

Becoming Australian? Two different approaches to health care reform in the United States

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THE “SUBSTANTIAL PRIVATE SECTOR”¹ ROLE in Australian health care has sometimes given rise to fears of “Americanisation” of the Australian health care system, particularly in the media. For example, in 2000 Kenneth Davidson wrote, “The US-style health financing route being taken by the Howard Government is mad and bad.”² The US system is the “leading example” of “inferior system performance”³ and is often viewed as a system to be feared and avoided.

Despite spending far more per capita than any other country on health care, the United States nonetheless fails to provide equitable health care for everyone. The system is “a paradox of excess and deprivation”,⁴ spending far more than other systems without providing adequate care and treatment for all.

Although the US system is seen as frightening in Australia, broad historical and political similarities such as the “strong”⁵ role and “long history”⁵ of private insurance and powerful, vocal physicians’ groups^{1,5} make the Australian experience a useful comparative one for US policymakers. As Altman and Jackson note, the US system will probably not develop into a fully public system, but a system combining private and public aspects along the lines of the Australian model is possible.⁵

Furthermore, while politicians in the US at the state and local levels have attempted to address the issue of universal or near-universal coverage

What is known about the topic?

There is substantial information covered in the literature and media regarding the inequity of health care and the lack of universal coverage in the US health care system. National attempts at health care reform such as former President Clinton’s are also found in the literature.

What does this paper add?

This paper analyses two recent sub-national developments in US health care reform together rather than in isolation and compares them to aspects of the Australian system.

What are the implications for practitioners?

This will provide practitioners with a better understanding of these current developments and allow comparative analysis with the Australian system.

for some time, previous efforts sought to expand coverage using existing programs instead of establishing a new system.⁶ More recently, the state of Massachusetts and the county (municipality) of San Francisco have introduced near-universal health care programs. Although introduced nearly simultaneously, their development processes and structures differ. In addition, the Massachusetts plan in particular was viewed as a potential model for future sub-national and possibly national health reforms.

Thus, this short paper examines the two plans as two different approaches to health care reform in the US and compares them to the Australian system, asking the question whether or not current reform efforts in the US make the system more like that in Australia, or are likely to do so in the future.

The US health care system

Unlike other industrialised nations, the US lacks universal health coverage for its population. In

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2007, 45.7 million people, or 15.3% of the population, were uninsured.⁷ A series of studies commissioned by a major national health advisory body^{6,8-12} highlighted the problems and costs of the current health care situation in the US, including the fact that the uninsured have worse health outcomes.⁶ Uninsurance also affects access to health care services and treatment.¹³ For example, cost was the main reason for over one third of uninsured adults failing to fill drug prescriptions, and not taking recommended medical tests or treatments.¹³ Similarly, a recent Centers for Disease Control and Prevention (CDC) survey found that over 40 million adults failed to seek needed care, including medical care, dental care and drug prescriptions, because they were unable to afford it.¹⁴

The US system is characterised by a strong reliance on employer-based private insurance, with public coverage for particular groups such as children and the elderly rather than the entire population. Individually purchased private insurance plays only a small role in the system.^{6,13} Thus, lack of employer-based insurance coverage, due to unemployment or because it is either not offered or not affordable if offered, combined with ineligibility for public programs puts an individual at high risk for uninsurance. Uninsured individuals are typically low-income working adults.¹³

Health care reforms

Despite the system's failure to cover a significant percentage of the population, it is extraordinarily expensive, consuming about 2 trillion US dollars in 2005.¹⁴ The high cost of health care in the US is of significant concern to US families¹⁵ and policy makers, particularly in light of the projections of a 25% spending increase by 2030 as the population ages.¹⁶ As health care costs continue to increase, the numbers of the uninsured do as well.¹⁷⁻¹⁸ Nonetheless, for some time comprehensive national health care reform has not seemed imminent. In 2006, with a major federal overhaul of the health system unlikely, individual states and municipalities began experimenting with various methods to achieve universal health care.

