The Foreign is the Enemy: Using International Experience to Resist Change in Health Policy: A Research Note

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A Note to Readers: As with most conference papers, but more so with this one, the following essay is a work in progress. Given its present state I have chosen to re-title it as a Research Note. Therefore, I would appreciate it if you could contact me before citing it as a more up to date version might be available.

Abstract

Policy-learning" is a well established if not always rigorously specified concept. When the concept is rigorously specified, as more than just adopting similar policies and/or strategies, but as engaging in a discourse or exchange that reshape an actor's understanding of an issue, empirical studies have found that policy actors sometimes fail to live up to its requirements. Nevertheless it is a concept that has persisted and is used frequently. Among the most frequently cited types of policy learning is "international" policy learning, where one jurisdiction learns from the success of another. What is less well researched is the use that opponents of change make of international experience so as to rally resistance to policy reform. In a recent article, Lowry (2006) has proposed that this sort of resistive learning is sparked by "focusing projects". These are proposed changes that are so far beyond the scope of ordinary reform, that the supporters of the status quo have no reference point within their own policy experience to draw on so as to meet the challenge of such proposals. A comparison of the politics surrounding the making of health policy in Canada and the United States provides an interesting venue to test this hypothesis as opponents of change in each country have held up supposed failures of the other to explain why sensible people ought to resist health policy reform. This Research Note lays out the theoretical basis for a study that will specifically look for evidence that international exchange increases between opponents of reform and groups on the other side of the border at times when potentially significant reforms to the way health care is financed and delivered take centre stage on the issue agenda.

Introduction: Fear-mongering, Deep Understanding or Both?

The May 2011 election campaign did not go very well for the Liberal Party of Canada. Liberals found themselves desperately fighting to stave off what would ultimately be their worst electoral defeat in their party's history. In such a situation the party decided to bring out all its heavy artillery in an attempt to undermine the credibility of Prime Minister Steven Harper. One result was a TV ad, "Harper on Health Care in Canada," that was filled with scary music, sirens and quotes from the Prime Minister's past speeches felt to be even scarier for the average Canadian voter. Ominously, we are warned by an anxious sounding narrator that in the past, Harper had even said that he is "Open to American-style for-profit health care" (Liberal Party of Canada 2011). A quick check of Hansard for October 1, 2002 shows Harper did say that he favours allowing more for-profit care. However, there is no mention of "American-style" care and twice he insists that the key principle Canadians need to defend is not public ownership of facilities, but access to care regardless of ability to pay.

In the United States, as debate heated up over health care reform, Republicans and their affiliated media sources frequently attacked President Obama's proposals as threatening to usher in "Canadian-style" health care (cf Van Sustren, 2010). Interest group funded advertising and voter awareness campaigns further pressed the charge (Pear 2009). From the very start of 2009 the attacks were so frequent that Democrats felt compelled to draw a clear distinction between what they were proposing and what is in place in Canada or any other country. Democratic Senate Finance Committee Chair Max Baucus was consistent in this. Speaking at the President's White House Forum on Health Reform in March of 2009, Senator Baucus stated that any bill he would endorse "has to be a uniquely American solution. We're not Europe, we're not Canada,

we're not Japan, we're not other countries. We're Americans, with public and private participation" (CNN, 2009). President Obama himself re-iterated this point during the press conference following the North American Trilateral Summit in the summer of 2009.

> I've said that the Canadian model works for Canada; it would not work for the United States. I suspect that we're going to have continued vigorous debate. I suspect that you Canadians will continue to get dragged in by those who oppose reform, even though I've said nothing about Canadian health care reform. I don't find Canadians particularly scary, but I guess some of the opponents of reform think that they make a good boogeyman (White House 2009).

