Australian Journal of Public Administration, vol. 74, no. 1, pp. 33–41 doi:10.1111/1467-8500.12135

RESEARCH AND EVALUATION

Success and Failure in Public Policy: Twin Imposters or Avenues for Reform? Selected Evidence from 40 Years of Health-care Reform in Australia*

Adrian Kay
Australian National University

Anne-marie Boxall
National Rural Health Alliance

In explaining policy reform, there is a tendency to assume that causes and outcomes are temporally contiguous and that the consequences of reform efforts unfold quickly. There is no obvious reason, theoretical or empirical, why this should be the case when considering the relationships between policy failure and policy success. This paper considers why and how policy failures may be causally linked to future policy events in sequences over extended periods of time. In particular, this paper focuses on the different mechanisms that might connect assessments of policy failure and subsequent reform success. Empirically, it draws on selected evidence from patterns of policy failures and successes in Australian health policy over a 40-year time period.

Key words: *policy reform*, *success and failure*, *health policy*

Introduction

How well do Australian governments govern? One of the enduring themes in the study of public administration, in Australia as well as internationally, concerns governance limits and policy failures. Indeed, more than 50 years of the policy sciences have not only produced a wide range of models and tools for supporting 'better' public policy-making, they have also produced various generations of research and analysis showing how often, and how badly, things may go wrong in public policy.

For example, the venerable policy implementation literature is built on studies of US social policy that stressed that many social programs failed to accomplish their objectives, that policies had serious unintended effects, and that public sector productivity was often poor. The public choice canon, in turn, focuses on systematic government failure and produced the Reaganite anthem that government was the problem and not the solution.

In turn, beginning in the early 1990s, the 'new public management' has become conspicuous with origins in, among other things, the 'reinventing government' movement in the United States. This represents an attempt to integrate market-oriented thinking into the organization and *modus operandi* of the public sector. Inspired by these developments, the now-established discipline of public management is replete with case studies of policy success, and associated lessons for public sector innovation, service delivery improvement, and value for money testing.

*This research was supported by an award to Adrian Kay under the ANZSOG research grant scheme (health-care reform project). This funding is acknowledged gratefully.

Despite these pendulum shifts in attitudes to governance limits and policy failure, important questions for contemporary Australian public administration endure. This paper tackles one of these; the relationship between policy failure and success over time. By presenting a temporal analysis of policy development in which the drivers of policy and observed policy events are not necessarily closely linked across time, indeed the temporal link between cause and effect may be stretched over relatively long periods, we seek to add a dynamic perspective to assessments of policy failure and success. This supports the underlying ambition to investigate how policy failures might count as feedback and input into future policy development.

The first section of the paper investigates the concept of policy failure to assist understanding of how policy failures play out in longer sequences of policy making. This leads into the main analytical focus of the paper: the structural constraints and opportunities embedded in moments of policy failure, and the subsequent ability of reform advocates overcoming the constraints and utilizing the opportunities presented in future policy-reform struggles. There is a large set of potential causal dynamics that connects policy making over time, and the process tracing literature remains in its relative infancy in articulating these theoretically and investigating them empirically. The paper pays particular attention to two mechanisms in this set: first, learning mechanisms that establish how assessments of policy failure at one point in time may enable and shape subsequent policy change to overcome failure; and second, deinstitutionalization mechanisms where initial failure can create the conditions for subsequent reform success through processes of institutional erosion, undermining, and exhaustion. These mechanisms are explored empirically using selected evidence from Australian health policy reform over 40 years. The current health insurance system has its origins in a tumultuous and foundational sequence of policy change between 1972 and 1984. Australia has an internationally important health insurance model, attracting widespread attention, in the United States in particular (e.g. Braithwaite 1995). It is an intriguing combination of universal public health insurance with financial and regulatory support for one of the highest percentages of duplicative private health insurance cover in the OECD (Paris et al. 2010). This distinctively Australian solution to the societal dilemma of who pays for health care was forged in a pattern of policy change well beyond the two-dimensional range: Australia is unique in being the only OECD country to have introduced a universal public health insurance program (Medibank) and then subsequently abolish it as happened under the Fraser government 1975–1983, before the Hawke government reintroduced the almost identical policy in 1984 as Medicare.

