanded, but HCFA staffing, far from increasing, had declined somewhat (Butler et al. 1999). Moreover, information systems used have been called "outdated and inadequate" (Mello 2002: 469). Medicaid experienced simi-

lar changes. In short, the federal spending power in the United States produces notable effects. However, it seems more circumscribed than in Australia or Canada and is subject to an ongoing assault by forces seeking to increase state flexibility.

The State of Intergovernmental Relations

Other things being equal, the more a federal government and lower-level governments trust each other and the more willing they are to cooperate, the greater the likelihood of the latter being prepared to concede an active role to the federal government in framing HCF policy and of the federal government being ready to grant considerable discretion to lower-level governments in interpreting and implementing that policy.

Over time, the Australian federal government may have acquired a leading role in health care, but overlapping responsibilities have been a source of significant intergovernmental tension and implementing major policy change has required agreement between governments. In recent decades, there has been increasing use of intergovernmental negotiation and cooperation via formal mechanisms, in particular the annual Australian Health Ministers' Conference (involving federal and state ministers) for "the promotion of a coordinated approach to health policy development and implementation" (Hilless and Healy 2001: 21). This has the technical backup of the Australian Health Ministers' Advisory Council, made up of senior federal and state health officials. Another key organ used to coordinate federal and state activities is the Council of Australian Governments (COAG). Set up in 1992, it has allowed the federal government and the states to "adopt common policies, coordinate programs and draw up common legislation" (Public Management Service [PUMA] 1997: 78). The council negotiates the five yearly health care agreements on the federal block grant to the states for hospital care. These arrangements seem to have contributed to smoother intergovernmental relations (Hilless and Healy 2001: 88), even though tensions do persist.

In a country like Canada, where responsibility for health care is highly decentralized but the federal government demands a key role in setting policy, it would be surprising if intergovernmental relations were not tense. The principal cause of conflict in the late 1980s and the 1990s was the federal government's unilateral reduction of grants to the provinces for health care, but that is just one chapter in a history of federal unilateralism in setting funding levels and defining the conditions attached to these. Federal and provincial health ministers meet regularly to negotiate health policy,

and this has occasionally produced important results. However, attempts to develop formal institutions for federal-provincial negotiation have so far had little success. The Social Union Framework Agreement was created in 1999 to serve as a negotiating body for social and health policy but is considered not to have lived up to expectations (Pelletier 2002). Intergovernmental relations in Canada have been described as “dysfunctional” and “intergovernmental conflict and mistrust are serious barriers to the smooth functioning and sustainability of Medicare” (Commission on the Future of Health Care in Canada 2002: 53).

In Germany, intergovernmental conflict mainly occurs at the central level over broad health policy. The Constitution, as noted, requires that any legislation approved by the Bundestag, the directly elected house of parliament, which affects the *länder* must receive approval in the Bundesrat, the members of which are nominated by the *länder*. This used to be estimated to involve approximately 60 percent of all federal legislation (although recent parliamentary reform has brought this figure down), and it can be a problem when the two chambers of parliament are controlled by different parties and law making stalls. The principal negotiatory body is the *Vermittlungsausschuss*, a joint committee of the two chambers (Benoit 2004). Since under the Constitution responsibility for implementing federal policy lies with the *länder*, it is clearly important that the two levels agree on specific measures. However, up to a point and at least in the short run, the fact of intergovernmental conflict may be less important in Germany, because detailed management of the HCF system lies with the self-governing associations, which are involved in a continuous process of negotiation regarding benefit packages, new services, remuneration levels for providers, and so forth.

Intergovernmental relations in the United States tend also to be less than serene. The states have complained long and bitterly about excessive federal intervention in their affairs, including health care (especially for the conditions attached to Medicaid financing), and there has been mounting pressure in recent years for greater freedom of action in this regard, called devolution or the New Federalism. Decentralization is no longer a cause supported only by Republican administrations and states' rights conservatives. It was actively promoted, for example, by the Clinton presidency. Although some observers continue to be skeptical about some of the alleged merits of devolution, prestigious nonpartisan research organizations such as the Urban Institute and the Brookings Institution are now taking it seriously.