Democratic leaders also felt the need to put some distances between themselves and the advocates of anything that could lead to a single-payer plan. President Obama's media spokesperson, Robert Gibbs, described US advocates of a Canadian-style, single-payer public plan or anything that could lead to it as "professional liberals," totally out of step with the President and the real world of public policy. He told one interviewer these extremists would not be satisfied until Americans "have Canadian healthcare and we've eliminated the Pentagon" (Youngman 2010).

From the perspective of health care research, the remarkable fact about this situation is that health care in the two countries seems very similar. The structure of medical education is often treated by practitioners and educators as a single system and medical schools in the two countries share a common accreditation council (Makdisi, et al. 2011: 67-68; Pott et al. 2011: 16). Meanwhile conditions of professional practice and the medical-cultures of the two countries are also very similar although some differences are present in terms of the attitudes physicians bring to treating patients and the use of resources (cf Berry et al. 2010). It is also something of a misnomer to speak of either country as having a health system. Rather federalism has insured that both countries experience significant regional variation in the organization of care, access and policies that seek to encourage outcomes such as cost control (Boychuk 2002).

In terms of arrangements for financing care, the two countries shared an apparently similar evolutionary path for the first half of the twentieth century. Both appeared to be gradually moving towards legislation that would mandate universal coverage for physician and hospital costs up until the late 1960s. In Canada the approach was to extend coverage to different sorts of services, beginning with hospital and diagnostic tests and ending with physicians bills. In the US the approach was to gradually add different groups of recipients. However, the drive to universal health insurance stalled-out in the US and has only recently come to fruition under President Obama (Cohn 1996; Sessions and Detsky 2010; Morone 2010; Fox and Markel 2010).

Sessions and Detsky (2010) explain the difference in simple institutional terms. In a parliamentary system such as Canada's, a determined executive can ignore interest groups and opponents to ram something through with the hope that once it is in place, people will come to accept it. Maioni (1997) also explains the difference in strategy and resulting outcomes as a result of institutional factors but adds the factor of differing party dynamics and federalism, such as the way Canadian federalism operates and the presence of a leftist party (the CCF-NDP) that caused the dominant Liberal and Conservative parties to be more open to popular demands. Boychuk (2008), while not dismissing this institutionalist approach, also argues that deeply embedded in the US approach to the expansion of public coverage are racial attitudes, which also made it difficult to move towards universal coverage. On the other side of the border, Canada's use of health insurance and other social welfare policies to develop and deepen territorial integration facilitated a move towards complete coverage.[1]

[1] Skocpol (1994) has made a similar argument about the entire structure of the US welfare state. She argues that its residual nature and the high degree of regional variability of coverage are a result of racial politics. Specifically she points to the deals that the Roosevelt administration struck to win the votes of Southern members of Congress and the Senate.

It is perhaps this point, one Boychuk (2008: xv-xvii) clearly makes in the Preface to his book that helps explain the situation. Health care in both Canada and the US is a symbolic issue. It is about more than what is most efficient and produces the greatest efficacy. It is a statement as to the values people in each country share and the political cleavages that divide them. Boychuk (2008) is not alone in making this claim about health systems in the US and Canada as being as much about symbolism as policy and the need to coordinate the two (Fox and Markel 2010: 1749; Romanow 2002: xv-xvi; Morone 2010: 1098).

We also cannot exclude materialist concerns expressed by organized interests. Health care is a significant slice of any modern economy and a source of wealth for investors and income for physicians, nurses and other health workers. Tuohy (1999) has argued that the evolutionary path followed by health care in the US and Canada has created differences in the dominant interest and the mechanism for control and accountability. In the US a system of private firms held accountable through market mechanisms has emerged and in Canada a system where physicians are in control and held accountable by collegial mechanisms is in place. As a result, the idea of an American-style health system, or a Canadian-style one is more than just symbolic, these arrangements also create power (and all that this implies) for different interests in society.

