

Nuffield Occasional Papers
Health Economics Series: Paper No. 3

Going for Gold

The Redistributive Agenda Behind
Market-Based Health Care Reform

Robert Evans

Introduction by
John Wyn Owen



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Market-Based Health Care Reform

This somewhat revised version of a paper first presented at the International Conference on Governments and Health Systems: Implications of Different Involvements, Jerusalem, Israel, 17th-22nd December 1995, is reprinted with permission.
The conference volume will be published by John Wiley & Sons, Ltd.

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FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

Published by
The Nuffield Trust
59 New Cavendish Street
London W1M 7RD

ISBN 1-902089-03-0

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INTRODUCTION

The government is once again undertaking a comprehensive health spending review. At the same time it has found funds to avoid a winter of emergency inpatient closures and lengthening waiting lists.

Sustainable financing of health care with appropriate mechanisms for individual community and national priority setting are important public policy objectives which have been under scrutiny over many years and must now be addressed with some urgency. The Trust has informed this debate in the past and will continue to do so.

These Occasional Papers offer the economists' contribution and should be of interest to policy-makers at the highest level as they strive to improve the effectiveness of the National Health Service, improve patient care and create the right incentives to reward efficient performance within inevitable financial constraints.

Paper 3 – *Going for Gold: The Redistributive Agenda Behind Market-Based Health Care Reform* – by Robert Evans, opens with a statement, quoted from an article in *Scientific American*, that “fundamental economic principles...put efficient, competitive health care markets in the same class as powdered unicorn horn.” The author explodes the myth that private, competitive markets, as described in economic textbooks or could exist anywhere in the world. The inherent characteristics of health and health care, where public and private action have always been combined, preclude such a possibility.

Evans concludes that there are powerful redistributive motives behind parts of the health care reform agenda worldwide and that much analysis, particularly of the economic variety, misdirects attention by failing to acknowledge this openly. Market mechanisms are only one type of managerial tool. They *cannot* be a substitute for the central role

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of government – to exercise general oversight of and political responsibility for each country’s health care system. Governments may choose to delegate part of this role but they should not be allowed to withdraw from it completely.

John Wyn Owen
January 1998

ABOUT THE AUTHOR

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Acknowledgements

This series of Occasional Papers was generously supported by the Nuffield Trust. In addition to the help and support from all the authors and the referees of their papers the editor would like to acknowledge the valuable and generous managerial and editorial assistance provided by Karen Bloor and Frances Sharp of the University of York.

FOREWORD

The application of economic analysis to health and health care has grown rapidly in recent decades. Alan Williams' conversion of Archie Cochrane to the virtues of the economic approach led the latter to conclude that:

“allocation of funds and facilities are nearly always based on the opinion of consultants but, more and more, requests for additional facilities will have to be based on detailed arguments with ‘hard evidence’ as to the gain to be expected from the patient’s angle and the cost. Few could possibly object to this.”*

During most of the subsequent twenty-five years many clinicians have ignored Cochrane’s arguments whilst economists busily colonised the minds of those receptive to their arguments. More recently clinicians and policy makers have come to equate, erroneously of course, health economics with economic evaluation. Thus the architects of the Department of Health’s R&D strategy have insisted that all clinical trials should have economic components and tended to ignore the broader framework of policy in which economic techniques can be used to inform policy choices by clinicians, managers and politicians. †

The purpose of this series of Occasional Papers on health economics is to demonstrate how this broad approach to the use of economic techniques in policy analysis can inform choices across a wide spectrum of issues which have challenged decision makers for decades. The authors do not offer ‘final solutions’ but demonstrate the complexity of their subjects and how economics can provide useful insights into the processes by which the performance of the NHS and other health care systems can be enhanced.

The papers in this series are stimulating and informative, offering readers unique insights into many aspects of health care policy which will continue to challenge decision makers in the next decade regardless of the form of government or the structure of health care finance and delivery.

Professor Alan Maynard
University of York

* Cochrane AL. *Effectiveness and Efficiency: random reflections on health services*. Nuffield Provincial Hospitals Trust, London, 1972.

† Maynard A and Chalmers I (eds). *Non-random Reflections on Health Services Research: on the 25th anniversary of Archie Cochrane's Effectiveness and Efficiency*. British Medical Journal Publishing, London, 1997.