One factor encouraging interest in and acceptance of a larger role for the states is the perception that state administrative and policy-making capacity has improved over time. Thomas Anton (1997: 706) believes that state government capacity to make policy has “vastly improved” over the last decades, while John Donahue (1999: 30) has held that now “the caliber of state officials frequently exceeds the federal standard.” This has been attributed in part to the participation by states in federal programs (Finegold 2005: 175). Not all observers are so enthusiastic. Frank Thompson (1998), for example, examines critically what goes to determine the capacity of states to manage Medicaid and concludes that capacity has advanced on some fronts but has receded on others and that large inter-state variations persist. However, the current assertiveness of the states makes it unlikely that they will accept a greater and clearer defined federal role in the health sector. Indeed, the establishment of SCHIP and repeated proposals for a block grant for health care suggest that the federal role in HCF policy risks further erosion.

Public opinion here is in favor of the states. Donahue (1999: 26–27) reports three opinion polls in this regard, all referring to 1995. One asked which level of government was “more likely to administer social programs more efficiently”: 74 percent of respondents chose the states, and only 20 percent chose the federal government. Another poll found that 61 percent of respondents trusted their state government over the federal government to “do a better job of running things” compared with 24 percent answering in favor of the federal government. A third poll reported that 75 percent favored giving the states more responsibility for programs currently operated by the federal government, no policy area excepted. Another source cites a poll, also conducted in 1995, which reported that 61 percent of those interviewed had little or no confidence that “when the federal government decides to solve a problem, the problem will be solved” (cited in Blendon and Benson 1998: 346). In 2000, a poll reported that 69 percent of Americans trust the federal government “to do what is right only some or none of the time,” an opinion held by only 22 percent in 1964 (Blendon and Benson 2001). There is a large literature on why people prefer the states to the federal government (see, e.g., Hibbing and Theiss-Morse 2001). It has been argued that “small governing units seem to be clearly a *legitimizing* in and of themselves in America: the smaller the scope of a government jurisdiction, the less intimidating and foreign it seems as an institution” (Fishman 2002: 46, emphasis added). An interesting finding is that popular support for state government is based on symbolic con-

siderations like partisanship or ideology rather than on objective proof or experience of superior results. Indeed, residents of efficient states are likely to trust the federal government more than residents of less efficient states do (Hetherington and Nugent 2001).

No new negotiation mechanisms have been created, at least in the health care sector, to accompany the New Federalism. The Medicaid program is described as a scheme “operated and funded as a *partnership* between the states and the federal government” (Council of State Governments Executive Committee 2004, emphasis added). SCHIP is also described as a partnership. There is probably a strong element of rhetoric here, but since both programs are jointly financed and administered by the states and the federal government, there is bound to be some intergovernmental interaction. How this is to be judged depends on the form it takes. There seems to be active intergovernmental collaboration in areas of mutual concern—for example, the fight against Medicaid fraud (*Medical Newswire* 2000)—and in the standardization of information flows. In addition, it is routine for different levels of government to consult each other with regard to how new rules and regulations should be interpreted and applied. Different levels also negotiate the contents of the Medicaid and SCHIP contracts between the federal government and states. Intergovernmental interaction most often is bilateral, which is probably inevitable given the numbers involved: compare the United States’ fifty states with Germany’s sixteen *länder*, Canada’s ten provinces, and Australia’s six states.

Almost twenty-five years ago, Thomas Anton (1984: 50)—referring to the federal grants system in general—assigned a key role to bargaining. Intergovernmental relations in the United States, he argued, are based on reciprocal dependence: just as there are state governments that need federal funds, so there are federal agencies with monies to distribute that, in order to justify the existence of their programs, need clients to finance. According to this view of things, the appropriate image is not one of a federal patron waving carrots in front of a state donkey but rather one of a rich shopkeeper (the federal government) bargaining on equal terms with a wily client (the state) in search of a good deal (Ingram 1985: 200). Federal-state shared programs are “often crafted in ways that maximize state and local flexibility and minimize federal control,” with states being heavily involved in the process of designing, implementing, and modifying these programs (Anton 1997: 695–696). Some observers consider that it is “rare” for the states not to be involved directly in this process (DiIulio and Kettl 1995: 17). The decision in 1965 to adopt the mechanism

of cofinancing and coadministration to address the problem of health care for low incomes meant that bargaining would be an inherent feature of Medicaid.