The Concept of Policy Failure: Who Judges and against Whose Standards?

Any reasonable claim of policy failure requires the statement of a standard or benchmark against which to brace the assessment. This might be an absolute line or a standard relative to some moving target. In the most recently developed literature on policy failure (Bovens et al. 2001; Marsh and McConnell 2010a, 2010b; McConnell 2010a, 2010b; Bovens 2010), there is no scientifically objective standard – absolute or relative – for judgements of policy failure; rather they are constructed socially through two *types* of inquiry: those undertaken by experts as against those emerging from public politics.

In the influential Bovens et al. (2001) book, *Success and Failure in Public Governance*, the two types of inquiry produce different standards of policy failure. For the expert inquiry, the standard of failure is premised on substantive rationality and stresses evidence-based, technocratic solutions to given policy problems. In the political inquiry, the stress is on the standard of procedural rationality and the construction and impact of public perceptions of policy performance. The former part of conventional policy evaluation research in public administration. The latter occurs in the public arenas of politics, and is the subject of political science approaches to public administration.

In practice, the results of these two types of policy inquiry may be closely aligned: policy may fail to achieve substantive policy results, and also result in political punishment. Alternatively, governments may do well in policy expert terms and at the same time reap the political benefits of this. These are the sorts of outcomes one may hope for from various accountability and evaluation institutions in any advanced democracy. However, the outcomes of expert and political types of inquiry in policy performance may also conflict. Governments may succeed in policy terms on a given issue; yet find that politically significant groups and forums judge themselves to be worse off. Likewise, governments may be able to politically 'reframe' any failures against expert standards so as to minimize the political costs they might incur. Bovens et al. (2001) reports the results of six-country, four-sector comparative study of 24 policy episodes from the mid-1970s to early 1990s. Government efforts to tackle these challenges both in expert (referred to in the book as 'programmatic') and political inquiry terms are considered. The headline conclusion from the research was that political assessment of some public policies is often weakly related, or wholly unrelated, to their programmatic performance. Major programmatic successes may go unrecognized and therefore underutilized; and major policy fiascos do not necessarily lead to appropriate investigation, accountability, sanctions, and reflective learning.

The diagnosis of an asymmetry between expert judgement and public political judgement of policy failure is far from novel in public administration. The dilemma of the democratic expert has an ancient pedigree with roots in Plato, and enjoyed great salience in the first half of the 20th century in the United States in celebrated debates between Lipman (1925) and Dewey (1927) about democracy in a technological age, and has recently made a return in both public policy and democratic theory in the notion of epistemic communities (Haas 1992). This latter literature has served to investigate how, under conditions of changing territorial scales and modes of governance challenged with ever more 'wicked' and complex policy problems, experts have come to have a far greater say in policy-making than the canons of democratic political theory seem to allow. In some discussions this trend is valuable; a more epistocratic or expert-led politics holds out the prospect of evidence-based decision making, embodying policy processes that optimize efficiency and rationality, enabling policy makers to deal with the challenges of a globalized world (Kay 2011). For others, this tendency augurs the arrival of a post-democratic epoch in advanced industrial society (Crouch 2004).

To ensure that the concept of policy failure is meaningful, and not simply a label for a rhetorical strategy used by the powerful in public arenas of politics to prosecute their interests, it must satisfy some generally accepted standards. Although the key insight of the policy failure literature to date is that judgements of failure are socially constructed, it is important for the concept to avoid this insight leading to a self-defeating relativism where all claims of policy failure are treated as analytically equivalent with the only relevant variation for understanding policy processes being the power of those advancing the claim.

Acknowledging that the process of expert inquiry will construct different standards of policy failure than those from the public arena does not preclude the statement of some basic criteria for policy failure. This paper offers two minimum standards for any claim of policy failure to satisfy in either type of policy inquiry. First, any standard of assessment constructed within a particular community of inquiry must be transparent and evidence able to be evaluated against it. Second, any policy failure must be demonstrably remediable; reasons must be provided as to why things can be or could have been better. This second criterion contributes to economy in the use of the concept by excluding doomed policy enterprises from its analytical reach. That a policy that is irremediable cannot be considered a failure is related to the case where a reform effort costs more than the policy failure it is solving. This is the test from public economics, where identification of a market failure is not sufficient alone to provide a rationale for public policy. Instead, it is also necessary to observe that the likely cost of government failure – a close

relative of policy failure – is less than the cost of the market failure identified as the reason for policy action.