ABSTRACT: SUMMARY PROPOSITIONS

Political conflict over the respective roles of the state and the market in health care has a long history. Current interest in market approaches represents the resurgence of ideas and arguments that have been promoted with varying intensity throughout this century. (In practice, advocates have never wanted a truly competitive market, but rather one managed by and for particular private interests.) Yet international experience over the last 40 years has demonstrated that greater reliance on the market is associated with inferior system performance – inequity, inefficiency, high cost, and public dissatisfaction. The United States is the leading example. So why is this issue back again? Because market mechanisms yield distributional advantages for particular influential groups. (1) A more costly health care system yields higher prices and incomes for suppliers – physicians, drug companies, and private insurers. (2) Private payment distributes overall system costs according to use (or expected use) of services, costing wealthier and healthier people less than finance from (income-related) taxation. (3) Wealthy and unhealthy people can purchase (real or perceived) better access or quality for themselves, without having to support a similar standard for others. Thus there is, and always has been, a natural alliance of economic interest between service providers and upper-income citizens to support shifting health financing from public to private sources. Analytic arguments for the potential superiority of hypothetical competitive markets are simply one of the rhetorical forms through which this permanent conflict of economic interest is expressed in political debate.

“...fundamental economic principles ... put efficient, competitive health care markets in the same class as powdered unicorn horn.”¹

1 There is in health care no ‘private, competitive market’ of the form described in the economics textbooks, anywhere in the world. There never has been, and inherent characteristics of health and health care make it impossible that there ever could be. Public and private action have always been interwoven.

2 The persistent interest in an imaginary ‘private competitive market’ is sustained by distributional objectives. These define three axes of conflict:

- ◆ the progressivity or regressivity of the health care funding system: Who has to pay, and how much?
- ◆ the relative incomes of providers: Who gets paid, and how much? and
- ◆ the terms of access to care: Can those with greater resources buy ‘better’ services?

3 The real policy choices fall into two categories:

- ◆ the extent of use of market-like mechanisms within publicly funded health care systems; and
- ◆ the extent to which certain services may be funded outside the public sector, through quasi-markets and under a mix of public and private regulation.

ABSTRACT: SUMMARY PROPOSITIONS

4 Proposals to shift towards more use of quasi-markets, through the extension of private funding mechanisms, are distributionally driven. They reflect the fact that, compared with public funding systems, privately regulated quasi-markets have to date been:

- ◆ less successful in controlling prices and limiting the supply of services; more jobs and higher incomes for suppliers;
- ◆ supported through more regressive funding sources; the healthy and wealthy pay less while the ill and wealthy get preferential access; and
- ◆ off-budget for governments; cost shifting in the economy looks like cost saving in the public sector.

5 Market-like mechanisms within publicly funded health care systems constitute a particular set of management tools, that might be used along with other more established mechanisms to promote the generally accepted social objectives of:

- ◆ effective health care, efficiently provided, and equitably distributed across the population according to needs;
- ◆ fair but not excessive reimbursement of providers; and
- ◆ equitable distribution of the burden of contributions according to ability to pay, within an overall expenditure envelope that is consistent with the carrying capacity of the general economy, or rather the collective willingness-to-pay of its members.

6 These general objectives seem to be widely shared internationally. Their specific content is of course much more controversial – they are fundamentally political statements – and as usual God and the devil are in the details. But the key point is that these social objectives have their origins prior to and at a higher level than the choice of any particular set of mechanisms for trying to attain them. They are *ends*; the mix and blend of public and private actions are *means* to those ends. (Markets were made for, and by, men, not men for markets.)

7 Market-like mechanisms, as a class, have no inherent or *a priori* claim to superiority as mechanisms for achieving these public objectives. Nor is there to date any overwhelming empirical support for their widespread use. There are a number of interesting examples, in different countries, of the use of economic incentives to motivate desired changes, and these bear close watching. But this is still very much an ‘experimental technology’ for system management. Moreover there are grounds for serious concern about negative ‘side effects’ from transforming the structure of motivations and rewards in health care.

8 The central role of governments remains that of exercising, directly or more traditionally by delegation, general oversight of and political responsibility for each country’s health care system. Governments are increasingly acting as a sort of ‘consumers’ co-operative’ or prudent purchaser on behalf of their populations. They should choose whatever managerial tools seem to work best for this purpose, subject to the political constraints created by the fundamental conflicts of distributional interests detailed above. In particular they may delegate some parts of this role, but should not be permitted to divest themselves of it. In the one country where a coalition of private interests has prevented government from taking up this responsibility, the results have been spectacularly unsatisfactory.

