Health Economics, Policy and Law (2018), **13**, 251–262
doi:10.1017/S1744133117000378

Can history improve big bang health reform? Commentary

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Abstract: At present, the professional skills of the historian are rarely relied upon when health policies are being formulated. There are numerous reasons for this, one of which is the natural desire of decision-makers to break with the past when enacting *big bang* policy change. This article identifies the strengths professional historians bring to bear on policy development using the establishment and subsequent reform of universal health coverage as an example. Historians provide pertinent and historically informed context; isolate the forces that have historically allowed for major reform; and separate the truly novel reforms from those attempted or implemented in the past. In addition, the historian's use of primary sources allows potentially new and highly salient facts to guide the framing of the policy problem and its solution. This paper argues that historians are critical for constructing a viable narrative of the establishment and evolution of universal health coverage policies. The lack of this narrative makes it difficult to achieve an accurate assessment of systemic gaps in coverage and access, and the design or redesign of universal health coverage that can successfully close these gaps.

Submitted 1 April 2017; revised 19 May 2017; accepted 1 July 2017;
first published online 26 January 2018

Professional historians have long argued that a more comprehensive yet nuanced understanding of history can, and should, make a major contribution to better policy formulation by governments. However, these claims often seem quaint or beside the point to public administrators and politicians.[1]

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1 Of course, some professional historians in various places and ways have tried to buck this trend. In the United Kingdom, for example, historians have addressed discrete policy questions and problems of interest to decision-makers by writing short papers based on their considerable historical research through the History and Policy initiative (History and Policy website). The Arts & Humanities Research Council in conjunction with the London-based Institute for Government has actually made the effort to investigate the value of history in policy-making from the perspective of both professional historians and policy practitioners in Whitehall (Haddon *et al.*, 2015).

First, the historian's reliance on concepts drawn from the humanities and methods based on time-consuming and patient primary research seem far removed from the practical demands and urgent pressures faced by governments. Decision-makers and their expert advisors rely mainly on the concepts and methods of social science disciplines such as economics and political science; moreover, they generally prefer 'harder' quantitative analyses to the 'softer' qualitative approaches dominant in many branches of professional history (Head, 2010; Green, 2016).

This is reflected in the preference for social science disciplines and methods rather than history in specialized graduate schools of public policy as they have evolved in the United States and Canada. Even with the development of public policy as an academic field of its own, the tendency has been to neglect history relative to economics, political science, and law in what is necessarily a multidisciplinary field of study (DeLeon, 2006; Smith and Larimer, 2016).

The natural gravity of policy-making is to minimize both history and the advice of professional historians. As senior public servant in Canada in the 1990s, I never once saw sophisticated historical research or interpretation integrated in the policy advice to cabinet in the lengthy cabinet memoranda intended to set out the arguments and evidence in favour of policy change. On occasion, these memoranda included highly simplified historical time lines and chronologies but always absent a rigorous historical analysis and interpretation. The policy experts preparing the advice were drawn from many academic disciplines, including a few from history, but they did not consider historical research, analysis and interpretation as directly germane to the policy decisions of the days.

As secretary to the provincial government cabinet in Saskatchewan in the 1990s, I was accountable for the quality of cabinet memoranda. On one occasion, the cabinet was on the precipice of making yet another major structural change to regional health authorities based on a highly technical analysis of the administrative efficiencies associated with greater centralization. I was concerned because of the lack of historical and comparative context so I provided a personal memorandum to the Premier of the province on the lessons to be drawn from the history of the National Health Service (NHS). This analysis was based in part on Charles Webster's (2002) historical assessment of the impact of continual restructuring, what health economist Alan Maynard (2015) has labelled the English penchant for re-disorganizing. I was fortunate in that the Premier I served was receptive to this comparative historical analysis and accepted its potential relevance to the problem at hand. We had a long discussion about the broader evidence required to justify such a potentially disruptive reorganization. This led to the creation of an external commission that then analysed the issue for almost a year, compiling and weighing the evidence in favour of structural change thereby providing a future cabinet (under a new Premier and a new secretary to the cabinet) with the appropriate evidence to make a better informed decision.

This case was the rare exception to the rule. More often I have found the opposite: policy experts and political decision-makers are impatient with, and

sometimes intolerant of, history. Given how useful I have found history as a policy practitioner and scholar, I have been perplexed by this attitude for some time. Some of it can be explained by the desire by some policy experts for the perfect policy blueprint and can be summarized in the oft-repeated question: "If we were starting from scratch, would we build a health system like the one we have now?" Of course, the answer expected of this rhetorical question is a resounding no but this is a shallow and highly problematic response if for no other reason than the fact that it is impossible to excise history in this way.