Health policy reform is a valuable case for exploring policy failure and success because there are many more reform attempts than successful reforms, and failure in health care reform often has high political costs. Health reform in Australia is useful in particular because of its relative frequency so that the time periods separating each success episode of reform are relatively short, and there is an opportunity to assess the links between them. Between 1975 and 1981, for example, six major changes to health insurance policy were implemented by successive governments. In an examination of health reform in Australia it is possible not only to assess what constitutes failure in health policy reform, it is also possible to assess whether there is a relationship between failure and success.

Mechanism 1: Learning from Policy Failure

Frameworks of policy learning are rarely used in health policy to analyses developments within countries, instead cross-national learning may inform much contemporary policy-making. However, equally important is the temporal dimension, longitudinal learning across different moments of failure (and success) in the same health-care system (Klein 2009). For the purposes of this paper, learning concerns the capacity of actors to reflect on, and draw accurate and useful lessons from, the policy processes within which they are involved. Whilst lacking complete information, political actors have some capacity to learn. They are reflective, routinely monitoring the consequences of their action, and their knowledge of the sources of failure will generally increase over time. Of course, because the broader and policy-specific context is both complex and evolving, any knowledge acquired is likely to be incomplete and asymmetrically distributed across actors in the policy-making process. Through their actions and the consequences of these, policy makers learn, apprehending more clearly the informal institutions in policy and the constraints/opportunities they impose, and providing the basis from which subsequent policy strategy might be formulated.

May (1992) moves beyond who is learning to what is being learned by distinguishing between policy learning (instrumental and social) and political learning. The insight that policy learning is not always instrumental but sometimes social is a seam that runs through many models of the policy process; and it has roots back to the earliest work by Lasswell on the distinction between contemplative and manipulative policy analysis and its cognate, analysis *of* versus analysis *for* policy. In principle, policy failure should leave opportunities for policy learning (Bennett and Howlett 1992); yet May finds that policy failure contexts tend to be conducive to political learning about the viability of different political strategies in the policy process, how better to advance ideas, or clues about coalition building. For example, Hawke learnt important lessons about health insurance reform from both the Whitlam and Fraser governments before him. Whitlam ignored the budgetary and economic consequences of introducing universal health insurance, whereas Fraser gave these issues priority, even at the expense of making coherent health policy. Hawke, in contrast, understood the inextricable links between health and economic policies. By building strong coalitions with both business and the unions, Hawke was able to successfully introduce Medicare – the same program that had previously been implemented and abolished – with relative ease (Boxall and Gillespie 2013). This leaves us short of firm propositions about policy failure and policy learning, but does suggest that there is no one-to-one mapping between types of failure inquiry (expert and public political) and types of policy learning.

Across the sources of policy failure, learning consists of apprehending more clearly the informal institutions in policy making and the constraints they impose and opportunities they create. Of course, because the broader and policy-specific context is both complex and evolving, any knowledge acquired is likely to be incomplete and asymmetrically distributed across actors in the policy-making process.

Importantly, policy makers are in situations of strategic interdependence and have to make estimates on the strategic motivations, intentions, and likely actions of other significant players in a constantly evolving context as a result of strategic interaction. Thus the presumption of cumulative learning toward a 'better' public policy is difficult to sustain: there is no guarantee that actors draw the 'right' lessons from failure, or have the capacity to judge which lessons are right and which ones are wrong. To illustrate, in order for Labor under Hawke to successfully introduce Medicare, it had to find ways of boosting the economy to pay for the expensive program. It did this by making the introduction of Medicare contingent upon the roll-out of large-scale economic and industrial relations reforms (outlined in the Price and Incomes Accord), and the scheme has endured. However both the Whitlam and Hawke-Keating governments failed to make substantial changes to the longstanding private health insurance scheme that sat alongside Medibank/Medicare. Whitlam was not in power long enough after the introduction of Medibank to have to deal with the problem of funding both universal health insurance and, to a lesser extent, private health insurance (through subsidies and rebates). The Hawke-Keating government dealt with the budgetary problem by progressively withdrawing all subsidies for private insurance. However near the end of its time in power, the Keating government was forced to quickly restore support for private insurance to prevent the collapse of some private insurance funds (Boxall and Gillespie 2013). Neither the Hawke-Keating governments nor any government since has heeded the lessons of the Fraser years about the challenges of balancing a universal, tax-funded insurance scheme alongside a substantial duplicative private insurance scheme.