DISCUSSION

The proper role of governments in health systems is an ancient debate. Its longevity reflects the permanence of certain fundamental conflicts of economic interest among the different groups involved in the organisation and financing of health services. The form and extent of government involvement, and its relation to the activities of non-governmental agents, significantly affect the balance of advantage in these conflicts.

The current world-wide resurgence of interest in the topic is driven by a number of different motives, covert as well as overt. There is, however, an unfortunate tendency to frame the issue as ‘government *versus* the market’, or ‘regulation *versus* independent action’, as if these were alternative, mutually exclusive frameworks for economic organisation. Such juxtapositions grossly misrepresent the relationships among the various institutions and actors composing modern health care systems.

‘State’ and ‘private’ institutions have always interpenetrated each other, to the extent that in most national systems it is often difficult, and inherently arbitrary, to classify a particular institution as ‘public’ or ‘private’. In reality there is a continuum along the line from civil service at one end to the privately owned, strictly for-profit corporation at the other. Most health care, in most countries, is provided by people and organisations that fall into neither category. The public regulatory framework (set by government) typically gives them much more autonomy than civil servants, while conferring both privileges and responsibilities that distinguish them in essential ways from participants in ‘normal’ markets.

The most obvious example of such interpenetration, so obvious that it long ago disappeared from the consciousness of most of those who approach health care systems from a ‘market’ perspective, is

professional self-regulation. Provider associations exercise the coercive authority of the state – the police power – to regulate and sometimes to suppress competitive behaviour among their members. Even more important, they are vigilant in preventing intrusions into their fields of practice by unlicensed persons. This process goes on, one way or another, in all systems, and has very deep historical roots.

The presumption, widely if not universally shared, is that professional self-regulation promotes more general social interests. There is room for considerable disagreement over the balance of public and private interests actually served, in general or in particular circumstances. But in any case the thing *happens*. Public regulatory authority and (collective) private interest are woven together in a complex way. (One of the best treatments of this relationship is Trebilcock *et al*² chapters 2 & 3, pages 35–64.) Where markets for health care exist, they are always ‘managed markets’. There may be, at different times and places, bitter political struggles over *who* should manage the market, but no one seriously questions the need for management.

Another example. The state confers monopoly rights, in the form of patents, on the developers of new drugs and devices. This blatant government interference with the free market is traditionally justified as encouraging further innovation – short-run costs for long-run gains. But the traditional story highlights the role of government in responding to ‘failure’ in private markets and regulating in the public interest. Patent-holding firms thus prefer to speak of ‘intellectual property’, implying that there is some sort of ‘natural right’ to exercise monopoly power (and to call upon the state to enforce it) that is prior to and more fundamental than whatever interpretation might be given to the public interest by the government of the day. This is legal nonsense, but can be very effective politics.

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So are patents regulatory interference with free markets, or simply recognition and protection of private property rights? Certainly, when a government tries to modify patent rights within its own jurisdiction – e.g. by introducing compulsory licensure as Canada did during the 1970s – patent-holders world-wide react to this as public intrusion into private markets. They may then be supported by their home governments, essentially claiming a modern form of ‘extraterritoriality’, backed up by a modern form of gunboat diplomacy. The rights of the stronger *do* seem more natural, at least to the stronger! (Thrasymachus may borrow Socrates’ language, without changing his principles.)

Self-governing professional associations react with equivalent outrage when governments try to modify the (public) legislation from which they derive their power. In general those who exercise and benefit from delegated public authority come to regard that authority as private property, and try to convince their fellow-citizens to share this view. Whether they succeed or fail, the process makes clear the foundation of private property in political consensus. How could it be otherwise?

The long and complex relationship between ‘the state’ and providers of health care thus goes far beyond the role of public agencies as payers for care. Economic analysts in particular tend to focus on the latter as if it were the only point of contact. This restricted view can lead to the representation of the supply side of health care systems in terms of the traditional categories of the microeconomic theory text-books. Such an imaginary system may then be hypothesised to be actually or potentially ‘competitive’, in the full text-book sense, with all that that implies for the potential role of private markets. These representations are both analytically convenient and intellectually familiar (to economists) – advantages that seem to compensate for their gross inadequacies as descriptions of actual institutions or behaviour.