Two recent reform efforts are the Massachusetts plan and the San Francisco plan. The Massachusetts plan garnered significant national press coverage due, at least in part, to the mandatory individual insurance purchasing requirement. The then-governor Mitt Romney declared that, "We insist that everybody who drives a car has insurance . . . And cars are a lot less expensive than people."¹⁹

The San Francisco plan was unique for two reasons, both of which helped it gain media coverage. The first reason was that it was the first US city to ever pass such legislation. The second reason, which differentiated the plan from its Massachusetts counterpart, was its emphasis on access, rather than insurance. Mayor Gavin Newsom's spokeswoman Jennifer Petrucione described the plan as "an actual system, whereby people have everything from primary care to pharmaceuticals."²⁰ A newspaper article described the San Francisco plan as the "reject[ion of] an insurance program in favor of expanded access to healthcare."²⁰ Despite these differences, both plans were said to be constructed around a sense of shared/collective responsibility, requiring employer, governmental and individual involvement. Furthermore, while both were sometimes described as "universal" care plans in the press, both contained significant exemptions and were thus more near-universal rather than truly universal care plans.

The Massachusetts and San Francisco plans

Beyond the obvious distinction that the Massachusetts plan is a state-level program and the Healthy San Francisco Plan (HSFP) is a county-level program, there are other important distinctions between the two plans.* Bodenheimer,²¹ drawing on the work of Bodenheimer and Grumbach,²² argues that there are essentially three

* Note that until April 2007, the Healthy San Francisco program was known as the San Francisco Health Access Program. See http://www.healthysanfrancisco.org/about_us/history.aspx for details on the name change.

broad types of universal health insurance: government-based (eg, single-payer), employer-based and individual-based. Using this classification, the Massachusetts plan builds on the current employer-based system widespread in the US, but mandates individual insurance for those outside the employer-based system. By contrast, the HSFP utilises the existing employer-based system but moves closer to a government-based system with its publicly funded and implemented plan.

In essence, the very philosophies of the two plans differ. The Massachusetts plan, especially the emphasis on individual purchase of private insurance, is closer in political spirit to former presidential candidate McCain's proposed health care plan. McCain's plan also shares similarities with plans proposed by ex-President Bush,²³ particularly the tax inducement for individual insurance and the loss of the tax break for employer-based insurance.^{23,24} These positions are conceptually grounded in the idea of uninsured individuals taking responsibility by purchasing individual insurance, with the implication that those who don't are free-riding. As noted by Glied, the "free-rider problem" is a core conceptual component of an individual mandate.²⁵

The HSFP, on the other hand, emphasises changing the current method of health care delivery to the uninsured. Its focus is therefore on a better system for health care access and delivery, rather than the individual purchase of private insurance. In addition, the HSFP is almost a system within a system: it may be seen as developing a new health care delivery system for the uninsured within the constraints of the existing framework.

The details of the plans, as well as the pre-plan situations, are contrasted in Box 1 and Box 2.

In part, differences in the uninsurance rate stem from Massachusetts' high rate of employer-based insurance.²⁶

By contrast, San Francisco's uninsurance rate is similar to the national uninsurance rate (about 15%) (Box 1).

The two plans have different emphases, with the Massachusetts plan focusing on the purchase of individual insurance with some employer

involvement and the San Francisco plan concentrating on employer contributions and some individual involvement. Also, the "choice" in both plans ends up on different sides. Massachusetts employers can decide which part of the provision of coverage/payment of penalties trade-off is most appropriate for them. San Francisco individuals can decide whether or not to participate in a program offering them access to care.

Another significant difference is the overall focus of the two plans. The Massachusetts plan is focused on expanding insurance coverage, while the HSFP does not emphasise insurance — the Universal Healthcare Council, when creating the plan, described it as "an affordable alternative to health insurance."³² The stated goal of the HSFP is to provide a primary care "medical home" for uninsured residents, and another objective is to make access to care easier.³⁴ In San Francisco, there are some nineteen health coverage programs for varying groups of people, and then several free clinics throughout the county for those ineligible for the aforementioned programs.⁴⁰ The provision of one "medical home" is thus an effort to simplify this complex and challenging system.