The central issue for this article is the significance of this kind of negotiation in the United States for HCF performance. Does it help or hinder? It is suggested that “waiver politics were (and are) a classic bargaining game in which greater state discretion is traded for enhanced public coverage and is customized, state by state” (Brown and Sparer 2003: 39). This regards, in particular, the eligibility conditions to be applied, the services that a state is obliged to provide and those that are optional, and the extent to which patient co-payments are allowed. Waivers involve the renegotiation of the Medicaid contract and have the effect of altering—in favor of the states—the existing distribution of property rights regarding the setting of HCF policy. Waivers may stimulate innovation by the states (Jordan, Adamo, and Ehrmann 2000), but the net effect of this kind of negotiation is greater interstate diversity. This raises the possibility that, if current waiver policy were to continue, it could reshape key elements of the Medicaid program (Mann 2003a). Moreover, is it appropriate that decisions on eligibility and on whether states can cut services, charge premiums, or increase cost sharing are determined by negotiation between state and federal bureaucrats, outside congressional control, and perhaps even against congressional intent (*ibid.*)? This contrasts with intergovernmental negotiation at its best in Australia, which has tended to undergird not undermine national standards. An interesting element of federal-state relations in Medicaid could be described as a form of intergovernmental cooperation, although it is perhaps more correct to term it “interaction.” In essence, each level of government plays off the other’s success in expanding coverage. Thus, the financial savings obtained by states via Medicaid waivers have been used to fill in gaps in Medicaid itself, while innovations by states to bring in uninsured children encouraged the federal government to introduce SCHIP. This has been called “catalytic” federalism (Brown and Sparer 2003: 38).

Of course, the need for bargaining would be reduced tout court if proposals for a health care block grant or federal spending ceilings were to be adopted. This would substantially reduce the transaction costs associated with negotiation but would also involve a major redistribution of the property rights in the area of setting health care standards, because most proposals for block grants allow the states to operate to a significant extent “outside the confines of current federal standards” (Mann 2003b: 12; Park

et al. 2003). In addition, the federal-state partnership would cease with the block grant, because the federal contribution would almost certainly be fixed rather than open ended. To sum up, intergovernmental cooperation in the United States produces mixed results, threatening to weaken the federal role in HCF but perhaps at the same time serving as a safety valve that prevents a buildup of pressure for a drastic shift in power to the states.

The Internal Politics of the Federation

There are three aspects to this fourth dimension. The first is the relationship between the federal executive and the legislative branches at the federal level. In the United States, there is a clear-cut constitutional separation between the federal executive and legislative branches, elected separately by popular vote and legitimated by that vote. Cabinet members cannot sit in the Congress, and Congress drafts and approves legislation that the president can veto. In the three comparators, which all have parliamentary systems of government, the central executive stems from the legislature, in that the prime minister and, as a rule, the cabinet are members of parliament. The executive depends for its legitimacy on parliament, in that it must hold at least a relative majority of parliamentary seats. It depends crucially on its having the confidence of parliament, the loss of which means the loss of the mandate to govern. In the United States, it is quite common for the party of the president to lack a majority in one or both houses, making it difficult for the executive to implement its programs. In Australia, the House of Commons is elected using the first-past-the-post system, while the Senate uses a proportional voting system. This can lead to different majorities in the two chambers, but only rarely has this blocked government health policy (Gray 1996: 606). In Germany, the fact that the Bundestag is popularly elected and the members of the Bundesrat are nominated by the *länder* governments can mean that the majority in the elected house is in the minority in the nominated one, and this has often constrained or stalled federal health policy. Members of Canada's Senate are nominated for life by the prime minister. This can be irritating for the government, if it represents a party that has spent a lengthy period in opposition (Studlar and Christensen 2006: 839). Nevertheless, in all three comparators, the central executive, unlike in the United States, tightly controls the legislative process. According to Studlar and Christensen (*ibid.*: 838), "few countries in the world have as much central cabinet dominance over Parliament as Canada. . . . Canadian fed-

eralism is executive centered.” Also in Australia, political control is highly centralized. In Germany, there is “executive dominance” and strict central control of legislative activity (Altenstetter and Busse 2005: 131). The federal executives in the three comparator federations should be better able, therefore, to guide the direction of HCF policy than their counterpart in the United States.