If this is correct then the above noted fear-mongering directed towards the general public/voters/patients is likely more than that; it is based first in a deeper understanding by organized political and public-policy actors regarding what the people of Canada and the US feel about their country and want their public policies to reflect; as well as calculations as to the economic impact of different arrangements for those that organized political and public-policy actors seek to represent. Therefore, it is also based, at least in part on an understanding of the sort of outcomes different arrangements for financing health care are likely to have. In short, at

some time or place, policy learning has occurred among both the advocates of different proposals to reform Canadian and American health care and their opponents who wish to see reform take an alternative course or to thwart reform altogether.

This research note will lay out the ground work for a study to test the theory proposed by Lowery (2006) that groups opposing change engage in international policy learning as a result of focusing projects that portend change so far outside of their own experience that they have no choice but to look outside of their national borders for advice, knowledge and support. In the next section of the paper I will take a deeper look at the literature on policy learning. In this section the different types of policy-learning that actors engage in will be discussed and predictions will be offered as to who engages in which sort in order to thwart changes in how health care is financed and when they do so will be offered. The next section after that seeks to identify events that spark learning. Next a summary will be presented of the different critical actors and the sort of learning they are hypothesized to have engaged in will be presented along with documentary evidence that would seem to support some of the predictions better than others but which does not refute any of them. Further research is underway to test these predictions through interviews with key informants and further collection and analysis of documentary evidence.

Policy Learning: Counter-Lesson Drawing and/or Counter-Social Learning?

"Policy-learning" is a well established if not always rigorously specified concept. Howlett and Bennett (1992) note that in the literature there is a debate between whether it should be understood as a deliberate attempt to obtain some sort of information to improve a specific policy (social learning) or a more nuanced less deliberate activity where interactions between people and reality cause actors to gain experience and knowledge that is later reflected in their

policy-making decisions (political learning). As well, there is also a stream of literature that discusses learning not in relationship to any specific policy but as the creation of structures that allow government to learn by monitoring and analyzing (government learning), another that focuses only on learning that has meaningful and enduring impact on the way actors see the world and choose to act around a specific issue (policy oriented learning) and one that links this last idea to the notion of reaching conclusions by looking at the positive and negative experiences of others (lesson-drawing). They argue that the different theories can be better understood by asking three key questions: Who learns? What is learned? What is the impact on policies? In doing so they are able to isolate three distinct types of learning with different actors, knowledge and consequences.

Table 1: Bennet and Howlett's three types of policy learning

	Who Learns	**What is Learned**	**To What Effect**
Learning Type			
Government Learning	State Officials	Process-Related	Organizational Change
Lesson-Drawing	Policy Networks	Instruments	Program Change
Social Learning	Policy Communities	Ideas	Paradigm Shift

(Source, Bennett and Howlett 1992: 289)

In interpreting and applying Bennett and Howlett's typology it is important to note that we have to recognize that in this particular case we are not dealing with reformers but those who wish to either substitute an alternate reform or thwart change they see as detrimental altogether. Although internal opposition to policy and infighting among different agencies are certainly well

known phenomena, to keep things manageable, I will assume that bureaucrats and their political masters in the executive in their entirety either favour the proposed reforms or required to remain silent due to conventions of bureaucratic neutrality and executive solidarity. Therefore my attention will focus on the bottom two rows of this table. Do the actors we are concerned with want to prevent a specific change in the way health care is financed? Or are they working to prevent a shifting in the boundaries as to what is seen as the politically acceptable range of policy options with regard to health care financing? In short, is what we are talking about counter-lesson-drawing or counter-social-learning?