Policies and the programs, laws, regulations, and even the values and political cultures with which they are associated, are built over historical time. New health policies must either build upon or replace existing policies which themselves are embedded within a structure and institutions that are themselves the results of generations of evolution. Even if it seems desirable in certain circumstances, it is never possible to start from scratch. One way or the other, we must deal with the health system structures and policies that are the product of history.

But this reality is in tension with the nature of momentous policy change requiring a major departure with the past. This is certainly the case when decision-makers are establishing a policy of universal health coverage (UHC) for the first time or attempting to make structural reform to existing UHC systems. Whether the policy is called Medicare, Obamacare or the NHS, major change has been, and will continue to be, extremely difficult. As President Trump observed when he first attempted to revamp Obamacare: "Nobody knew health care could be so complicated" (Hellman, 2017). The stakes are enormous, both for those who benefit from the *status quo* and therefore are likely to oppose major change, and for those whose interests are poorly served by the *status quo* and have some incentive to be part of a coalition advocating major change.

It should be of no surprise that decision-makers and their advisors who are intent on introducing or reforming UHC think of themselves as breaking with history. They see the past as creating a web of policies, structures, laws, relationships and incentives that reinforce the path dependency of a given policy. The significant investment made by stakeholders in the policy status quo means that they are likely to oppose major change. This explains the paradox of why societies put up with suboptimal and even dysfunctional policy regimes for long periods of time. In this sense, history can understandably be seen as a major obstacle to change (Pierson, 2000).

But how can we conceptually distinguish between major and more incremental change? Decades ago, political scientist Peter Hall posited the idea of first-order, second-order and third-order change. First-order change is the most common and incremental of policy change: using the metaphor of a machine room, only the settings on existing policy instruments – laws, regulations, policy directives, public bureaucracies and their structures – are changed to achieve a policy goal. Second-order change involves modifying a few of the instruments while changing the settings on other existing instruments to achieve the same goal. Third-order

change involves modifying the policy goal itself and this can require more radical changes to instruments and their settings (Hall, 1993). This type of policy change is often described as discontinuous because of its departure from the policy and institutional *status quo* (Thelen, 2009).

Hall's analytical framework has since been expanded to four categories by Carolyn Tuohy (2018), adding what she explicitly calls 'big bang change'. Tuohy's big bang change is restricted to policy shifts which she defines as both large-scale *and* fast-paced. Big bang change therefore involves not only setting a new policy direction but doing so within a relatively short period of time.

Without question, the introduction of UHC constitutes major policy change as defined by Hall (Gauld, 2000; Kingdon, 2011; Marchildon, 2012; Fox and Blanchet, 2015), but does it meet Tuohy's higher standard of change that is both large-scale and high velocity? Canadian Medicare, as UHC is called in Canada, provides an excellent test case given the apparently gradual nature in which Medicare evolved – first through the implementation of universal hospital coverage in Saskatchewan (1947) and then in the rest of the country through the federal spending power (1958–1961), and again with universal medical care coverage in Saskatchewan (1962) and Canada (1968–1972).

On closer historical examination, however, the introduction of single-payer universal hospital coverage in the provinces (and this is where it really counted) was both large-scale and rapid. Implementation time was short in each jurisdiction and the degree of change – for hospitals, health insurers and patients – was profound. The second phase of implementing physician coverage was similarly large-scale and high velocity. This phase was also one of the most turbulent in the postwar policy history of Canada in that it involved a major standoff between government and the medical profession as well as within and among federal and provincial governments (Badgely and Wolfe, 1967; Naylor, 1986; Taylor, 1987; Bryden, 2009; Marchildon and Schrijvers, 2011).

The confrontation between interest groups and the state – particularly the medical profession and provincial governments – diminished after Medicare was implemented but in recent years, has flared up again. The main venue for this conflict has gone beyond the traditional political arena and entered the courts. Although governments in Canada have shown limited interest in expanding or structurally reforming Medicare for almost a half century, in recent years, private physician litigants such as Dr Jacques Chaoulli and Dr Brian Day have attempted to use the *Canadian Charter of Rights and Freedoms* to alter the Canadian model of Medicare (Flood and Thomas, 2018).