Second, there is the question of national differences in the character and role of the political parties. In the comparator countries, these tend to be machines for promoting party platforms and programs. There is a pact that members of parliament, once elected, will support their party in parliament. This means that, provided the government has a majority, it can, under normal circumstances, be reasonably confident of winning approval of its programs. If necessary, the executive can impose its will by calling for a vote of confidence, presenting its parliamentarians with the choice of bowing to party discipline or risking new elections. Even if the president’s party in the United States has a majority in both houses of Congress, there is no guarantee that his or her programs will receive congressional approval. Political parties in the United States have traditionally been considered to be weak at the national level compared with those in other countries. Rather than presenting programs, as in Canada or Australia, they have been depicted as being more interested in fund-raising and in organizing support for the campaign (Gray 1996). Representatives and senators, according to this view, see themselves as owing their first allegiance to their congressional district or state and can vote against their party or president without risking a vote of confidence and new elections or other sanctions. The sanctions are seen to be greater for appearing to neglect the interests of their district or state than for changing their position and not supporting that of the party (Hacker 1996: 687). “Partisan majorities do not necessarily produce policy majorities in American politics” (Oberlander 2003: 3). Presidential legislative proposals must go through a virtual labyrinth of congressional committees and subcommittees. Committee chairpersons, including those of the president’s own party, have considerable power to take detailed policy initiatives independent of and possibly in contrast with the presidential agenda, including, for example, matters regarding conditional grant programs. An example of this is the plan for a health care block grant approved by a Republican-dominated Congress in 1996 and subsequently vetoed by President Clinton. Of the hundreds of bills regarding reform of the health care system presented to Congress over the years, including some backed by the full authority of the president, not one has reached the stage of a floor vote in Congress

(Peterson 2005: 209). The Clinton reform law was the first ever to be debated by Congress on the floor, but it was not even presented for a floor vote in either of the houses. However, this “traditional view” of things, according to some recent thinking, “drastically understates” the power of the party leadership in the United States, at least regarding the Republican party and especially in the House of Representatives (Hacker and Pierson 2005: 138). The power of committee chairpersons has been greatly reduced in recent decades, and powerful instruments have been devised for controlling and disciplining individual elected members. Hacker and Pierson report that research shows that members tend to vote the party line on partisan issues and that power has become highly centralized. This suggests that the differences between the United States and the comparators in this regard may be less marked than described earlier in this article. However, in and out of office, the Democratic party is less cohesive, the party leadership continues to be weak, and individual members are still hard to control (*ibid.*: chapter 5).

Finally, there are the nuts and bolts of the policy process. There are two aspects of this in which there are quite marked differences between the United States and the other federations: the activities of interest groups and the character of the decision process within the executive branch. The highly centralized nature of the Canadian federal government has militated against interests having a strong role in health policy making. Instead, interest groups have historically been powerful in Germany (the self-governing bodies) and in Australia (private health care providers and insurers). In the former, their influence stemmed from the fact that government delegated to them the task of policy implementation, but as Döhler (1995: 386) observes, this made them targets for government policies, and Altenstetter and Busse (2005: 128) report that, since the 1990s, the interests have been excluded as veto players from key stages in the preparation of reform legislation. Private interests in the Australian health care sector have traditionally exerted powerful pressure on policy when governments have been formed by so-called nonlabor parties that favor a strong role for private medicine and health insurance, but since the mid-1990s, health policy, regardless of the parties in power, has supported public health care (Gray 1996; Hall 1999). In any case, the centralized character of government power in Australia has meant that the interests have had limited power to exploit the “fissures and cracks” of federalism to block national policy (Gray 1996: 607). The size and complexity of the U.S. HCF system, examined as a contextual factor, and the fragmented nature of the country’s federalism have combined to spawn a plethora of powerful lobbies