Furthermore, overall care has the potential to be much more coordinated under the HSFP. The Universal Healthcare Council agreed on a package of services that will be provided to uninsured individuals under the new plan. By contrast, despite the "minimum creditable coverage"^{38,41} provision that commences in 2009, the Massachusetts plan has a much more individualised focus. For example, there are several new insurance

I Pre-plan uninsurance statistics

Category	Massachusetts ²⁶	San Francisco ²⁷
Number of uninsured residents	550 000	82 000 (adults; children covered under a prior program ²⁸)
Uninsured as proportion of population	10%	15%

products as part of the Massachusetts plan, including special policies for people between the ages of 19 and 26.⁴² Approved plans are sorted into “tiers” which vary by the cost and services provided.⁴²

Finally, another difference between the two plans is the manner in which they were developed. The Massachusetts plan incorporated philosophies from both the US political right and left.³¹ Altman and Doonan also note that critical to the plan's passage was the “active engagement of businesses, hospitals, insurers and a sophisticated advocacy community”.³¹ Similarly, Hager also notes the “unprecedented involvement of the interfaith community” in developing the Massa-

chusetts plan,⁴¹ although the extent and means of engagement from these different groups is not clearly spelt out. By contrast, this was much clearer in the HSFP's case, as the Universal Healthcare Council was designed to be a collaboration and it included representatives from hospitals, business groups, various advocacy groups and labour unions.³²

There are several factors to consider in the links between political process and outcome. First, and possibly foremost, at the time of legislation Massachusetts was led by a Republican governor (Romney) with a primarily Democratic legislature, in contrast to the San Francisco government,

2 Comparison of the two plans

Category	Massachusetts Plan ^{29-31,38,39}	San Francisco Plan ³²⁻³⁷
Key date	July 1, 2007 (individual mandate begins)	July 1, 2007 (enrolment into the HSFP begins)
Mandate/core of plan	Individual insurance mandate — all individuals required to purchase insurance, and penalised for not doing so if it is “affordable”	Combination employer expenditure mandate and individual enrolment option — focus on affordable access to care, not insurance
Method(s) of achieving affordability	“Insurance market reform” Subsidies for low-income individuals State authority to determine annual “affordability schedule”	Income-based sliding scale for premiums, copayments
Eligibility requirements	Subsidies only for those ineligible for other programs	Ineligible for other public programs Earn below 500% of the federal poverty level Immigration status not part of eligibility criteria Aged 18–64 years
Individual's role	Must purchase insurance if able to afford it, or face taxation penalty	Encouraged to participate but no penalty for non-participation
Employer's role	Annual “assessment” if not providing insurance “Free rider surcharge” if not providing insurance and employees use state-provided “free care” beyond certain threshold Employers with 11 or more workers must offer plans letting workers buy insurance with pre-tax money	Must contribute financially to employees' health. Can take various forms, eg, expenditure on actual care, purchase of insurance, etc. Cost varies by business size
(Local) government management role	Enforce individual mandate using tax returns Creation of the Connector, a state authority serving as “intermediary” between individuals and insurers Authority can set policies, eg, “minimum creditable coverage”	Responsibility for implementation and overall management
Major exemptions	Businesses with 11 or fewer employees Individuals who cannot afford insurance or have religious objections to it	Businesses with 20 or fewer employees, or non-profit organisations with 50 or fewer employees Employees working less than a minimum number of hours per week

which had a Democratic mayor (Newsom) and a largely Democratic legislature. The Massachusetts plan was thus more likely to be a compromise between Republican and Democratic health care approaches, and the San Francisco one was not. Second, San Francisco's municipality status and comparatively smaller size made undertaking a more community-based approach much more feasible. It was thus always very likely that the plans could substantially diverge in terms of final design due to both structural and process differences during their development.

Current status

Both plans were implemented as scheduled, and both have encountered challenges after implementation. Though it is too early to fully investigate success or failure, some brief summaries of the situation can be undertaken.

San Francisco

The employer spending requirement was quickly challenged in court by the local restaurant association.^{28,43} Although the restaurant association initially won in local court,²⁸ enrolments continued during appeal⁴⁴ and a higher court ultimately struck down the earlier ruling favouring the restaurant association in October 2008.⁴⁵ However, further legal challenges cannot be ruled out.