In order to untangle who is likely to engage in which sort of learning it is worth considering a recent study of policy-learning in the European Union and North America by Eric Montpetit (2009). In this essay Montpetit disputes the commonly asserted claim that the unique political structures of the EU (lacking the hierarchical authority of a traditional state) promote policy learning to a greater extent than other forms of political organization where decisions are easier to make on authoritative rather than consensual grounds. What he does find is very important in determining whether or not actors are open to policy-learning is the role they occupy in the policy process. Government and interest group actors were more likely to engage in policy-learning that supported consensual decision-making than independent experts or advocacy group members. This is a conclusion that is in keeping with many common theories as to how different sorts of actors tend to behave in the policy process (Cohn 2002). Second, Montpetit argues that the perception that on a given issue actors lack legitimacy is a strong incentive to engage in policy-learning geared towards achieving consensual decision-making. Putting this together with Bennett and Howlett's (1992) typology, we can begin to draw a hypothesis as to who is likely to engage in counter-lesson-drawing and counter-social-learning and the likely intensity of their actions.

Actors from industry and groups that represent them, as well as some political opponents (with less intense concerns) are likely to be heavily involved policy-learning that allows them to engage in counter-lesson-drawing. This is an activity that allows them to preserve the potential for an eventual consensus on a compromise policy. Meanwhile, actors from advocacy groups, independent experts and political opponents (depending on their intensity of concern) are likely to engage in counter-social-learning. Their aim is to undermine the entire legitimacy of the proposed reforms and thwart what they see as a policy with potential to shepherd a paradigm shift into public life.

Among the most frequently cited types of policy learning is "international" policy learning, where one jurisdiction learns from the success of another (see for example Gilardi 2010; Lee and Strang 2006). What is less well researched is the use that opponents of change make of international experience so as to rally resistance to policy reform. Lowry (2006) has proposed that this sort of resistive learning is sparked by "focusing projects" and "focusing events." These are proposed changes that are so far beyond the scope of ordinary reform, that the supporters of the status quo have no reference point within their own policy experience to draw on so as to meet the challenge of such proposals. Is it possible to identify examples of such focusing projects in each country? Second, is it possible to identify who has engaged in policy-learning around these events and whether it is of the counter-lesson-drawing or counter-social-learning variety?

Can Focusing Projects that would Spark Counter-Lesson-Drawing and Counter-Social-Learning be Identified?

Lowry (2006) notes that most of the literature on policy change emphasize unpredictable events that create a context where policies previously seen as impractical or even unwise become

feasible. He describes the unpredictable events that draw attention to this situation as focusing events. He also identifies a second set of events known as focusing project. These are deliberate attempts to change public policy that while they might (or might not) maintain traditional policy appear to some actors to go so far as to be transformative. These projects are seen as being so far from the known world of their opponents that they must engage in international policy learning to confront them. Lowry's distinction between focusing events and focusing projects allow for a simplification of the task I face. Instead of seeking to identify the possible policy junctures where events might have created a context for change in the model of Canadian and US health care financing, I can instead focus on actual policy proposals put forward by governments with potential to be transformative. What would such a policy look like? Following the logic laid out at the front of the paper where I suggested that health care systems have both symbolic and material implications, I am going to argue that a focusing project would be a policy reform that has the potential to actually displace a dominant interest and/or change the symbolic meaning of the policy. Two policy projects that fit this description are President Obama's drive to reform American health care and the decision taking by the province of Alberta under Premier Ralph Klein to legally authorize private for-profit hospitals during the late 1990s.

Obama Care

In 2009 President Barack Obama asked Americans to join with him in a drive to reform US health care financing so as to eliminate the situation where an estimated 40 million Americans lacked health insurance and also to put in place more effective cost controls so as to make insurance more affordable whether paid for by individuals or employers. The package of policies that would ultimately become the Patient Protection and Affordable Care Act (2010) included a mandate that all Americans obtain health insurance coverage, either through third

parties or direct purchase or pay a penalty tax; subsidies to help individuals and businesses to better afford coverage, a prohibition on insurers denying coverage to anyone in the geographic areas in which they operate due to pre-existing conditions; mechanisms to ensure that consumers and third party payers have competitive choices and mechanisms to restrain costs (*New York Times* Editorial Writers 2010). One of the proposals contained in the initial package as adopted by the Democratic Party controlled House of Representatives was the so called "public-option". This was a proposal to create a government run competitor for private insurance. It was meant to ensure all consumers had competitive choices and to put pressure on private insurers to restrain costs (Halpin and Harbage 2010).