capable of making a major contribution to blocking change (e.g., the Clinton reform) and shaping legislation (e.g., the 2006 Medicare Part D drug benefits). The power of the lobbies has been reinforced by the nature of U.S. federalism (checks and balances), which gives opponents of change the time to construct appropriate blocking strategies (Hacker 1996: 688). However, also regarding the power of the lobbies, Hacker and Pierson (2005) beg to differ. According to them, under the Republicans, lobbies are used to promote their agenda, turning “the stereotyped relationship between the lobbyists and the lobbied on its head” (*ibid.*: 142). Help to lobbyists for the causes they promote is forthcoming only if they behave as ordained by the party leadership.

The decision process within the executive branch is an untidy business in any country, but the cabinets in Australia, Canada, and Germany tend to work closely with their federal bureaucracies in the preparation and execution of health policy. This contrasts with the particular nature of the decision-making process of the modern U.S. presidency. Timothy Garton Ash (2004: 114) warns that “we should always beware of the danger of attributing to an American (presidential) administration a coherence that it does not possess.” He is referring to U.S. foreign policy, but his caution also seems valid here. Cabinet members, agency administrators, and senior presidential advisers may hold widely different views on the suitability, feasibility, and importance of specific policy issues and will work hard to have their particular view prevail. These tensions within the executive branch may be accepted by the president and perhaps even encouraged. Hence, it would be surprising if there were not at times conflict between a secretary of the Department of Health and Human Resources, the administrator of CMS, and presidential advisers over, for example, policies regarding the coverage of public health insurance programs. The end effect may be to block such policies or to make them less incisive. By the same token, there may be conflict over strategy between senior CMS career staff and the administrator nominated by the president.

The internal politics of the federation may make a nonmarginal contribution to explaining differences in HCF performance between the United States and the other countries. Only a few aspects of the internal politics are considered here. We might also look at the political uses made of medium- to long-term projections of aggregate federal spending and those of health spending in the debate on HCF policies. In most countries, for example, there is an ongoing debate on the sustainability of current health expenditure growth rates, but the United States is somewhat exceptional in that these rates are used by some to justify proposals for drastic modifica-

tion of HCF policy. Also internationally exceptional are policies for temporary tax cuts followed by calls for making the cuts permanent and for financing this by reductions in public HCF. However, factors of this sort could arguably be seen as contributing to the definition of context rather than as being an element of a federal model. With specific regard to the internal politics of the federation, while it seems clear that the relationship between the executive and legislative branches is a matter of federalism, a fuller analysis of the role of the parties and of the nuts and bolts of the policy process might conclude that they are contextual.

To sum up the discussion of federalism and HCF, in the case of one of the comparator countries, Germany, federalism seems to have very little to do with HCF performance. Health policy is increasingly set at the national level, and the debate is essentially a political one between the ruling government coalition and the opposition parties rather than between federal and state actors concerned with protecting or extending their turf. The second tier of government, the *länder*, is involved in health care, but chiefly as an implementer of nationally set decisions. Responsibility for the detailed operation of the social health insurance system is delegated to the representative associations of the doctors, hospitals, and insurance funds, which together negotiate, within a reference framework set by the central government, on such matters as benefits, insurance contribution rates, and provider reimbursement levels, which are then applied uniformly throughout the country. For Australia, all four dimensions of federalism that we consider seem to contribute to creating a well-performing HCF system: allocation of constitutional powers for health care that permit direct federal action in important sectors of HCF; energetic use of the federal spending power in areas of health care in which the federal government does not intervene directly; recourse to tried and tested mechanisms capable of promoting effective intergovernmental negotiation and cooperation; and tight control of the national legislature and, therefore, of the HCF policy agenda by the federal executive. The record for Canada is quite different. The Constitution is extremely parsimonious in the responsibilities for health care that it grants the federal government, and this, compared with Australia, severely limits its capacity for direct action. However, the federal government enjoys very broad spending powers. Attempts to institutionalize effective mechanisms for intergovernmental cooperation have so far had little success and relations can be tense, also because of how the spending power has been used. An important positive federal dimension for HCF performance in Canada has probably been the tight control over the legislature exercised by the central government.