If policy failure is the result of expert and/or public political inquiry, an important dimension for study is the beliefs held by government officials and various other types of stakeholders continuously and actively involved in policy formulation and implementation. When these beliefs concern failure and are updated, changed by reflection on processes or outcomes then we have learning. This learning may act casually in our accounts of policy development. This type of policy learning by actors occurs within a structure that may constrain certain actions and facilitate others. This structure may also facilitate and constrain which lessons are learned from policy experience and which are ignored. Because policy, as an institution, also reflects the outcome of past power struggles, learning may be constrained by power.

The lessons learnt by former Prime Minister John Howard on health insurance serve as an interesting example. As treasurer during the Fraser years (1977–1983), Howard and his department fought hard to abolish the expensive Medibank scheme. Howard strongly opposed the idea of compulsory, tax-funded insurance and advocated instead for the restoration of a market for private health insurance, which had been in operation since the early 1950s. Ultimately, Howard's view prevailed and Medibank was abolished. As opposition leader in 1987, Howard declared that his government would move quickly to dismantle the hugely popular Medicare scheme if elected (it was not). By 1995, and during his second term as opposition leader, Howard had changed his mind about Medicare. He explained:

> when Medicare was first introduced I was critical of it ... and so were a lot of other Australians. But over the years people have grown to support it. It gives them a sense of security and it now has our total support. And there's no law in politics that says that you can't over a period of time change your view about an issue. (Elliot 2006, p. 133)

Another related way to make progress on the link between failure judgments and policy learning mechanisms may be to think in more-general feedback terms. The politics of failure may reveal constraints and opportunities to reflective and skilful reform advocates who want to change policy in particular directions and to those who desire the status quo and at the most willing to accept limited adjustments to address the most immediate policy problems. These perceived opportunities and constraints influence the power balance within the policy process by empowering some actors

with particular interests and weaken others who hold differing views on the desired direction of policy evolution regardless of whether or not these views are motivated by power concerns or are outcomes of genuine learning processes. Whitlam, for example, was the chief protagonist for Medibank in the Labor party, both in opposition and government. He succeeded in pushing his policy preference upon the party (even though others supported alternative proposals) because his party knew that it was his electoral appeal that gave them the best chance of winning the 1972 election. Fraser, too, dominated his party in opposition and government. It was Fraser's decision to reverse the Coalition's longstanding commitment to abolishing Medibank in the lead up to the 1975 election; it was a decision that shocked and riled his colleagues. Although the Fraser government did eventually abolish Medibank, there is substantial archival evidence showing that Fraser's commitment to 'maintaining Medibank' was genuine and highly influential in policy deliberations during his years in government.

As previously stated, health policy reform is a useful case because there are many more reform attempts than successful reforms, and failure in health care reform often has high political costs. Although governments are understandably keen to distance themselves from policy failures, both experts and politicians are not always so keen to move on. This may be desirable for instrumental or social learning reasons; in the emerging literature on experimentalist governance, failure is to be expected and succour drawn from failure as a prelude to establishing 'what works' through strategies of 'trial and error' and 'learning by doing'.

Mechanism 2: Policy Failure as a Catalyst for Deinstitutionalization and Institutional Change

Institutionalist insights have recently been adapted for the more fine-grained concept of policy by recognizing that clusters of governmental decisions, actions, and norms can – over time – form policy systems, reinforced by feedback mechanisms, which function as institutions. Institutions are defined conventionally as sets of regularized practices with a rule-like quality that structure the behaviour of political and economic actors in policy making and that cannot be changed easily or instantaneously (e.g. Mahoney and Thelen 2010). The crux of institutionalism for policy studies is the claim that institutions matter in the analysis of policy change, providing constraints on as well as opportunities for change, and that they emerge and develop within a wide variety of historical processes and sequences.