For the insurance industry the public-option represented a clear focusing project as it had the potential to unseat the industry as the dominant interest in the US health care system. Industry analysts predicted that in a straight up competition between for-profit plans and a public option, the public plan would have such great advantages that roughly 70% of all patients insured by private plans in 2009 would likely switch or be switched by their employers to the public option within a few years (Sheils 2009). One widely respected political columnist described the public option as "the most contentions in the health reform debate, with opponents arguing - and some advocates trumpeting - that it will lead to a Canadian-style, single-payer system (Kondracke 2009). While not enthusiastic about the bill, the removal of the "public option" at least allowed the health insurers to grin and bear it while reflecting on the fact that many million more Americans would be purchasing insurance and government subsidies would be available to further encourage uptake. These last two elements proved so tantalizing to the insurance industry that its dominant spokesgroup -- America's Health Insurance Plans -- does not endorse Republican plans to completely nullify or repeal the law, now that the GOP controls the House

of Representatives. Rather, the insurers only wish to see the law reformed (Adamy and Weisman 2010). For the intellectuals and social advocates of the US conservative movement, Obama's health care initiative (with or without the public option) was an even bigger symbolic threat, representing Washington's attempt to seize control of a large swath of the US economy, a fundamentally private choice and also to impose the will of the centre on individual states (Boehner and McConnell 2010; Leavitt 2011; Anderson 2011). Worse still, if Washington succeeded it was argued this project would be followed by other ones as the legitimacy of government intervention grew and grew. One Conservative commentator described the resulting law as "The most massive threat to limited government and individual liberty in recent history" (Tanner 2011). Another describes it as a tantamount to a threat to the American way of life:

> The Progressive vision of the administrative state, which concentrates power in federal bureaucracy, has never been more triumphant than with the enactment of the national health care law. It changes the relationship of American citizens to public officials. It becomes a relationship of dependence, and thus subservience (Moffit 2011).

Given these feelings it is not surprising that a advocacy group was set up especially to fight against President Obama's proposals "Conservatives for Patients Rights." Their founder (once president of the largest for-profit hospital corporation in the US) made it clear what he opposed were the importation of foreign ideas into US health care and Canada was a prime example of these. The group's first radio ads warned Americans against adopting "[a] system like England or Canada, where national boards make your health-care decisions and waiting lists reign supreme" (Eggen and Connolly 2009). Two other groups, The Americans for Prosperity Foundation and Patients United Now, also spent millions of dollars purchasing advertisement warning against the adoption of a "government-run Canadian healthcare system" Edny and

Condon (2009). AfPF and Patients United Now were the groups responsible for airing the infamous ad featuring a Canadian woman who supposedly would have died of a brain tumour had she not paid herself to go to the US for treatment (Plautz 2009). The Conservative movement also clearly reached out across the border to allies in Canada for evidence to use in their campaigns. One particular conduit appears to have been Canadian-born Sally C. Pipes, a former researcher with Vancouver's Fraser Institute who is now President of the Pacific Research Institute in San Francisco. Another appears to have been Canadian-born physician David Gratzer, a senior fellow with the Manhattan Institute, both of whom campaigned actively against the Obama proposals (Pacific Research Institute 2011; Manhattan Institute 2011).