The key objective of UHC – that of ensuring an entire population has a right of access to a defined basket of health services based on need – fundamentally alters the *status quo* where ability to pay has been the main determinant of access. No different than most UHC systems, Canadian Medicare redistributes from the healthy and wealthy to the ill and the poor. This redistribution creates winners and losers and is the underlying reason why introducing, extending or structurally

reforming UHC is necessarily big bang reform. Such large-scale reform requires new laws and associated regulations, new organizations, an expansion in the stewardship responsibilities of government, and new set of dynamics and relations between the health professions and the state.

Those trying to break these policy impasses can be very impatient with professional historians whose job it is reconstruct the arcane detail of the past, thereby explaining why things are the way they are. Ironically, the greater appreciation of what policy theorists call the "lock-in" of a given policy in a particular institutional environment – the details of which professional historians excel at describing – can make major change appear even more insurmountable to decision-makers. They know such changes are both difficult, that in the mandate of any particular government, the opportunity to achieve major change comes rarely.

The stars must align in the sense that the government has the necessary political capital to convince a majority of the population of the need for major change and the strength to incur the wrath of a minority who benefit directly from the *status quo*. Such occasions generally occur after an election at the beginning of the government's term where the major policy change – the establishment or fundamental reform of UHC – was a prominent platform promise. This political opportunity is generally preceded by a cause and effect narrative that identifies the *status quo* as the problem and a new UHC policy or the major reform of an existing UHC policy as the solution.

Of course, the more precise policy solution in terms of its design features must also be on offer and acceptable to a critical mass within the population. Kingdon (2011) described three streams – political, problem and policy – based upon case studies of major policy shifts in the United States. The streams are normally separate, but very occasionally converge, offering a rare opportunity for momentous policy shifts. These critical junctures are associated with policy entrepreneurs who are active in orchestrating the winning advocacy coalitions. Unsurprisingly, Kingdon (2011) was able to apply his analytical framework to UHC efforts in the United States to explain why President Bill Clinton's reforms failed in the 1990s and President Barrack Obama's Affordable Care Act was passed in 2010.

Kingdon's analytical approach invites the kind of nuanced and historically contextualized narrative that is the natural expertise of historians. Although there is no study of this, I suspect that historically trained scholars have been central to establishing dominant narratives on the implementation and major reform of UHC in a number of countries. Britain's NHS has its own official historian (Webster, 1988, 1996) as well as narratives by historically trained scholars such as Daniel Fox (1986) and Rudolf Klein (2013). These and other authors have produced a rich historiography that is marked by competing interpretations (Gorsky, 2008). One of the authors of a recent history of UHC in Australia was trained as an historian (Boxall and Gillespie, 2013). As for Canada, I have previously commented on the limited contributions by professional historians in establishing or contesting the dominant narrative of Canadian Medicare (Marchildon, 2012).

However, even the medical and social scientists whose accounts have become the dominant narrative of Canadian Medicare have used historical methods and primary sources (Naylor, 1986; Taylor, 1987; Maioni, 1998).

Admittedly, UHC will always be a subject that calls for multidisciplinarity. The extensive – indeed often overwhelming – archival record upon which UHC narratives are based require an intimate knowledge of government organization and state bureaucracies generally better known to policy scholars and (some) political scientists than to professional historians. Such changes generate tonnes (terabytes) of documentation by governments and stakeholders that must eventually be navigated and parsed by scholars. Finally, at least in the case of federations, especially highly decentralized federations such as Canada, there may not be a national history. In these cases, financing, regulation and administration of UHC can be highly fragmented among sub-national governments and health systems. This presents unique challenges because it requires highly distributed, time-consuming research. It also puts a premium on the creative skills to organize this research within an overarching narrative.

Given this, how might professional historians contribute to a better policy understanding by policy-makers as well as better decisions when reforming UHC programs and policies? I have been a lawyer, a public administrator, an academic historian, as well as a policy scholar and advisor. Based on this experience, I would like to suggest what I think are the competencies, capacities and qualities policy practitioners would like to see in professional historians so that they can meaningfully contribute to developing better health systems and policies. These include the ability to:

1. provide pertinent context, in particular by placing a given UHC policy and structure into a historically informed – in terms of both sources and interpretation – trend and the corresponding logic for the trend;
2. separate the truly unique elements of existing or proposed UHC policies and structures from those elements which not novel; and
3. isolate the key forces that produced critical junctures allowing for the introduction or major reform of UHC policies and structures in the past and the relevant (as well as non-relevant) policy lessons to be drawn from history.