In the United States, like Australia but unlike Canada, the federal government has been able to intervene directly in HCF for quite a sizable proportion of the population (most notably with Medicare), and major expansion can occur here, as exemplified most recently by the new Medicare drug benefits. Such direct action has been facilitated by the fact that the dividing line between federal and state responsibilities is ill defined. In addition, the federal government (as in both Australia and Canada) has been able to make quite broad use of the spending power, allowing it to help meet the HCF needs of large sectors of the population (Medicaid, SCHIP, and safety-net provision). However, the states have worked hard, with some success, at constraining the conditionality of federal grants and obtaining waivers of federal regulations. Waivers have been the currency used by the federal government to buy wider Medicaid coverage from the states. Compared with Australia and Canada, the federal executive in the United States has had limited control over the legislative branch and, therefore, over the HCF policy agenda. Overall, the United States compares quite unfavorably with both Canada and Australia for executive branch control over the legislature and with Australia, but not with Canada, for intergovernmental relations and cooperation. Instead, it has had a distinct advantage over Canada for the intergovernmental allocation of responsibility for health care and is not markedly inferior to Australia in this regard. Finally, the exercise of the federal spending power in the health care sector in the United States has been very active but is probably more constrained compared with Australia and Canada.

Final Considerations

The differences that emerge between the workings of the U.S. model of federalism and those of the other federalisms do not seem sufficient to explain the gap in recorded HCF performance between the United States and the rest, particularly given our doubts about some aspects of the internal politics factor being more contextual than federal. This suggests much of the action is contextual. We saw that there have been quite large differences in how solidaristic Americans are compared with the other populations. While in Australia, Canada, and Germany such sentiments have been strongly supportive of a high-performing HCF system, the United States is striking for the qualified nature of social solidarity that seems to take concrete expression in fragmented HCF arrangements. This contextual factor, together with moderate to strong rights to care, appears to positively condition the federal factors in the comparator states. Epitomized in

Canada by the people's grant to the federal government of the sacred trust for the protection of the principles underlying existing HCF arrangements, there seems to be a positive interaction between context and federalism. In Australia, context tends to interact positively with all federal factors; context and federalism work in tandem. With Canada, context is sufficiently strong that it compensates for the potentially negative effects of the limited federal responsibility for health care and of poor intergovernmental relations. In the German case, social solidarity, combined with the society's rights-based orientation, dominates the picture, and federalism remains on the sideline. In the United States, context and federalism also interact, but this time possibly negatively. For example, the internal politics factor may work to magnify the deleterious effects of qualified solidarity: this latter factor probably encourages some legislators, lobbyists, and on occasion the federal executive itself to propose HCF retrenchment and to oppose attempts to reduce fragmentation. Unlike elsewhere, calls for drastic modification are not politically taboo and may indeed end up reinforcing sentiments of qualified solidarity in the population. The size and complexity factor may also be at work, negatively, here. The principal hero or villain then seems to be context and not federalism. Federalism does not emerge as an independent variable, and the effects that it generates may, to a considerable degree, be a function of context.

One should remember that this article is exploratory. In particular, we would have to see if the range of dimensions used to examine federalism and, perhaps particularly, context could be profitably expanded. However, to the extent that the emphasis on social solidarity is warranted, it suggests that if we wish to improve HCF performance in terms of the criteria used here, we will have to concentrate on attenuating the qualified nature of the United States' sentiments of social solidarity. Judging by past experience, major advances in this respect are unlikely in the short to medium term, and we shall probably have to be content with patiently eroding the citizenry's reservations about guaranteeing more uniform treatment to residents. This is what incrementalism may be about—sandpapering away at the margin to blur the dividing lines between the different categories of health insurance.

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