In an analytically separate mechanism to learning, policy failure inquiries may also trigger deinstitutionalization processes. For example, in certain policy contexts as policy failures begin to occur they tend to exhaust institutions, lead them to be less widely observed or become imperfectly reproduced. At other times, policy failure may surprise and induce institutional change (e.g. wholesale replacement or adaptation or conversion or layering) and subsequent policy change. This paper posits that it is the relationship between relatively informal and formal institutions that is essential to understand how judgements of policy failure may trigger deinstitutionalization and subsequent institutional change.

As a basic conjecture, the claim is that *the informal tends to subvert the formal* as policy failure undermines institutions. Formal or law-like institutions that are codified and enforced by third parties are by their nature 'stickier' than informal institutions. Policy failure as a negative feedback affects informal institutional practice more immediately, absent of any grand reform, as things are done slightly differently in response to failure inquiries. This may be unconscious but can steadily accumulate over time to the point where related formal institutions are undermined. This is beginning to happen in health care with the stark divide between the public and private systems gradually eroding at the service delivery level even though there have been no major changes made to our mixed public-private health insurance arrangements for over 30 years.

Over time, demand for elective surgery (e.g. joint replacements and cataract surgery) has continued to rise and along with expectations

about access to timely care, regardless of whether they are publicly or privately insured. While privately insured patients are able to access care quickly, publicly insured patients (those covered only by Medicare) often have to wait excessively long times. In some states, governments have begun to solve this problem by expanding the use of public sector contracting – the government pays private providers to provide care to public patients. While good for patients, some in the private sector (both hospitals and health insurance funds) have expressed concern, arguing that the practice blurs the distinction between the public and private sectors too much and undermines the value of private sector altogether. In response, some of private sector executives are now advocating for large-scale (institutional) reform to Australia's health system, in particular to the longstanding arrangements that support our mixed public-private insurance scheme (Boxall et al. 2014).

Neither functional necessity nor performativity guarantee institutional stability. Sometimes institutions can undermine their own foundations (Jacobs and Weaver 2013; Polanyi 1944). Even a self-correcting capacity embedded in an institution in which policy failure seems to be a positive self-reinforcing feedback because of the presence of equilibrating adjustments can bring down or exhaust an institution over time. For example, the density of rules to cope with policy failures *qua* exceptions increases, and such density and complexity can lead to rules over time become self-disorganizing. Some policies fail slowly; imperceptibly undermining their own political support by failing to meet changing contexts and there can be expert discussions of new policy options or wholesale paradigm change. But there is always a double movement, resistance back. It is when the pushback in response to failure no longer provides resistance to change. Simply, point is that failure repeated can gradually weaken institutions, exhaust them; failures are both a symptom but also a cause of de-institutionalization. Where learning breaks the paradigm is the interesting point, when social learning takes over from instrumental learning that we see change.

Australian Health Policy Sequences: Failure, Success, Success, Failure?

Australian health insurance policy reform between 1972 and 1984 represents an 'extreme' case study for investigating change because of its highly unusual pattern. The case provides a powerful means to explore the three hypotheses because it displays, within a decade, two major reforms sitting at both ends of a period of gradual but transformative change. This pattern is beyond the analytical reach of two-dimensional policy change typology. The concepts of layering and conversion contribute to opening up for empirical analysis endogenous processes of policy change.

Medibank is an example of policy-layering and evidence-reinforcement mechanisms alongside endogenous change pressures operating in the period has been collected such as (i) an opportunity for exit from the public element of the health insurance system possibly encouraging a reduction in loyalty to and undermining political support for that public element; (ii) policy tensions in the trade-off between the goals of equity and efficiency in a health-care system; (ii) segmentation in health financing, particularly where private health insurance has high political and public visibility, which may introduce significant collective action problems in policy implementation.

The Whitlam bills to introduce Medibank were at the top of the agenda of the unique joint sitting of the house of representatives and senate in August 1974, following the double-dissolution 1974 federal election; the only time that members of both houses of the Commonwealth parliament have sat together as a single legislative body under section 57 of the constitution. This seminal 'big bang' moment initiated a sequence of policy change that was far from 'locked-in', nor immediately transformative. The tentative proposition from the evidence so far is that key actors in the decade after 1974 regarded Medibank variously as a failure but a constraint to be observed and possibly converted, but also at other times failure that required major reform.