Most policy historians would have little difficulty with my first two points. However, I suspect some will object to the third point. In 2002, Lynn Hunt (2002), the president of the American Historical Association warned her members against 'the tendency to interpret the past in presentist terms'. I think that the fear of that accusation seems to keep many otherwise qualified historians from engaging in contemporary policy analysis.[2]

2 Over three decades ago, Daniel Fox, wrote a fascinating article on the natural tension between history and health policy. Although he had to that point enjoyed distinguished careers as both a public administrator and academic historian, he had refused to speak out on how the knowledge and skills he gained in both domains support each other for fear that he would be 'labelled a presentist by historians and a fool' by policy practitioners (Fox, 1985: 349).

The past is always, necessarily, viewed through the lens of the present. This explains why historical interpretation – historiography – shifts with time and with each new generation of historians. As Giselle Byrnes, an historian and author-editor of *The New Oxford History of New Zealand* puts it so eloquently: 'our present-day values and attitudes' inevitably 'inform how we look back and review what has gone before' and even 'the questions we put to the past' (Byrnes, 2012: 2). For this reason alone, there cannot be a single standard of objectivity and any history, including the history of the NHS in the United Kingdom or the history of UHC in any other country is fated to be, as Byrnes describes, 'a constant conversation with the past' (2012: 2).

One of the greatest strengths of professional historians is their skill in accessing and using primary sources in order to find new or corroborating facts, and their ability in weighing and judging these facts. The challenge is that the closer you get to the present, the fewer the primary sources in part due to the 25-year rule on access to government documentation. Most professional historians avoid the very recent past for this reason. However, in addition to providing decision-makers with the historiography of the past establishment or reform of UHC policies, they can use their ability in judging sources to evaluate facts and beliefs about current UHC policies in the context of the longer-term historical development of these same policies. If this is presentism, then I fail to see its danger.

Professional historians trained in the methods of social history are well placed to deal with the attributes of policy often overlooked by policy technocrats. Whether UHC is established or structurally reformed in any given jurisdiction is more a product of power and money than the administrative capacity of the government or the logic of the policy's design. This is something which any experienced politician or senior public administrator knows (Fox, 1985).

Here, it is the health policy experts, with their deep belief in rational decision-making and design, who have the disadvantage. Contemporary social historians are accustomed to studying non-state actors – and the power differentials among them – and their ability (or inability) to influence state action. Here again, historians have much to contribute in terms of explaining why and how UHC is introduced or structurally reformed in some jurisdictions and not in others.

By its very nature, UHC is contested policy. UHC policies vary considerably in terms of the extent, depth and breadth of coverage. They also differ substantially in terms of their design features. It is a truism to say that every UHC system is unique – differences abound between countries in terms of financing, administration, regulation and delivery. The only common connection is the policy goal of facilitating access to necessary health services by all citizens through public subsidy, coverage or direct services (World Health Organization, 2010; Marchildon, 2014). Historians are well placed to identify these differences and the unique social, political and economic contexts that produced them.

Except in the United States where the *Affordable Care Act* is of more recent and fragile vintage, UHC has been part of the policy landscape of many Organization

for Economic Co-Operation and Development countries for decades. The contemporary policy issue is whether existing UHC systems and policies are in need of major structural reform. There are two key issues involved here. The first is how a particular model of UHC has been characterized or mischaracterized as part of the pursuit of major reform or in defence of the *status quo*. The second is how the contemporary problem is framed and therefore what policy solution or range of solutions might be effective in addressing the problem. Historians are particularly well equipped to address the first issue and have been, and should be, key actors in the interpretation and criticism of the way in which we have come to understand the evolution of UHC in any given country.

The characterization of the evolution of a particular UHC policy is what I would call a cause and effect narrative, or what policy theorist Debra Stone refers to as causal stories. These stories establish what most of us believe when evaluating whether structural UHC reform is required. These narratives isolate the factors that are at the root of a particular problem, and then convert the problem into a policy-amenable solution requiring a shift in policy direction (Stone, 1989).

A historical understanding that is relatively true to the facts can potentially prevent serious errors in how policy problems are framed and in the alleged reforms that are regularly advocated to address such problems. This means that, to the greatest extent possible, the dominant historical narrative should be sound. Such narratives necessarily omit considerable detail so they must be sound in the selection of key facts, events and forces. Causal UHC narratives need to be regularly tested and probed for weaknesses and should be the subject of active debate by scholars, especially historians.