But the convenience is not only for the analyst. The pretence that the provision of health services either is, or ever was, or ever could be, organised along the lines of markets for shoes or ships or sealing-wax serves to draw a veil over the activities of those who do in fact exercise power, and to screen them from public accountability for its use. ‘Nobody here but us competitors, all obeying the laws of the market.’ Attempts to modify the institutional rules so as to align private activity more closely with public interests or objectives can then be portrayed, by those with private interests to defend or advance, as simply wrong-headed political meddling in an otherwise smoothly functioning private market-place.

The primary concern of this paper is to identify the economic interests defended or advanced by the extension of private market mechanisms in health care. A recent paper by Rice provides a comprehensive survey of an extensive literature demonstrating that the simple-minded application to health care of economic theories about competitive markets is both descriptively invalid and theoretically unsound.³ Here we consider why advocates of the private marketplace might continue to rely on just such analysis.

Standard economic analyses of ‘the market’ suppress its inevitable distributional implications. If market advocates do in fact have a distributional agenda, but one that is not widely shared, then they have an obvious interest in promoting the use of an intellectual framework that makes distributional questions difficult or impossible to ask. If that framework also yields a conclusion (valid or erroneous) that private markets are socially ‘optimal’ in some technical sense (bearing no relation to the common use of the word), so much the better.

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Distributional questions may be suppressed in economic analysis, but they remain at the forefront of public policy debates. Private markets have been reduced to a subsidiary role in all developed countries, other than the United States, largely on the basis of distributional concerns. This may explain why advocates of private markets tend to make their arguments as if the last forty years had never occurred. The issues that were contentious in the 1950s and 1960s are being dragged out again, with all sorts of old *a priori* arguments being dusted off, repainted, and presented as ‘new’ thinking about the role of the private sector.

But we have now had several decades of international experience with different mixes of public and private funding systems, and the broad lessons are pretty clear. In the developed world a general consensus has evolved that White labels ‘the international standard’ for health care systems.⁴ Behind wide variations in detail, there is a broad similarity of system characteristics:

- ◆ Universal coverage of the population, through compulsory participation,
- ◆ Comprehensiveness of principal benefits,
- ◆ Contributions based on income, rather than individual insurance purchase,
- ◆ Cost control through administrative mechanisms, including
 - binding fee schedules,
 - global budgets, and
 - limitations on system capacity.

While the processes vary, there seems to have been a progressive convergence in both the mechanisms used for administrative management of system costs, and the understanding of system dynamics on which these are based. Cost control is always incomplete; in all countries there are powerful interest groups arrayed on the other side trying to promote continuous system expansion. But in all developed countries, Wildavsky's Law of Medical Money:⁵

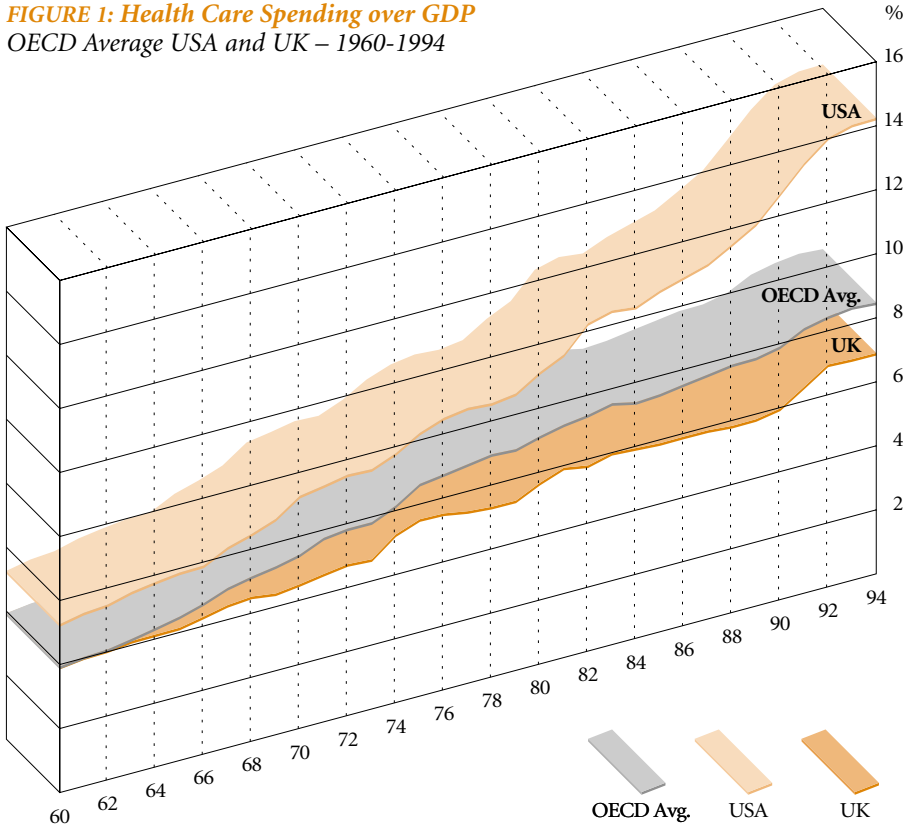
"...cost will increase to the level of available funds ... that level must be limited to keep costs down."