Alberta's Bill 11

When Ralph Klein took over the leadership of Alberta's Progressive Conservative Party Government in 1992 the party embarked on an important change of direction. The party, already in power for over twenty years shifted from being proponents of a centre-right form of government rooted in social consensus building to the advocacy of militant neoliberalism. The sense that this was an alien development in Alberta and Canada as a whole was captured by the editors of a book critical of the changes who chose the title "Trojan Horse" for their volume (Laxer and Harrison 1995). The government embarked on an ambitious project to shrink the size of the Alberta state so as to allow for both deficit reduction and ultimately tax cuts in one of the already lowest taxed jurisdictions of Canada. As part of the drive, an attempt was made to wring greater efficiency out of the health care system by creating regional authorities with the aim of rationalizing health delivery and right-sizing the inventory of beds and facilities within each jurisdiction. As a result a large number of hospital buildings were declared surplus and

defunded. The not-for-profit or civic organizations which owned them either had to find new purposes for their facilities or dispose of them. As with all provincial governments which tried to force change in health care from the top down during the 1990s, Alberta discovered that while it could effectively control the resources available to the health system, it could not force physicians to change the way they practiced medicine. Given the misfit between the way physicians chose to practice and the resources available a crisis was inevitable and quickly manifested itself and the speed of the changes only magnified the difficulties (Church and Smith 2006: 498; Philippon and Wasylyshyn 1996; Cairney 1995).

Determined, but not always succeeding in sticking to its commitment to bring down the rate of growth of health spending the government began to look to the private sector as a source of financing. When a group of investors headed by a former executive of Calgary's regional health authority purchased one of that city's surplus hospitals and proposed creating a for-profit facility some saw it as a way to add some economic discipline to the system by (hopefully) contracting with the public sector at a lower cost and also add some sort of escape valve to the system by treating private insurance and private pay patients who would otherwise be in the public ques. The government responded with what would ultimately become known as Bill 11. From its point of view the bill simply allowed it to regulate something that had never been regulated before in Alberta, for-profit hospitals. From the point of view of their critics, it allowed something that had never been allowed before in Alberta, for-profit hospitals (Taft and Steward 2000). Opponents saw the scheme from a variety of perspectives. Some simply pointed to the economic logic and evidence which shows for-profit facilities actually raise costs, not reduce them. Others, given the paucity of economic evidence in favour of the scheme, saw the introduction of private hospitals as a direct challenge to the fundamental principles of

Canada's system of single-payer provincial health insurance plans. In that it would create the infrastructure required for a parallel private-pay health system to emerge universality would be undermined (Evans et al. 2000: 37). This was in spite of the fact that unlike its predecessor which was withdrawn (Bill 37), Bill 11 specifically prohibited private hospitals from accepting patients for any service insured by the provincial plan other than under contract from a regional health authority (Church and Smith 2006: 493). Canadian medicare has important symbolic overtones. Because of its high quality and universal character, it is the one element in Canada's welfare state that stands in stark conformity to Canada's otherwise logical placement in Esping-Andersen's liberal welfare state category of which the US is the arch-typical case (1990). Canada's health insurance scheme is not just something different from that found in the US but something that makes Canadian society different (Boychuk 2008: 143-144). This might also explain why such a large coalition of public interest groups emerged to fight Bill 11 and groups such as Friends of Medicare expressed their opposition not just in terms of dollars and cents for taxpayer/patients but within the wider context of resisting the rightward shift of society (Church and Smith 2006: 501). In interviews given to the press the organization expressed concern that once one for profit-corporation was allowed to operate in the province, NAFTA would require the province to licence any and all US hospital corporations that wanted to come in (Pedersen 1998b). A central element of the groups rhetoric is the need to prevent U.S.-Style Health Care from becoming established in Canada (cf Farrell 1999). Opponents to the Klein government's proposals were intellectually supported by a University of Alberta based research centre, The Parkland Institute. Researchers affiliated with the institute published a monograph explaining why the Klein government's proposal should be seen as bad for Alberta (Taft and Steward 2000). Their argument was simple. If you want to see what effect corporate ownership of hospitals will have on Alberta, look at the US. Opponents clearly had contact with US experts and even

brought one, Dr. Claudia Fegan, then Medical Director of Chicago's Michael Reese Hospital and President of Physicians for a National Health Program to Alberta to speak against corporate hospitals (Thorne 1999).