For example, in the dominant historical narrative of the NHS, there was little to suggest that from its inception, the NHS was a corporatist accommodation with organized medicine (Greener and Powell, 2008). Challenging the founding myth perpetuated by historians of the NHS, Rudolf Klein colourfully described this critical feature as the 'politics of the double bed' shared by physicians and the British government (Klein, 1990). For Klein, this feature of the NHS was essential to its founding and essential to any proper diagnosis of problems in its development. This is the same point made by historian Sally Sheard in her study of the failure of successive postwar reforms to address unreasonably long wait times in the NHS. The fact that successive administrations have never recognized the extent to which physician management of elective wait times on behalf of their patients is the core of the problem has produced a series of reforms that have never been able to supplant more individual and subjective judgements with a more collective and objective method of ordering wait time patients (Sheard, 2018).

The importance of the causal narrative can be illustrated in a contemporary court case involving Canadian Medicare. Since September 2016, the British Columbia Supreme Court has been hearing a trial in which two key aspects of the Canadian model of Medicare, as implemented in provincial law and policy, are

alleged to have contravened the provisions of the *Canadian Charter of Rights and Freedoms* and therefore should be eliminated. One involves British Columbia's prohibition on the sale of private insurance for UHC services, generally referred to as duplicate or parallel private health insurance (Flood and Archibald, 2001; Marchildon, 2005; Madore, 2006). The second involves the provincial laws, regulations and policies that discourage physicians from providing private services to patients while providing Medicare services to patients who are exempt from paying at the point of service, commonly known as dual practice (Eggleston and Bir, 2006; García-Prado and González, 2011). If the courts find that these two aspects of Canadian Medicare are unconstitutional, this could trigger big ban policy change, and produce UHC that is neither single-tier nor single-payer.

Numerous experts on both sides have prepared extensive affidavits on the nature of Canadian Medicare and many of these documents are interesting exercises in the differential framing of Medicare's problems and, ultimately, the reforms, both major and minor, that are needed to 'fix' Canadian Medicare. While I am only one of dozens of experts involved in this case, I was alone in being asked to provide a history of Medicare with a focus on the evolution of provincial policies concerning duplicate private health insurance and physician dual practice. In reality, however, almost every expert affidavit has an implicit, if not explicit, causal narrative. Of course, they vary in terms of the quality of the research, the sophistication of historical interpretation and the ways in which evidence, including historical evidence, is used and abused. My narrative makes it clear that there was considerable variability among provincial governments in the manner in which they implemented and regulated Medicare.

This is not to suggest that my historical interpretation or any other single historian's selection and interpretation of the evidence or constructed narrative about the evolution of Canadian Medicare should be treated as the only truth. This could hardly be the case. However, using primary sources to fill in gaps left by, or to check the accuracy of, existing accounts, carefully sifting through and then weighing and judging the evidence, providing previously undiscovered facts relevant to current debates, and exercising caution in drawing conclusions, are the daily work of professional historians. Like all scholarship, this work can and should be reviewed, debated and probed for weaknesses by other scholars in the discipline. Indeed, a Canadian historian who had previously provided his own narrative of Canadian Medicare as part of a larger policy prognosis scrutinized my affidavit as well as the historical evidence and interpretation of other expert witnesses called on behalf of the Attorney General of British Columbia (Bliss, 2010). It is now up to the trial judge to weigh the strength of this mass of expert evidence and to determine who has the narrative that best and most accurately captures the essence of the development of Medicare in Canada.

Based on his experience with the famous *Irving v. Penguin* libel case involving the weighing of historical evidence as it pertained to the Jewish holocaust in the Second World War, the historian Richard J. Evans has argued "the encounter

between history and the law in trials of this kind does violence to the principles of both" (2002: 32). While I accept that the legal rules of evidence and legal standards of proof do differ from the professional historians rules of evidence and standards of proof in theory, I do not think they differ in actual practice as much as Evans suggests (Mulvihill, 1999). In the end, judges have to sift, weigh and make judgements on evidence in ways that often parallel that of historians, and I think the court will be much better off for having the benefit of historical evidence including differing historical interpretations. The alternative is to be limited to truly presentist expert evidence. Given the court's new role in potentially triggering big bang health reform in Canada (and other countries), this may lead to a legal decision that both gets the problem wrong and opens the door to structural reforms that undermine rather than improve existing UHC structures and policies.

Acknowledgements

The author would like to thank Erika Dyck, Colleen Flood and two anonymous reviewers for their very helpful comments and suggestions on the original draft.

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