GOVERNMENT AND MARKET IN THREE TYPES OF HEALTH CARE SYSTEM: THE PRACTICAL DIALECTIC OF ACCOMMODATION

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How governments and markets do and should relate to each other has become a pressing issue in many health care systems, but the topic invites misunderstanding. The costs and inefficiencies of systems that are run, or decisively conceived, by the public sector have convinced some policymakers that "the magic of the marketplace" (to recall Reagan's phrase) is surely worth invoking. This devout and sometimes desperate wish has led to heated debate about government "versus" markets, and about how to "choose between" the two sectors.

In this essay, I will argue that this image of mutual exclusion is mistaken. The challenge for policy is to accommodate both government and market forces. What superficially appear to be choices between sectors may really be dialectical patterns: The strategic "thesis" of one sector elicits an innovative antithesis from the other, leading to new syntheses. The key practical question -- admittedly devoid of much ideological drama -- is how policymakers can effectively steer the process of accommodation. While a broad comparative survey offers no formulae for success, it does provide some food for thought.

Most societies view health care as both a civic right that government should secure through the fiscal socialization of risk (national health insurance), and a proper object of economic exchange among purchasers, providers, and others. Government and market, in other words, are antagonistic but interdependent forces whose interactions differ with place and time. They differ with place because nations vary in their preferences for governmental direction or open exchange among the health system's economic interests. They differ with time because societies may change the government-market balance as they ponder their dissatisfaction with prevailing arrangements or are drawn to promising approaches on view elsewhere. This paper has three objectives: First, to sketch three broad types of accommodation evident in a range of western nations; second, to indicate the major challenges these systems have confronted and responses they have adopted in recent years (mainly during the 1980s); and third, to identify patterns of convergence,

evolution, and cross-national emulation spanning the three types of accommodation.

Market and Government: The Strategic Panorama

In its broadest sense, a market is a set of social rules and arrangements that permit or encourage the exchange of goods or services that have some perceived material value. In health care, such rules and arrangements can operate at one or more of five different levels: the consumer, provider, purchaser, payer, or the "system". The main applications of market mechanisms at the level of the consumer include: cost sharing (people who pay more of their own money for care will tend to consume less of it, or at any rate be less subject to the temptations of moral hazard, than those who pay less); provision of information by means of advertising or other sources (helping the cost-conscious consumer to favor providers who offer more value, or less risk, for money); freedom of choice of providers (consumers "locked into" providers cannot effectively penalize them by taking their trade elsewhere); tax incentives (consumers who buy care or coverage with untaxed or pre-tax dollars may demand too much; by the same token, tax credits might help shape consumer preferences); and the presence of a private sector "safety valve" for those discontented with the public system.

At the provider (supplier) level, key market issues include: ease of entry into medical and related professions and into the universe of hospitals and other institutions; the validity of the target-income hypothesis and Roemer's law (the degree to which normal market dynamics fail because physicians define the demands they then meet, and because more beds encourage more use); and the incentives (embodied in fee schedules, relative value scales, price lists, and other payment systems) that influence specialization patterns and volume levels.

Purchasers both public and private face market choices about competitive contracting (should they entertain bids to meet specified performance standards and award their business to the "best" providers or insurers?); opportunities for monopsony leverage achieved by concerted action among purchaser units (public ministries, business firms, sick funds) in bargaining with providers; and (again) tax incentives which may influence how much health coverage or care they buy and from whom.

Payers (insurers) are market players insofar as they compete for subscribers on price or other grounds; try to limit financial risks by medical underwriting,

restrictions on coverage for pre-existing conditions, exclusions of employee sectors from coverage options, or demanding that public subsidies compensate for risks incurred; or incorporate providers into their organizational networks in order to gain direct financial control over their behavior.

Finally, although most societies pick and choose rather unsystematically from among the range of these market mechanisms (and a few reject most of them on principle), one occasionally finds grand market-based schemes that envision and demand carefully-ordered strategies that integrate these market fragments into a coherent, incentive-driven whole. A leading case in point is Alain Enthoven's widely noted consumer choice health plan.[1]