has been understood and acted upon through the development of countervailing public authority.^{6,7}

The turning-point seems to have come, for most countries, at some time during the 1970s. Figure 1 displays the share of GDP spent on health care averaged (unweighted) across all the countries of the OECD for which complete data are available, from 1960 to 1994. This average is bracketed by the experiences of the United States and the United Kingdom, as representing high- and low-cost countries. For the first half of the period, the aggregate international cost experience paralleled that of the United States, with the United Kingdom becoming more and more of an outlier on the low side. But since the mid-1970s the average experience is of substantially slower growth in health expenditures relative to GDP – roughly paralleling the UK trend – with the United States progressively diverging and the UK expenditure accelerating after the internal market reforms. Taking 1977 as a mid-point, the OECD average share of health spending in GDP rose 25 per cent in the second half of this period, compared with 76 per cent in the first.

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FIGURE 1: Health Care Spending over GDP
 OECD Average USA and UK – 1960-1994



The United States is of course the exception to White’s generalisation, departing in a major way from his international standard in both structure and performance. The same point was made ten years earlier by Abel-Smith,⁸ observing that the United States was the ‘Odd Man Out’ among modern health care systems. As such, it provides an enormously valuable point of comparison for the rest of us. What

happens if a country does *not* move towards a central role for government in the financing of health care? The decade between Abel-Smith's observation and White's review has reinforced the earlier conclusion. The United States has a health care system that is, by most measures, not only unique in the developed world but also uniquely unsatisfactory. Within the United States it may be daring⁹ or heretical¹⁰ to question (publicly) the axiom that 'America is Number One', but most external observers (and some internal) would put its health care system closer to the *bottom* of the league tables.

This is not to say that the health *care* provided in the United States is of poor quality. Some is, but much is excellent; some is the best in the world. And American patients typically express a high degree of satisfaction with their own care – as do patients in Canada, or the UK or most other countries. But as a *system* for organising, delivering, and particularly for financing health care, the American approach is by international standards grossly inefficient, heart-breakingly unfair, monumentally top-heavy with bureaucracy, and off the charts in both the level and the rate of escalation of costs.

While the specific numbers may be controversial the broad empirical facts do not appear to be in dispute. And these are so glaring as to render the details essentially unimportant. No one denies, for example, that the uniquely American form of health insurance generates very large administrative costs, much higher than in any other national system. Woolhandler and Himmelstein have done the most to focus attention on these excess costs; their estimates relative to, say, the costs of administering a Canadian-style universal system, would now be well over \$100 billion.¹¹ Others have generated lower estimates; but the point is that whether unnecessary paper-pushing costs Americans \$80 billion or \$120 billion, the amount is *large*.

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Similarly one can debate whether the number of Americans without health insurance at any point in time is closer to 35 or to 40 million, or whether one should count only those uninsured for a year, or only citizens ... and how much care do the uninsured really get anyway? Again, the point is that the number is very large, both in total and as a share of the population, and would not be tolerated in any other developed country.