Gillespie (1991) presents an important political history of the early period of the Australian health-care state up to 1960, but in terms of tracing the policy path from Medibank to Medicare the literature is relatively limited: Sax (1984) along with Boxall and Gillespie (2013) provide the most in-depth and comprehensive accounts of the period; and there are several important journal articles or edited book chapters on different aspects or sub-periods of the 1972 to 1984 time slice (e.g. Cass and Whiteford 1989; De Voe and Short 2003; Hunter 1984; Najman and Western 1984; Scotton 2000; Scotton and Macdonald 1993). The pressing gap in our understanding remains: how the judgements of Medibank reform failure shaped subsequent political dynamics. Missing in current work is an assessment of the critical endogenous processes operating during the period, such as the construction of failure in institutionalized policy areas, and policy failure as a destabilizing force in institutional reproduction, as well as learning in reform design.

Most work attempting to explain health policy development in Australia continues to rely on variants of Sidney Sax's influential (1984) book, *A Strife of Interests: Politics and Policies in Australian Health Services* (e.g. Duckett 1984; Gardner 1989; Hunter 1984; Najman and Western 1984), which adopts a pluralist interest group approach to political analysis. This general approach has struggled to sustain explanations of the timing and nature of substantial health policy reform in different OECD health-care systems (Hacker 2004).

Conclusion

The results of an explicitly temporal and causal analysis of a selection of reforms over the last 40 years suggest, unsurprisingly, that the sequence in which different causal factors occur will be critical in identifying how and when health insurance policy changes in the period. The reproduction of policy over time is not an automatic or self-perpetuating process; and judgments of failure play an important and contingent role in deinstitutionalization in different policy subsystems of Australian health policy. There is a degree of plasticity built into the design and implementation of mixed public-private health insurance systems: whilst they are relatively durable, costly to overturn, and may enter as causal factors in the behaviour of different groups, they always remain contested settlements sustained by specific configurations of political coalitions. These tensions are at the foreground of the relationship between failure and success; those who benefit from policy institutions, whilst they will have a preference for ensuring institutional continuity, must mobilize political support on an ongoing basis as well as actively seeking to resolve the tensions in processes of learning and deinstitutionalization in their favour. This is relevant as Australia is in the midst of another significant reform to its health-care system left as the legacy of the Rudd-Gillard governments combines uneasily with the ambitions of the Abbott government. Although the current reforms ignore the structural tensions between public and private funding established by Medibank, this is a longstanding source of judgments of policy failure; from the Productivity Commission's predecessor as far back as 1997 (Banks et al. 1997) and was clear in both the private health insurance rebate 'policy patch' under the Howard government (Kay 2011) as well as in the report of the National Health and Hospitals Reform Commission (2009).

References

Banks, G., H. Owens and B. Kearnery. 1997. *Report No. 57: Private Health Insurance*. Canberra: Industry Commission.

Bennett C. J. and M. Howlett. 1992.'The Lessons of Learning: Reconciling Theories of Policy Learning and Policy Change.' *Policy Sciences* 25(3):275–294.

Bovens, M. 2010.'A Comment on Marsh and McConnell: Towards a Framework for Understanding Policy Success.' *Public Administration* 88(2):584–585

Bovens, M, P.'t Hart and B. G. Peters (Eds.). 2001. *Success and Failure in Public Governance: A Comparative Analysis*. Cheltenham: Edward Elgar Publishing.

Boxall, A. and J. Gillespie. 2013. *Making Medicare: The Politics of Universal Health Care in Australia*. Sydney: UNSW Press.

Boxall, A., T. Tobin and J. Gillespie. 2014. 'Public Problems, Private Solutions? Short-term Contracting of Inpatient Hospital Care, Issues Brief.' Canberra: Deeble Institute for Health Policy Research, Australian Healthcare and Hospitals Association.

Braithwaite, J. 1995.'Health Care Reform under President Clinton: Issues, Ideas and Implications.' *Australian Journal of Public Administration* 54(1):102–112.