Each occasion for the more or less free play of market forces poses its corresponding challenge to government, and does so quite aside from whether a polity tends in general to favor or deplore a wide role for markets in health care. What role should cost sharing play in a system of national health insurance? Should government steer consumers' choices among providers by generating and disseminating information, and will it allow providers to bid for business by advertising? How free will consumers be to change providers at will, or to seek alternative consultations? Is a private sector to be permitted, and if so, on what terms? Should the tax code be used as an instrument of health care policy, and if so, how? Should any aspiring physician be allowed to enter medical school and practice? How free should hospitals be to locate, relocate, expand, contract, and acquire equipment? If the target income hypothesis holds, how might government constrain volume without damaging quality or infringing on professional autonomy? If Roemer's law is right, how can it help to define and realize optimal levels of bed availability and use? Among myriad options, what are the relative merits of payment by fee-for-service, fee schedules, capitation, global budgets, per diems, and DRG-based case mix systems? Should government try to identify "preferred providers" and contract selectively with them? Or should it shun invidious comparisons, or leave them to agents like sick funds? Does government's role as author and protector of a national health insurance statute imply that it should intervene directly in containing costs and bargaining with providers? How should it cooperate with private sector purchasers? Should it use the tax code to manipulate provider behavior? How much competition among insurers, if any, should government allow, and on what terms? Should it flatly proscribe risk-

[1] For example, see Enthoven, A.; and Kronick, R. 1989. "A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy". *New England Journal of Medicine* 320:29-37, and 320:94-101.

based selection, and what compensations should it extend to insurers with a concentration of unfavorable risks? Should it encourage the diffusion of entities akin to health maintenance organizations, which integrate providers and payers? If it does, how can it square this with free patient choice of providers and with physicians' freedom to accept patients and practice as they choose?

These questions define (incompletely to be sure) a perpetual dialogue between theoreticians and practitioners of market and government "approaches" -- a dialogue that can range from dogmatic insistence on choosing between the two, to pragmatic efforts to mix and match the best of both worlds. These dialogues differ with place and time, but they seem to display a fairly consistent dialectical character, visible in most places most of the time. After the governmental "thesis" has prevailed for a prolonged period, the eternally unruly problems of the health care system make the market antithesis look fresh and promising. Then trials prove that market forces are as much subject to error as are those of their public sector antagonists, and government regains legitimacy and elan, triggering continuing tensions -- never dispelled -- that fuel new practical strategic syntheses. However much logic may demand a clear division of labor between markets and government, reality requires eclectic, impure admixtures of both.

There is, of course, a weighty, analytical and normative body of literature on how societies **should** sort out relations between the two sectors. I shall concern myself very little with these issues here, because I believe the more compelling question is how societies manage in practice to accommodate both spheres, how the strategic dialectic between them has evolved, and where it may be heading.

Model 1: The United States -- Undisciplined Markets in Search of a Political Framework

The United States stands out as the site of the most extensive and innovative thinking about the role of markets in health affairs and the least productive and coherent practical application of them. The U.S. health system is market-driven in several ways. First, lacking a policy requiring universal entitlement to uniform benefits, most of the population gets coverage from the market in a very literal sense: Private employers decide how much health insurance (if any) to offer their workers, and on what terms. Employers buy coverage from a range of competing insurance firms (some for-profit, others voluntary) that are regulated weakly by the states and insignificantly by the federal government. Because this system is obviously inadequate for the retired elderly and the unemployed poor, these groups have been covered, since 1965, by public programs: Medicare and Medicaid. Nevertheless, about 15% of the

non-aged population (37 million people) "fall through the cracks", and have no health coverage whatsoever.

In the United States, market forces among providers too tend to be strongly indulged and weakly disciplined. For decades, physicians in both private and public plans were paid their usual, customary, and reasonable charges and hospitals their actual costs, retrospectively. Correctly perceiving that such payment schemes were a "blank check" for providers, in 1970 the federal government began innovating along two lines. One approach was regulatory (a path that led in time to the Prospective Payment System and its diagnostic-related groups, and to the Resource Based Relative Value Scales). The other was competitive, which meant efforts to promote market forces, correction of incentives, and consumer choice by means of health maintenance organizations (HMOs), independent practice associations (IPAs), preferred provider organizations (PPOs), and other such instances of what are now known generically as managed care plans.

The first public policy steps down the market road were taken 22 years ago, and no summary judgement can do justice to their complex legacy. Nevertheless, I shall offer what I take to be an accurate balance sheet: The competitive "reforms" in the U.S. have left the system less disciplined, less efficient, less equitable, and more costly than before. (What might have happened in their absence is of course a hard call.) In 1989, the U.S. had 37 million uninsured citizens, spent 11.8% of its Gross Domestic Product (GDP) on health care, and devoted $2354 per capita to these services (40% more than Canada, second on the list, and 71% more than Switzerland, third on the list).[2] Today it is witnessing a growing political and economic crisis of affordability that has finally begun to mobilize middle class voters. If "competition American style" is working, its effects would seem to be subtle indeed.