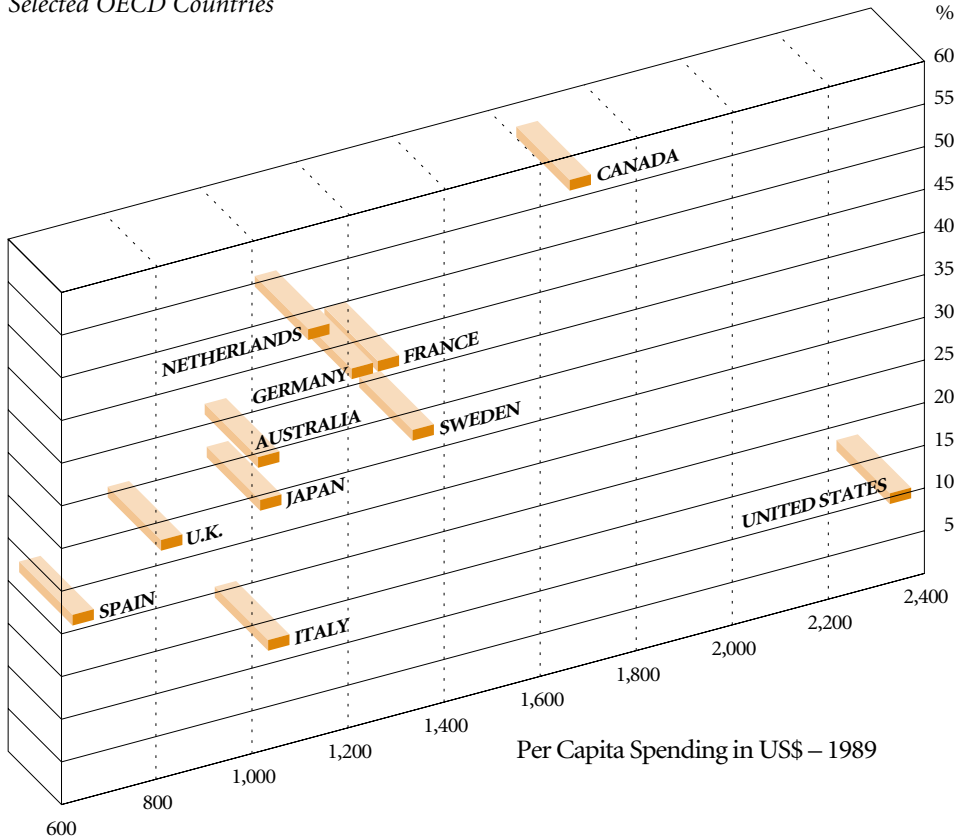
International comparisons of health care (or any other) expenditures are of course subject to a number of sources of bias and distortion, as well as periodic revision. But no amount of statistical adjustment is likely to narrow the gap between the United States, now spending roughly 14 per cent of its national income on health care, and the next most costly countries at about 10 per cent. And for all that, Americans are not particularly healthy, relative to the rest of the developed world.

Yet even while the United States maintains the institutional forms, and the rhetoric, of a private system, it has over time shifted more than half its health care funding to the public sector. By 1994, 44.3 per cent of total health expenditure was reported as coming from one or other level of government.¹² But the tax expenditure subsidy for private health insurance, the failure to tax employer-paid premiums as income in the hands of the employee, represents an additional public contribution of nearly ten per cent in the form of foregone tax revenue.

This American reality, in the face of the most powerful expressions of anti-government ideology, suggests that it may simply be impossible to support a modern health care system predominantly from private funds. One can, however, have public funding without comprehensive public oversight and control, at least as long as one is willing to put up with pretty dismal results.

FIGURE 2: Satisfaction with Health Care
 Selected OECD Countries

Percentage 'System Works Well'



These observations are not always put so bluntly, but their substance is not in dispute. No serious student of health care systems, in or out of the United States, tries to defend the American *status quo*. Indeed American citizens have also figured this out, and give their system very low marks. Figure 2 combines responses by citizens of different countries to a standard set of questions constructed by the

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Harris polling organisation¹³ with expenditure data from the OECD Health Datafile. The defeat of the Clinton reforms is attributable, not to general satisfaction with the *status quo*, but to the effectiveness of sophisticated and well financed disinformation campaigns in creating myths and confusion. Widespread support for reform could not be consolidated behind any one single alternative, and was thus dissipated.¹⁴

What is most striking is not simply that Americans expressed a relatively low level of satisfaction with their health care system (*not* with their own personal health care), but that they depart so markedly from the pattern found across all other countries surveyed. There is a surprisingly close linear relationship, among countries that have evolved an institutional framework conforming to White's international standard, between *per capita* spending on health care and the average level of public satisfaction with the health care system. More spending leads to more satisfaction.