Cass, B. and P. Whiteford. 1989. 'Social Policies from Fraser to Hawke.' In B. W. Head and A. E. Patience (Eds.), *Australian Public Policy in the 1980s* (chapter 11). Melbourne: Longman.

Commonwealth of Australia. 2009. A Healthier Future for All Australians. Final Report of the National Health and Hospitals Reform Commission. Canberra: Australian Government.

Crouch, C. 2004. *Post democracy*. Cambridge: Polity.

De Voe, J. E. and S. D. Short. 2003.'A Shift in the Historical Trajectory of Medical Dominance: The Case of Medibank and the Australian Doctors' Lobby.' *Social Science and Medicine* 57:343–353.

Dewey, J. 1927. *The Public and Its Problems*. Ohio: Ohio University Press.

Duckett, S. J. 1984. 'Structural Interests and Australian Health Policy.' *Social Science and Medicine* 18:959–966.

Elliot, A. 2006. 'The Best Friend Medicare Ever Had? Policy Narratives and Changes in Coalition Health Policy.' *Health Sociology Review* 15(2):132–143.

Gardner, H. (Ed.). 1989. *The Politics of Health: The Australian Experience*. Melbourne: Churchill Livingstone

Gillespie, J. A. 1991. *The Price of Health: Australian Governments and Medical Politics 1910–1960*. Cambridge: Cambridge University Press.

Haas, P. 1992.'Epistemic Communities and International Policy Coordination.' *International Organization* 46(1):1–35.

Hacker, J. S. 2004. 'Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform.' *British Journal of Political Science* 34: 693–724

Hunter, T. 1984.'Medical Politics: Decline in the Hegemony of the Australian Medical Association?' *Social Science and Medicine* 18:973–980.

Jacobs, A. and K. Weaver. 2013.'Self-undermining Feedback and Endogneous Policy Change.' APSA Annual Meeting, Chicago, August 29–September 1.

Kay, A. 2011.'Evidence-based Policy-making: The Elusive Search for Rational Public Administration.' *Australian Journal of Public Administration* 70(3):1–10.

Klein, R. 2009. 'Learning from Others and Learning from Mistakes: Reflections on Health Policymaking.' In T. Marmor, R. Freeman and K. Okma (Eds.), *Comparative Studies and the Politics of Modern Medical Care* (pp. 305–318). New Haven: Yale University Press.

Mahoney, J. and K. Thelen (Eds.). 2010. *Explaining Institutional Change: Ambiguity, Agency, and Power*. Cambridge: CUP

Marsh, D. and A. McConnell. 2010a.'Towards a Framework for Establishing Policy Success'. *Public Administration* 88(2):564–583.

Marsh, D. and A. McConnell. 2010b.'Towards a Framework for Establishing Policy Success: A Reply to Bovens.' *Public Administration* 88(2):584–585.

May, P. J. 1992.'Policy Learning and Failure'. *Journal of Public Policy* 12(4):331–354.

Maynard, A. (Ed.). 2005. *The Public-Private Mix for Health*. Oxford: Nuffield Trust.

McConnell, A. 2010a. *Understanding Policy Success: Rethinking Public Policy*. Houndsmills: Palgrave Macmill

McConnell, A. 2010b.'Policy Success, Policy Failure and Grey Areas In-between.' *Journal of Public Policy* 30(3):345–362.

Najman, J. M. and J. S. Western. 1984.'A Comparative Analysis of Australian Health Policy in the 1970s.' *Social Science and Medicine* 18:949–958.

Paris, V., M. Devaux and L. Wei. 2010. OECD Health Working Papers No. 50, Health Systems Institutional Characterstics: A Survey of 29 OECD Countries. Paris: OECD.

Polanyi, K. 1944. *The Great Transformation: The Political and Economic Origins of Our Time*. Boston: Beacon Press.

Sax, S. 1984. *A Strife of Interests: Politics and Policies in Australian Health Services*. Sydney: George Allen and Unwin.

Scotton, R. B. 2000.'Milestones on the Road to Medibank and Medicare.' *Medical Journal of Australia* 173:5–7.

Scotton, R. B. and C. R. Macdonald. 1993. The Making of Medibank. Australian Studies in Health Service Administration No. 76. Sydney: University of New South Wales, School of Health Service Management.