How can one explain the failure of market forces to deliver the promised efficiency in the U.S.? So many reasons, so little space. Here I shall apply to this expansive question three basic explanations. First, proponents have

[2] Schieber, G.J. et al. 1991. "Health Care Systems in Twenty-Four Countries". *Health Affairs* 10:24-25.

never agreed on what "market reform" means in practice.[3] Over the years, three quite dissimilar notions found fame and favor. The first emphasized instilling "correct" incentives and higher cost consciousness in **consumers**. After several years and the expenditure of several millions of federal research dollars, the legendary RAND study proved that people who were made to pay more for health care tended to use less of it.[4] Policymakers could therefore overcome the baleful effects of third-party payment and first-dollar coverage, and arrest the erosion of the medical marketplace by increased cost sharing.

A second school focused instead on providers and payers and argued that reform should enhance competition among a sizable universe of **organizations** that embodied the right incentives by casting off third-party payment and fee-for-service practice and embracing the principle of pre-paid group practice, rechristened HMOs. If enough plans were put out there and enough people were motivated to join them, competition within the HMO sector and between it and traditional insurers would make costs rise more slowly.[5]

A third camp contended that market forces would work properly only if competition were contained and constrained by a well-designed larger **system**, a set of rules of the game that stopped market segmentation, risk skimming, and cost shifting. Such pro-competitive regulation, articulated most forcefully in Enthoven's consumer choice health plan, entailed a large governmental role in establishing benefit packages, enrollment procedures, conditions on premium setting, and more.[6]

The practical significance of each of these approaches became clear when market advocates tried to agree on a package of legislative reforms to advance their ends. There was virtual unanimity on provisions mandating that

[3] See Brown, L.D. 1988. "Afterward". In: *Competition in the Health Care Sector: Ten Years Later*, Greenberg, W. (ed.), pp 139-141. University Press, Durham, North Carolina.

[4] For example Manning, W.G. et al. 1987. "Health Insurance and the Demand for Medical Care: Results from a Randomized Experiment". *American Economic Review* 7:251-277.

[5] On the genesis of the HMO development effort see Brown, L.D. 1983. *Politics and Health Care Organizations: HMOs as Federal Policy*. Brookings Institution, Washington, D.C.

[6] Enthoven, A. 1980. *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*. Addison-Wesley, Reading, Massachusetts.

employers offer several distinct health plans for their workers, that employer contributions be limited to the premiums of the most efficient plan (obliging employees who want higher-priced brands to pay for the extras themselves), and that the tax code be changed to limit the dollar value of employer contributions to health coverage that are excluded from employees' taxable incomes. Some analysts argued, however, that reforms that went only this far risked triggering rampant market segmentation. The good risks (young, healthy types expecting to use few services) might go for the bad plans (those with low premiums but high deductibles and copayments, and many limitations and exclusions) while the bad risks (older, sicker people in need of everything) would gravitate to the good plans (those with higher premiums and some restrictions on freedom of choice, but with little cost sharing, and few exclusions or limitations). If so, HMOs could drown in a sea of adverse selection. Faced with this possibility, the pro-market forces split: Some declared that markets promise no one a rose garden and should be allowed to play out their liberating dynamics, wherever they lead. Others (especially Enthoven) countered that competition is desirable only if it serves the larger social good, which demanded extensive pro-competitive regulation to make the world safe for HMOs. Faced with this split among the pro-market forces, policymakers hesitated -- then cast their lot mainly with budgetary regulation.

Second, pro-market policy has yet to find a significant constituency beyond the halls of academe and the offices of government budgetmakers. In the debates on competitive reforms in the early 1980s, the elderly, labor, hospitals, organized medicine, HMOs, and business all found reason to object to one or another provision of the proposals then in vogue. The reticence of the U.S. corporate community was -- and remains -- especially inhibiting. Although business executives generally endorse competition on principle and wish that a proliferation of managed care plans in their communities would unleash the market forces they honor and trust, they have exerted little leadership to make this happen. The political and economic timidity of these most capitalistic interests in this most capitalistic of societies must give Marxists pause. A thorough overhaul of policy would seem clearly to be in business's interest, for firms have long complained loudly about their large share of high and rising health care costs. Yet no CEO, corporation, or business trade association has sustained significant leadership in the national debate about reform. Nor have many businessmen been more active in the communities where they buy health coverage. CEOs generally resist appeals to concert corporate leverage into the monopsony power required by "buy right" strategies that might enable them to drive a hard bargain with local providers. Corporate heads seldom wish to hold hostage to group decisions their flexibility to manipulate and maneuver in the local universe of health plans.