Enrolment into the plan continued: by December 2007, 7400 people were enrolled²⁸ and over 31 000⁴⁶ (or over 37% of the uninsured⁴⁷) had enrolled by October 2008. However, about 6% had left the program, with a significant minority (42%) doing so because of the program fee.⁴⁷ Although some had left to join other programs, this "disenrolment" indicates that coverage of all uninsured residents may not occur.⁴⁷ The eligibility criteria were expanded in February 2009,⁴⁸ and enrolments have continued to increase steadily, with 36 622 enrolled by late February 2009.⁴⁹ However, the plan's exemptions (for example, small businesses and non-profits) make universality unlikely.

In summary, the plan has had some successes but also encountered serious obstacles and it ultimately seems likely to provide near-universal, though probably not fully universal, care.

Massachusetts

Massachusetts similarly experienced a fairly high and rapid enrolment, with 440 000 previously uninsured people getting coverage by June 2008, leading to a 6% decrease in the adult uninsurance rate.⁵⁰ However, the majority signed up for subsidised coverage, so expenditure has been higher than projected.⁵¹ These costs, partially due to an underestimate of the true number of uninsured,⁵⁰ remain a significant challenge.⁵¹

A related issue is that of affordability.⁵² While "affordability standards" have been set, premium increases pose a challenge to making coverage truly affordable for Massachusetts residents.⁵¹ Furthermore, there have been concerns about the cost of insurance for "lower-middle-income families" who are ineligible for subsidies.⁵³ In particular, such families may be required to spend significant amounts to purchase limited service packages that will leave them "underinsured."^{53,54} A survey of Massachusetts employers indicating that "affordability" issues were inhibiting employee insurance participation³⁹ highlighted this problem.

Although there were initial concerns that the "token penalties" for employers would lead to a decrease in employer-sponsored coverage,⁵³ thus far a majority of employers appear to support the plan⁵⁵ and employer-sponsored coverage seems to have increased.⁵¹

Additionally, there are exemptions, including one for religious beliefs.³⁸ Furthermore, the stated aim of the program is "to provide near-universal coverage",⁵⁰ so universality seems unlikely.

In summary, like the San Francisco effort the Massachusetts plan has also had some successes but also faces serious challenges, although the challenges in this case are mostly financial rather than legal. Furthermore, the Massachusetts plan also seems likely to achieve near-universal rather than universal care.

Conclusion

Both the San Francisco and the Massachusetts health reform efforts are currently underway, and have both encountered significant challenges. In

addition, though both plans have had high, rapid enrolment, both are unlikely to achieve fully universal coverage (despite press and journal article headlines⁵⁶). The successes of the plans, as well as their challenges and limitations, highlight the difficult path ahead for reform in the US health care system, as well as the need for more comprehensive, national-level reform if true universality is to be achieved.

In terms of national reform, the plan that was proposed by President Barack Obama during his candidacy appears to lie closest to the Massachusetts plan. Similar to Massachusetts, Obama proposed a national Connector-type “exchange” and regulation of plan benefits.⁵⁷ However, there is no individual mandate, except for children, and a public plan would be available as an option for the uninsured as well as those “want[ing] new health insurance.”⁵⁸ While the details are not entirely clear, this appears to contrast with the San Francisco plan, which is not available to insured individuals, and the Massachusetts plan, which has no “public option” except government subsidies to assist low-income individuals in purchasing private insurance.

The Obama plan resembles the framework set forth by Schoen et al,⁵⁹ which also draws on the Massachusetts model. Again, a Connector-like mechanism is utilised, as is an individual mandate. Like the Obama plan and unlike the Massachusetts plan, the Schoen plan proposes “new options for the insured.”⁵⁹ This is a broader-based approach than both the Massachusetts and San Francisco plans, which are explicitly targeted at the uninsured. Because of this broader outlook, approaches like that of Obama and Schoen et al could be more able to lead to larger changes in the system, such as a shift away from employer-based insurance towards a public plan,⁶⁰ than the San Francisco and Massachusetts approaches.