For Alberta's doctors, the introduction of private hospitals posed something of a challenge as the introduction of for-profit corporations into health governance could potentially challenge their professional authority and role as the dominant actor in Canada's health system. However, in almost all of the proposals physicians themselves were key investors (Church 2008: 498; Taft and Steward 2000) allowing arguments to be raised that these were not corporate organizations beholden to far away investors but professionally responsible organizations. Alberta's College of Physicians and Surgeons twice refused to accredit the first private hospital proposed for Calgary and then when asked to generically set standards for such facilities refused to do so until the government succeeded in passing legislation to authorize their creation. While public (non-physician) members of the College's governing council described the decision in terms of defending single-payer universal health care, physician members of the council remained largely silent in public but appear to have had a number of concerns as to their authority to make such decisions and whether a private facility could meet the quality standards they felt were necessary. It is unclear if these concerns applied to just this specific application or all private facilities (Geddes 1999; Pedersen 1998a; Church and Smith 2006: 497).

The Alberta Medical Association came out against the government's first attempt to regulate and allow for-profit hospitals, Bill 37, demanding a wider consultation before the Association could endorse the proposal, a request the government granted when it appointed a commission to study the bill and make recommendations (Pedersen and Johnsrude 1998; Johnsrude 1998). The legislation that ultimately passed embraced many of the concerns

expressed by physicians, strengthening the control that the College could exercise over private hospitals and better integrating with public system. Private hospitals could act as a contractor to the public system in the provision of publicly insured services but not offer them on a private-pay basis. Ultimately the doctors did not endorse the bill because it would do nothing to improve resourcing in public hospitals and because they just thought it was wrong to allow for-profit corporations into the hospital business. However, there were deep divisions on the matter (Pedersen 2000; Church and Smith 2006). The specific reasoning as to whether the Alberta Medical Association took this stand was because the organization feared the loss of professional control or because of wider concerns about the fate of single-payer universal health insurance is difficult to untangle from documentary sources that are presently available to me.

A Good Argument so Far More Research Needed and Underway.

The previous sections of the paper have laid out the ground work for an argument as to why organized political actors who either wish to see policy reform take a different tact or who wish to outright resist change might engage in international policy learning of specific types when faced with a focusing project (Lowery 2006). In this paper I have defined a focusing project is a policy reform that has the potential to actually displace a dominant interest and/or change the symbolic meaning of the policy. Based on the policy-learning literature it was suggested that different types of actors might engage in different types of learning. Actors from industry and groups that represent them, as well as some political opponents (with less intense concerns) are likely to be heavily involved policy-learning that allows them to engage in counter-lesson-drawing. This is an activity that allows them to preserve the potential for an eventual consensus on a compromise policy. Meanwhile, actors from advocacy groups, independent experts and political opponents (depending on their intensity of concern) are likely to engage in

counter-social-learning. Their aim is to undermine the entire legitimacy of the proposed reforms and thwart what they see as a policy with potential to shepherd a paradigm shift into public life. It was also suggested that these predictions are in keeping with many common theories as to how interest groups tend to operate in the public policy process (Bennett and Howlett 1992; Montpetit 2009; Cohn 2002).

Background sketches were presented for two cases where the foreign was regularly portrayed as the enemy. Documentary evidence seems to indicate clearly that the actors from advocacy groups, independent experts and political opponents used the foreign as the enemy in a way that would reflect some sort of counter-social-learning took place and that they were seeking to undermine the entire legitimacy of the proposed reforms, fearing not just their practical implications but their wider symbolic value. While it can logically be inferred based on their behavior that industry groups and less militantly opposed politicians engaged in counter-lesson-drawing, the sort of learning that would help them deal with the practical consequences of policy reform and seek to modify proposals, the documentary evidence available does not yet make the drawing of this conclusion plausible. While the hypotheses advanced in this research note seem to still have merit, they cannot be confirmed without further documentary research and interviews with key informants who participated and witnessed these events. This research is presently under way.

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