But at the same time few care to use this flexibility very often, lest they alienate workers with longstanding ties to insurers or providers by behaving as if buying health coverage is like buying ice cream. Few executives, in other words, take the trouble to shop and switch continually to realize the highest value for their corporate premium dollars. Because business is the only "natural" ally for market reformers in academe and government, its unwillingness to back pro-competitive rhetoric with political and economic muscle has left market forces in limbo.

Third, the market reforms that may "work" do so by imposing constraints which relatively few consumers and providers seem to be willing to accept, at least to date. Mature, well-run Pre-paid Group Practices (PGPs) like Kaiser-Permanente provide reasonable access to good quality care at affordable rates, but the HMOs, IPAs, and PPOs inspired by such organizational paragons are usually more loosely-structured and less tightly managed. The current American infatuation with managed care may boil down to this: Purchasers, payers, consumers, and providers are seeking to realize the benefits of PGPs without incurring such attendant costs as restricted freedom of choice, full-time physician commitment to the plan and "bureaucratic medicine". The image of the desirable standard-bearer of reform has steadily diffused, with no small loss of coherence. HMOs, popular in the 1970s, PPOs, an important 1980s addition, and variants of them now take their place under the broad umbrella of "managed care", which covers anything from PGPs to conventional insurance plans with utilization-review and physicians who are paid a modest capitation sum to style themselves (and perhaps even conduct themselves) as "gatekeepers". Once the more glaring sources of waste, such as recurrent emergency room visits for routine ailments and needless self-referrals to specialists, have been squeezed, it will remain to be seen whether these more casual arrangements can save much money and whether managed care can surmount the sizable, growing cost shift from the hard-pressed public sector to private payers. It is questionable, in short, that managed care offers the painless solution -- reliable cost-containing mechanisms that disturb but mildly familiar, weakly disciplined U.S. practices and institutions -- that its proponents seek. "Real" managed care -- the type that stands a serious chance of saving significant sums of money -- means significant curtailment of freedoms of choice and practice. These constraints have never appealed much to Europeans, who have opted for very different cost-containment measures, and one may doubt whether they will prove much more attractive to Americans.

In a sense, market-government relations in the U.S. remain as uncertain and confused in 1992 as they were 20 years ago. A nation innately suspicious of

government and of late inclined to ratify conservative Republican ideology, looks to markets for relief from oppressive health costs. Public and private purchasers remain split and ever ready to contain their own costs by shifting them elsewhere. Powerful payer and provider interests profit from the perpetuation of weak discipline over costs, while business -- the sector with the most tangible stake in serious reform -- fails to meet the challenge. After two decades of deep thought and ceaseless innovation, the signature of U.S. policy remains market forces in search -- so far in vain --- of a lucid policy framework that might show what they can do.

Model 2: The Continent -- Social Markets in Search of Political Discipline

Nations on the European Continent tend to finance care by means of social insurance contributions (employers and workers are the basic contributors, with some admixture of public revenue), and to contain costs by means of structured negotiations between purchasers and providers (governmental involvement differs with time and place).[7] The key loci of market forces correspond to these two basic structural features. For purchasers, the rate of growth of payroll extractions is the most salient datum; for providers, financial stakes are defined by the level of collective resources committed to payments and by the methods and levels of allocation adopted within the professional and institutional sectors themselves. By virtue of the deliberate design of these systems, these market decisions are inseparable from social decisions about how much purchasers will pay in aggregate for health services and about how many health resources each provider sector can claim. The German team *soziale Marktwirtschaft* captures fairly well the dominant motif.

Unlike the U.S. system, those on the Continent have succeeded in securing reasonable access to technically appropriate care and, in most cases, have elicited high levels of citizen satisfaction.[8] Moreover, structured negotiations over fee schedules and institutional budgets have preserved the peace between purchasers and providers. In the 1970s, however, health costs in most European nations grew rapidly. Negotiations were evidently not a sufficient source of fiscal discipline. The public's expectations were high, and sick funds were eager to deliver the goods to their constituents. Employer associations were apparently asleep at the fiscal switch, or at any rate reluctant

[7] For an overview of several systems, see Glaser, W.A. 1987. ***Paying the Hospital.*** Jossey-Bass, San Francisco; and Glaser, W.A. 1991. ***Health Insurance in Practice.*** Jossey-Bass, San Francisco.