Finally, the Obama plan, compared with the San Francisco and Massachusetts plans, has the potential to be a step closer towards universal coverage within a mixed public/private system. The plan proposed during Obama’s candidacy may be able to produce a mixed public/private system with some similarities but also some sub-

stantial differences to the Australian system, particularly because employer-based insurance is likely to continue to play a significant role. Applying Bodenheimer’s classification²¹ to mixed public/private systems, Australia would fall closer to the government-based end of the classification while a successful Obama plan would be closer to the employer-based end. By contrast, the Massachusetts plans would be in between the employer- and individual-based ends and the San Francisco plan would be between the employer- and government-based ends. Finally, neither the San Francisco plan nor the Massachusetts plan is likely to provide either fully universal care or a system with a strong public component resembling the one in Australia.

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Competing interests

The author declares she has no competing interests.

References

- 1 Hall J. Incremental change in the Australian health care system. *Health Aff (Millwood)* 1999; 18: 95-110.
- 2 Davidson K. Howard’s health plan mad and bad. *The Age* (Melbourne) 2000; 26 Jun.
- 3 Evans RG. Going for the gold: the redistributive agenda behind market-based health care reform. *J Health Polit Policy Law* 1997; 22: 427-65.
- 4 Enthoven A, Kronick RA. Consumer-choice health plan for the 1990s: universal health insurance in a system designed to promote quality and economy (1). *N Engl J Med* 1989; 320: 29-37.
- 5 Altman S, Jackson T. Health care in Australia: lessons from down under. *Health Aff (Millwood)* 1991; 10: 129-46.
- 6 Committee on the Consequences of Uninsurance; Board on Health Care Services; Institute of Medicine; The National Academies. *Insuring America’s health: principles and recommendations*. Washington, DC: National Academies Press, 2004.

- 7 DeNavas-Walt C, Proctor BD, Smith JC. Income, poverty and health insurance coverage in the United States: 2007. US Census Bureau current population reports: P60-235. Washington, DC: United States Government Printing Office, 2008. Available at: <http://www.census.gov/prod/2008pubs/p60-235.pdf> (accessed Oct 2008).
- 8 Committee on the Consequences of Uninsurance; Board on Health Care Services; Institute of Medicine; The National Academies. Coverage matters: insurance and health care. Washington, DC: National Academies Press, 2001.
- 9 Committee on the Consequences of Uninsurance; Board on Health Care Services; Institute of Medicine; The National Academies. Health insurance is a family matter. Washington, DC: National Academies Press, 2002.
- 10 Committee on the Consequences of Uninsurance; Board on Health Care Services; Institute of Medicine; The National Academies. Care without coverage: too little, too late. Washington, DC: National Academies Press, 2002.
- 11 Committee on the Consequences of Uninsurance; Board on Health Care Services; Institute of Medicine; The National Academies. Hidden costs, value lost: uninsured in America. Washington, DC: National Academies Press, 2003.
- 12 Committee on the Consequences of Uninsurance; Board on Health Care Services; Institute of Medicine; The National Academies. A shared destiny: community effects of uninsurance. Washington, DC: National Academies Press, 2003.