[8] Blendon, R.J. 1989. "Three Systems: A Comparative Survey". ***Health Management Quarterly*** 11:2-10.

to invest much political capital in a fight to contain health costs. Increasing numbers of physicians and widely-endorsed efforts to improve the wages and work conditions of nurses and other non-physician workers also put pressure on costs. Negotiators tended to yield too easily to medical "advances" and to the fee and rate increases these implied. Worried over payroll tax extractions that outstripped the growth of consumer prices and the gross domestic product (GDP), governments began to intervene more assertively in social market forces from which they had previously stayed more detached.

Like the U.S., Continental nations responded pragmatically: They preached, and practiced, both market reform and regulation. But the market and regulatory strategies they embraced were distinctly un-American in their elegance and simplicity. The two "modal" responses stood at opposite poles, so to speak: Micro-interventions fostered new market incentives by increasing consumer cost sharing for certain services, on the one hand, and macro-interventions imposed ceilings on the flow of funds into the system (or specific sectors within it) on the other. On the micro side, policymakers identified medical goods and services that seemed to be severely overused -- drugs were a leading case in point -- and (with no evident debt to RANDian extravaganzas) imposed small, new copayments to encourage frugality while raising revenue to boot. On the macro side, societies that had formerly allowed aggregate health spending to ratify bargaining agreements began formulating crude but pointed and workable aggregate limits on the rate of growth of health spending. In the late 1970s, the West Germans created a multi-member concerted action body to set annual ceilings on rates of increase for physician services and drugs, which negotiators for payers and providers were expected to honor.[9] The French moved toward "global envelopes" that tied the rate of growth of health spending to the growth of the GDP.[10] The Italians emulated the British by replacing their social insurance-based system with a publicly-funded National Health Service.[11]

None of the Continental systems (excepting that of the Netherlands) showed much taste for elaborate American scenarios of comprehensive competitive

[9] Stone, D. 1977. "Health Care Cost Containment in West Germany". *Journal of Health Politics, Policy and Law* 4:176-199.

[10] Godt, P.J. 1987. "Confrontation, Consent, and Corporatism: State Strategies and the Medical Profession in France, Great Britain, and West Germany". *Journal of Health Politics, Policy and Law* 12:459-480; and especially 12:467-469.

[11] Brown, L.D. 1984. "Health Reform, Italian Style". *Health Affairs* 3:75-101.

reform. When prodded, the market mechanism they pulled from their strategic arsenal was the simplest and crudest: nominal increases in consumer costs for specified services. (Needless to say, this approach is very different from the premium-linked shares that render insurance unaffordable for some Americans, and from the deductibles and copayments for covered services that can leave even insured Americans with an onerous out-of-pocket burden, should they need care.) Nor were these nations much enamored of complex American schemes for scientific regulation (French enthusiasm for DRGs is a main exception here). When convinced that social markets lack political discipline, their leaders moved resolutely to policies that may strike Americans, steeped in the marvels of policy analysis and health services research, as simplistic: caps on growth rates that are linked to growth of the GDP or of consumer prices.

The straightforward, analytical nature of these strategies by no means exempted them from vigorous political conflict, proving that health cost containment admits of no quick and lasting fixes, but rather demands eternal vigilance and continual reaffirmation of political will. Because it directly and recurrently hits the wallets of millions of consumers, cost sharing has been a hot issue in party competition; electoral winners (and sometimes incumbents) have undone and redone their predecessors' work. Societies have capped some services sectors only to watch costs continue to rise in others, thus shifting the arena of conflict and ensuring cost controls and the group struggles that attend them a constant place on the government agenda and in the public eye. Germany offers an instructive a case in point. In 1977, a "cost dampening" law established the above-mentioned concerted action body to negotiate ceilings on the annual growth rate of physician and drug costs. The law was a first step forward, but it left unchecked the largest and fastest-rising source of costs: hospital care. Hospitals proved to be a tougher political target than physicians. Nurses and other non-physician personnel, defended by Leftist politicians who had not blinked at confronting the physician "elite", wanted to protect and extend their belated wage and other work-related "catch-ups". The Lander, encouraged by Rightists who were wary of a stronger role for the central government in health affairs, contended that hospitals lay constitutionally within their purview. Eventually (in 1982) agreement was reached on new fiscal constraints for hospitals, but the reformers' work was not done.[12] Iglehart cites seven major pieces of cost containment legislation

[12] On recent German developments, see Altenstetter, C. 1987. "An End to a Consensus on Health Care in the Federal Republic of Germany?" *Journal of Health Politics, Policy,* (continued...)

in Germany over the last decade,[13] which offers a suggestive lesson (especially for the United States): Cost containment policy is harder than it looks, but more feasible than some think.

In sum, in responding to cost crises that arose after government established the rules of a social bargaining game from which it then withdrew, Continental nations have embraced policies that look logically antithetical: They have constrained the entire health system by imposing simple but powerful measures of budgetary regulation while applying small doses of cost sharing to individual consumers. Neither stratagem owed much to academic policy analyses. Neither has had a soft ride politically. But in concert these (and other, related) policies have largely attained their goal, namely, a significant deceleration in the rate of growth of health care spending in the 1980s.[14]

Model 3: Commonwealth Nations -- Market Reforms as Ideological Answers in Search of Political Questions

Despite their substantial differences, Great Britain and Canada (here conjoined under the heading "Commonwealth" societies) share an important property that sets them off from the U.S. and most Continental nations: They fund their health systems largely from general revenues, eschewing the complexities of social insurance, sick funds, and other "middlemen", not to mention the chaotic public-private mix of the U.S. This financing method has two direct consequences. First, it strengthens and highlights the directive role of government, the fiscal fiddler who calls the policy tune. Second, it extends little invitation to markets. A model that affirms health care as a public right, as a set of goods and services to be defined by the durable values of the polity and not by the vagaries of the economy, cannot easily explain why its citizens should incur cost sharing to exercise that right. The principled primacy of the

[12](...continued)
and Law 12:505-536; Webber, D. 1991. "Health Policy and the Christian-Liberal Coalition in West Germany: The Conflict over the Health Insurance Reform, 1987-8". In: *Comparative Health Policy and the New Right: From Rhetoric to Reality*, Altenstetter, C. and Haywood, S.G. (eds.), pp.49-90.; Hurst, J.W. 1991b. "Reform of Health Care in Germany". *Health Affairs* 10:13,17; and Schneider, M. 1991. "Health Care Cost Containment in the Federal Republic of Germany". *Health Care Financing Review* 12:73-101.

[13] Iglehart, J.K. 1991. "Germany's Health Care System". *New England Journal of Medicine* 324:1754.

[14] On the trends see Hurst, J.W. 1991a. "Reforming Health Care in Seven European Nations". *Health Affairs* 10:13, 17.

public sector is consistent with quite different institutional expressions in the two countries. Great Britain has a National Health Service (NHS) that uses capitation payments for most physicians, but permits a private sector that serves a small percentage of its population. Canada allows wide variation among its ten provinces as long as they honor a few principles set down by the central government, but allows no private insurance that would duplicate public coverage. Granting such variations, however, the Commonwealth Model embodies a more overt role for government and a more problematic market presence than the two models discussed above.

The centrality of government financing to the Commonwealth Model has at least six significant implications for government-market relations. First, it thrusts the health system squarely into the hurley-burley of political competition: Policymakers who would tinker with well-liked systems or who fail to propose immediate correctives for wide-spread grievances do so at their electoral peril. They lack the institutional intermediaries (especially sick funds) that confer a measure of political insulation. Second, because it incorporates the global budgets and caps that Continental nations have begun to improvise, public financing makes government the undisguised resource allocator of first and last resort for the supply side of the system and for incomes that are plainly dependent on (though not necessarily determined by) governmental appropriations. This, too, enhances politicization: One observer's cost-effective resource allocation is another's unconscionable rationing. Third, when the health budget is largely a public one, health care spending competes with other public activities. When economic growth slows and government receipts diminish, even a frugal system may seem too expensive; this encourages weary public budget balancers and citizens worried about access to care to ponder partial privatization as a safety valve. Fourth, although providers bargain with public ministries and consumers have means to express their concerns beyond the simple act of voting, the absence of sick funds as intermediaries for consumers and private purchasers, and the zero-sum character of providers' claims on public resources within so patently public a system, may give consumers and providers alike a sense of weak representation and enfeebled responsiveness to their preferences. Fifth, a system that is unapologetically funded and planned by government offers a broad, ever present target for conservatives for whom it is an article of faith that bureaucracy can do no right. Predictably, when conservatives take power in these regimes they seek to impregnate the health system with market elements, and they find allies in providers who assume that discrediting the public system and fragmenting payment sources will send more funds their way. But sixth, market reformers tend to be frustrated by voters who (to

bring the six factors full circle) want a bigger and more accessible system, as long as it does not grow much more costly or less egalitarian.