- 13 Kaiser Commission on Medicaid and the Uninsured; Henry J Kaiser Family Foundation. The uninsured: a primer. Key facts about Americans without health insurance. Washington, DC: KCMU, 2006. Available at: <http://www.kff.org/uninsured/upload/7451.pdf> (accessed Aug 2006).
- 14 National Center for Health Statistics, Centers for Disease Control and Prevention. Health, United States, 2007. Hyattsville, Md: NCHS; 2007. Available at: <http://www.cdc.gov/nchs/data/abus/abus07.pdf> (accessed Nov 2008).
- 15 Collins SR, Kriss JL, Davis K, et al. Squeezed: why rising exposure to health care costs threatens the health and financial well-being of American families. The Commonwealth Fund; 2006 September. Available at: http://www.cmwf.org/publications/publications_show.htm?doc_id=402531 [accessed 2007 April 12].
- 16 Centers for Disease Control and Prevention & The Merck Company Foundation. The state of aging and health in America 2007. Whitehouse Station (NJ): The Merck Company Foundation, 2007. Available at: <http://www.cdc.gov/aging/saha.htm> (accessed 2007 April 11).
- 17 Chernew M, Cutler DM, Keenan PS. Increasing health insurance costs and the decline in insurance coverage. *Health Serv Res* 2005; 40: 1021-39.
- 18 Davis K. Uninsured in America: problems and possible solutions. *BMJ* 2007; 334: 346-8.
- 19 Fahrenthold DA. Mass. bill requires health coverage: state set to use auto insurance as a model. *The Washington Post* 2006; 5 April. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2006/04/04/AR2006040401937.html> (accessed Apr 2007).
- 20 Lin II R-G. San Francisco plans to offer healthcare to uninsured residents: The city is on the verge of passing a plan to provide comprehensive care to estimated 82,000 people at an annual cost of \$200 million. *Los Angeles Times* 2006; 20 Jul [copy received from San Francisco Department of Public Health 2006 August 31].
- 21 Bodenheimer T. Insuring the uninsured: will the 2004 election provide an answer? *Ann Intern Med* 2004; 141: 556-61.
- 22 Bodenheimer T, Grumbach K. Understanding health policy: a clinical approach. 2nd ed. New York: McGraw-Hill, 1998.
- 23 Buchmueller T, Glied SA, Royalty A, Swartz K. Cost and coverage: implications of the McCain plan to restructure health insurance. *Health Aff (Millwood)* 2008; 27: w472-81.
- 24 Davis K. The 2007 state of the union address: the President's health insurance proposal is not a solution. New York: The Commonwealth Fund, 2007. Available at: http://www.cmwf.org/aboutus/aboutus_show.htm?doc_id=448217 (accessed Apr 2007).
- 25 Glied SA. Universal coverage one head at a time — the risks and benefits of individual health insurance mandates. *N Engl J Med* 2008; 358: 1540-2.
- 26 Kaiser Commission on Medicaid and the Uninsured; Henry J Kaiser Family Foundation. Massachusetts Health Care Reform Plan. Washington, DC: KCMU, 2006. <http://www.kff.org/uninsured/upload/7494.pdf> (accessed Aug 2006).
- 27 Fraser JF. About the numbers: a profile of uninsured adults in San Francisco. San Francisco Health Plan, 2006. Available at: http://www.sfhpa.org/files/PDF/SFHAP/2006_ProfileofUninsuredinSF.pdf (accessed Mar 2009).
- 28 Katz MH. Golden gate to health care for all? San Francisco's new universal access program. *N Engl J Med* 2008; 358: 327-9.
- 29 184th General Court of the Commonwealth of Massachusetts. Health care access and affordability. Conference committee report. Boston, Mass: 2006. Available at: <http://www.mass.gov/legis/summary.pdf> (accessed Sep 2006).
- 30 Steinbrook R. Health care reform in Massachusetts — a work in progress. *N Engl J Med* 2006; 354: 2095-8.