In the Commonwealth Model, one finds in short a kind of asymmetrical ambivalence defined by a solid core of popular satisfaction that is subject to marginal erosion by market notions proffered by a minority of disgruntled consumers seeking easier access to high-tech services, by providers who think a broader mix of payment sources will work to their economic advantage, by government budgetmakers who seek to ease the pressure on public revenues, and by ideologues convinced that private is inherently superior to public in matters of resource allocation. This ambivalence gives market reforms the character of answers perpetually floating about in search of clear questions. In Great Britain, for example, the Thatcher government intimated that the fairly extensive privatization it prescribed for the ills of the larger economy might work nicely for the NHS, too. Rocked by a hostile public outcry, the "marketeers" retreated from proposals to reform **the** system to much more modest initiatives for reforms **within** a system largely held harmless from major change.[15] Measures to promote "internal markets", a British variation on American selective contracting, will permit local purchasers (health districts) to solicit bids from community hospitals, which will presumably rise to the challenge by producing value for money as never before. Whether this theoretical promise will be fulfilled in institutional practice has been cogently questioned on various grounds by John Posnett, among others.[16]

Canada, spared the bracing stimulation of a long spell of dogmatic conservative rule, is facing similar discontents with more diffuse responses. Some consumers complain that access to advanced diagnostic and treatment equipment and facilities is too limited. The Canadian system is "great if you have a sore throat", sniffed one citizen-critic on television recently. Doctors grumble that they are paid too little and denied the technical tools they need to do their best work; the provinces think that Ottawa gives them too little financial support; meanwhile, government budgetmakers fear that the system may already be too expensive to sustain. (Though thoroughly in line with Continental norms in the percentage of GDP it spends on health care, Canada's

[15] Day, P.; and Klein, R. 1991. "Britain's Health Care Experiment". *Health Affairs* 10:39-59.

[16] Posnett, J. 1991. "The Political Economy of Health Care Reform in the U.K.". Paper presented at the health policy symposium, "Competitive Health Policy Reforms; Appraisal and Prognostication", at the University of Urbana-Champaign, Illinois, November.

$1683 per capita put it second only to the U.S. among OECD nations.) Nonetheless, Canada has shown little interest in developing a private sector as a safety valve; presumably, significant diversity among the provinces serves this purpose to some extent and mitigates concentrated criticism of central government policies. Some reformers have wondered aloud whether and how HMOs might fit into the Canadian system and (if they could be made to fit) whether they might not enhance efficiency and responsiveness, but so far it appears that no one has made a compelling case for such innovation. Canada's system may be entering a winter of discontent, and market reforms may in time lead it back into the sun. Today, however, dissatisfaction is neither deep nor well focused, and market answers have yet to encounter a suitable, practical question.[17]

The Government-Market Dialectic, or, Models as Musical Chairs

Each of the three models sketched here exhibits its peculiar mix of benefits and costs, and each has its peculiar perceptions of the benefits and costs of the others. The principal strength of the U.S. system is that it offers those who can afford it easy access to technically advanced care. Its main disadvantages are that a sizable number of citizens cannot enter the system (at least not easily or on dignified terms), that technically-advanced care seems to be overused at the expense of more appropriate generalist care, and that the system is hugely, and probably unnecessarily, expensive. Through the vapors of the U.S. debate about competition and other market correctives one can discern some tentative steps toward the Continental Model. The prime accomplishment of U.S. policy in the last 20 years has been the development of modest functional substitutes for structured negotiations: HMOs, managed care plans, and such regulatory inventions as PPSs and RBRVSs all oblige purchasers and providers to transcend their hitherto prized and indulged autonomy and begin bargaining with each other over mutual interests. This achievement is real though entirely minor: Until the system exchanges its scattershot financing for broader social insurance mechanisms and puts system-wide caps on spending, its problems will remain largely unresolved.

[17] On Canada see Marmor, T.R.; and Mashaw, J.L. 1990. "Northern Light: Canada's Lessons for American Health Care". *The American Prospect*, Fall:18-29; and Evans, R.; and Stoddart, G.L. (eds.) 1986. *Medicare at Maturity: Achievements, Lessons and Challenges*. Banff Center School of Management, Banff.

The main attractions of the Continental Model are social insurance financing that diffuses costs and reduces conflict over health care budgets, and structured negotiations between purchasers and providers that foster among key players a sense of participation in decisions while leaving to the government substantial flexibility in deciding when and how to intervene. But these virtues have their vices: Diffusion and stability in spending decisions can weaken fiscal discipline, and negotiations among key players too often conclude that "more is better" is the best attainable compromise. Continental nations have therefore sought measures of what Commonwealth societies enjoy in abundance -- namely, a firm government hand on aggregate health care spending. Though most have not embraced full-scale public budgeting, they have refined what they view as the next best thing: caps and ceilings, linked to larger economic indicators, on rates of growth of health spending. In this way they have begun to rein in the free play of social markets that mediate between government and consumers.