- 31 Altman SH, Doonan M. Can Massachusetts lead the way in health care reform? *N Engl J Med* 2006; 354: 2093-5.
- 32 Universal Healthcare Council. Final report to Mayor Gavin Newsom: San Francisco Health Access Program — serving uninsured adults. San Francisco, Calif: 2006. Available at: <http://laborcenter.berkeley.edu/healthpolicy> (accessed Aug 2006).
- 33 University of California Berkeley Labor Center. The San Francisco Health Care Security Ordinance: overview of the ordinance with questions and answers. Berkeley: 2006. Available at: <http://laborcenter.berkeley.edu/healthpolicy> (accessed Apr 2007).
- 34 San Francisco Health Access Plan; San Francisco Health Plan. Frequently asked questions. San Francisco Department of Public Health, 2006. (Copy received from San Francisco Department of Public Health Aug 2006).
- 35 Healthy San Francisco Plan; San Francisco Health Plan. Frequently asked questions. San Francisco: Calif, 2006. Available at: <http://www.sfhp.org/HealthySanFrancisco/FAQ/> (accessed Apr 2007).
- 36 City and County of San Francisco. San Francisco Health Care Security Ordinance. 2006. Available at: <http://laborcenter.berkeley.edu/healthpolicy/index.shtml>
- 37 Healthy San Francisco. Visitors: who qualifies. Department of Public Health. Available at: http://www.healthysanfrancisco.org/visitors/Who_Qualifies.aspx (accessed Nov 2008).
- 38 Steinbrook R. Health care reform in Massachusetts — expanding coverage, escalating costs. *N Engl J Med* 2008; 358: 2757-60.
- 39 Commonwealth Health Insurance Connector Authority. Report to the Massachusetts Legislature: implementation of the health care reform law, Chapter 58, 2006-2008. Available at: <http://www.mahealthconnector.org/portal/site/connector/menuitem.662b0c7793f3a4b2dbef6f47d7468a0c?fiShown=default> (accessed Nov 2008).
- 40 San Francisco Department of Public Health. Health care access: a guide to health care programs in San Francisco. San Francisco, Calif, 2006 (accessed Apr 2007).
- 41 Hager CL. Massachusetts health reform. *J Leg Med* 2008; 29: 11-22.
- 42 Commonwealth Health Insurance Connector Authority. Massachusetts health care reform 2007/2008 progress report. Available at: <http://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c?fiShown=default> (accessed Nov 2008).
- 43 Vesely R. San Francisco's solution. Plan to cover uninsured already facing lawsuit. *Mod Healthc* 2007 Aug 20; 37(33): 17.
- 44 California Healthline. Ruling lets provision of San Francisco health law continue. California Healthline, 2008 Feb 22. Available at: <http://www.californiahealthline.org/articles/2008/2/22/Ruling-Lets-Provision-of-San-Fran-cisco-Health-Law-Continue.aspx?topicID=37> (accessed Jun 2008).
- 45 Sorrel AL. Court upholds San Francisco employer insurance mandate. *AMedNews*, 2008 Oct 27. Available at: <http://www.ama-assn.org/amednews/2008/10/27/gvsb1027.htm> (accessed Nov 2008).
- 46 Healthy San Francisco. About us: program stats: 10.18.2008. Available at: http://www.healthysanfrancisco.org/about_us/Stats.aspx (accessed Nov 2008).
- 47 San Francisco Health Commission. Healthy San Francisco: program update. 19 Aug, 2008. Available at: http://www.healthysanfrancisco.org/about_us/Reports.aspx (accessed Nov 2008).
- 48 Healthy San Francisco. Visitors. Available at: <http://www.healthysanfrancisco.org/visitors/> (accessed Mar 2009).
- 49 Healthy San Francisco: About us: program stats: 02.28.2009. Available at: http://www.healthysanfrancisco.org/about_us/Stats.aspx (accessed Mar 2009).
- 50 Commonwealth Health Insurance Connector Authority. Health Connector facts and figures October 2008. <http://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c?fiShown=default> (accessed Nov 2008).
- 51 Kaiser Commission on Medicaid and the Uninsured; Henry J Kaiser Family Foundation. Massachusetts health care reform: two years later. Washington, DC: KCMU, 2008. Available at: <http://www.kff.org/uninsured/upload/7777.pdf> (accessed Jun 2008).
- 52 Sarpel U, Vladeck BC, Divino CM, Klotman PE. Fact and fiction: debunking myths in the US healthcare system. *Ann Surg* 2008; 247: 563-9.
- 53 Himmelstein DU, Woolhandler S. Massachusetts' approach to universal coverage: high hopes and faulty economic logic. *Int J Health Serv* 2007; 37: 251-7.
- 54 Anonymous. Costs could derail Massachusetts health reforms. *Lancet* 2006; 367: 1291.
- 55 Wilson JF. Massachusetts health care reform is a pioneer effort, but complications remain. *Ann Intern Med* 2008; 148: 489-93.
- 56 Anonymous. Universal health care in Massachusetts. *Lancet* 2007; 370: 103.
- 57 Antos J, Wilensky G, Kuttner H. The Obama plan: more regulation, unsustainable spending. *Health Aff (Millwood)* 2008; 27: w462-71.
- 58 Democratic National Committee. Barack Obama and Joe Biden's plan to lower health care costs and ensure affordable, accessible health coverage for all. Available at: <http://www.barackobama.com/issues/healthcare/> (accessed Nov 2008).
- 59 Schoen C, Davis K, Collins SR. Building blocks for reform: achieving universal coverage with private and public group health insurance. *Health Aff (Millwood)* 2008; 27: 646-57.
- 60 Hacker JS. Putting politics first. *Health Aff (Millwood)* 2008; 27: 718-23.

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