The Commonwealth Model enhances both planning capacity and efficiency by eliminating the institutional middlemen (and their attendant administrative costs) that fragment control on the Continent and defeat it in the U.S.. The model also, however, makes government a lightening rod for criticism of under-investment and rationing by providers and the few consumers who share their views, and subjects it to the attacks of conservatives who "know" big government can never work right. When slow economic growth and heightened competition for public revenues coincide with a conservative political ascendancy policymakers labor to implant market models elaborated (but, ironically, little deployed) in the U.S..

Some will view these cases of cross-national "learning" as a rational closing of the circle of diffusion of innovation; others will take them as lamentable proof that evolution need not mean progress. Be this as it may, the intrinsic, inescapable pressures of consumer expectations, demographics, bio-technical progress, personnel costs, and interest group power make it unlikely that the game of musical chairs will generate a stable, lasting, higher synthesis of government power and market dynamics. Even as dialecticians on the Left and Right urge policymakers to clarify their goals and purify their means, the practical models of accommodation are likely to grow everywhere less pristine and more mixed as governments find that they must intervene more forcefully in the struggle to control costs, and as that imperative of public intervention stimulates both theoretical and practical demands that market alternatives get new and due consideration as counterweights to public power and as superior vehicles of efficiency. The political economy of accommodation is inherently -

- and appropriately -- unstable and therefore disruptive of settled expectations, if any such remain in the tumultuous health policies of the 1990s.

Conclusions and Lessons

Five lessons emerge for policymakers seeking to steer public-private accommodation. First, cliche though it be, the absence of quick strategic fixes bears reiterating. Modern health care systems face powerful intrinsic pressures to expand and raise costs. These include consumer expectations, technological progress, demographics, the need to attract and retain suitable personnel, and the unfolding of epidemics such as AIDS and drug abuse. Policymakers will never fix the system and then leave it alone. An eternal political struggle rests on a pointed political paradox: The bigger the health system becomes the stronger the pressures to control it; but the bigger the system gets the stronger the pressures not to control it.

Second, given these pressures, government will of necessity intervene increasingly and enmesh itself more deeply in the system and its reform. Realism begins, then, with dismissing the American fallacy that markets can be made to substitute for government. Only government can create a policy framework for effective strategic coping.

Third, the inevitability of increased public sector activism and intervention is all the more reason to make creative use of markets where and when they can help. The more government does, the more mistakes get made, the greater the dissatisfaction and disillusionment, the sharper the sense that there must be a better way, and the stronger the interest in market alternatives. Markets can be important as a symbol (as evidence that beleaguered public sectors are not unresponsive or complacent); as safety valves (private sectors can relieve demand and cost pressures on public systems); as correctives for overuse (cost sharing); and as sources of creative payment mechanisms. The larger government's role, the greater the attention to markets -- and rightly so.

Fourth, however, the role markets play can be no better or stronger than the policy framework that sets the rules of the incentive-based game. The more ingenious and complex the role one envisions for markets (for instance, actuarial estimates, refined adjustments for risks, predictions of provider responses to payment rules) the more one demands of the architects of government policy. Market solutions that cleverly but unwisely exceed government's legislative and regulatory "technologies" or abilities do little good.

Fifth, market reforms may come to little if they are treated as exclusively technical exercises, ventures in the manipulation of "disembodied incentives" that are artificially detached from powerful institutional contexts. Policymakers would do well to step back periodically from seductive analytical models and insist on answers to a few questions that are at once simple and highly complex and that deserve to be frequently revisited. What exactly is **meant** by markets, competition, and the rest? Do these meanings harbor latent disagreements that confound policy? Is there a clear, shared understanding of the goals of market reform? What will such reforms ask consumers to give up? What will consumers gain instead? Are putative new benefits salient? Can everyone emerge a winner? What is the constituency for market reform? (Government can ram reforms down the system's throat -- and perhaps sometimes it should -- but public-private marriages go more smoothly if affected interests accept them.) What is the "technology" -- organizational, managerial, and regulatory -- required to make market reform work in publicly-structured systems? Do our market models accurately capture institutional behavior? (Most reflect little more than guess-work about institutional realities.) And if they do not? Will market reforms be monitored, evaluated, and adjusted according to clear criteria? By whom? Will monitoring schemes permit explanation of what happens?

Perhaps because these questions are too seldom asked and but rarely answered, successful models of government-market accommodation are few. This is regrettable, for the challenge to achieve successful accommodation will surely grow stronger.

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