These observations are not good news for the cost cutters of the 1990s. Moreover they have the curious feature that reported satisfaction is related to *total* spending. Since the relative price of health care varies considerably across countries (see below), this Figure would look quite different if *per capita* spending were adjusted to reflect the varying *per capita* quantities of services available in each country. The linear relationship would tend to break down. This implies that Figure 2 does *not* simply reflect the crude economic assumption that people are happier when they use more services. What then is the connection between spending and satisfaction?

The United States is different – and Americans are not happy about it. The regularity of the international relationship, and the remarkable

deviation of the United States, forms a context for a claim sometimes made to explain the American experience, that the threats to health are simply greater in the United States. The health care system must therefore work harder, and needs more resources. This is the international version of ‘Our patients are sicker.’ (Alternatively, Americans’ expectations are higher.) Figure 2 requires them to be ‘very different’ not just from some one other country, but from the general pattern shown by all developed countries surveyed. *A priori*, one might have expected that the differences among ‘the rest’ would have been greater than the differences between the United States and, say, Canada. The only obvious factor differentiating the United States from *all* these other countries is, as Abel-Smith and White have pointed out, its health care system.

But for the United States, the international standard appears to be politically inaccessible. ‘Managed care’ and ‘competition’ have thus emerged as a sort of lateral move in response to failure and frustration, marketed as an opportunity for the United States to innovate and leap over the experience of other countries to a position of leadership. If we cannot do what everyone else does, well then we’ll do something else. And it will be much better! Desperation may explain the high level of enthusiasm, despite the lack of any record of success. The triumphs of managed care are still, as they always have been, in the future.

But is the future finally here? American advocates of ‘the market’ may well see vindication at last in the national health expenditure estimates for 1994. At \$949.4 billion, total spending was only 6.4 per cent above its 1993 level – the slowest rate of increase in thirty years.¹² And the 1993 level was itself only 7.0 per cent above 1992. In both years, increases were lower in the private health insurance sector than in the public Medicare system, with the gap particularly wide in 1994. Quite understandably, this has led some to argue that (whatever else may be

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going on) the great American cost explosion is finally over – ended by the increasing pressure of market forces.

‘Whatever else may be going on’ covers a vast field, from improved effectiveness, efficiency, and responsiveness to patients at one end, to deliberate under-servicing and exploitation of patient vulnerability at the other. A broader discussion is far beyond the scope of this paper. A recent and very extensive review by Consumer Reports, including a survey of over 30,000 of their members, concludes (p. 41):

“The new age of managed care... [is] an appealing picture – but today, it’s a mirage.”¹⁵

Likewise Zwanziger and Melnick (p. 190):

“The transformation is not yet over. In fact, we are far from the finish, and the process is so complex that we cannot easily predict the outcome.”¹⁶

Hair-raising scenarios in which health absorbs nearly twenty per cent of the American GDP by the year 2000 now look decidedly out of date, the products of another era. But is the long American expansion, finally, permanently, *really* over? A closer look at the recent American data suggests continued caution. First, a part of the slow-down is associated with falling rates of general, economy-wide inflation. When one looks at ‘real’ or inflation-adjusted health spending, the increases of the last two years are still low, but there is an interesting historical pattern. Since 1960 there have been three periods of very low rates of increase: 1974/5, 1978/9 and 1993/4. In each of these, major federal initiatives of public insurance and/or cost control were under discussion and close to enactment. In the past, failure of these measures has been followed by a cost rebound. The recent organisational changes in the American health

care system have been much more profound than any in the past; but it is too soon to tell whether they have brought about a permanent shift in the growth path.

A longer period of experience is available from California, indicating that market forces have exerted sustained downward pressure on cost escalation.¹⁷ But to date, initially very high Californian expenditures have simply converged to a national average that has itself steadily risen.¹⁸ Moreover, the health care market in California has always been strongly promoted and actively managed by the state government.¹⁹ ‘Successful’ managed care through private markets, if it can be achieved at all, will require continued and quite sophisticated intervention by governments.¹⁷

Furthermore, even if the reduced rate of growth should be permanent, the recent United States ‘achievement’ looks rather different from outside the country. 1994 was after all a year of strong economic growth, and yet health care still maintained its share of the American GDP. In Canada, by contrast, the percentage fell from 10.1 per cent in 1993 to 9.7 per cent in 1994. And several European countries – Sweden, Germany, the Netherlands – have been shrinking this ratio for several years. American costs remain extraordinarily high, in international terms, and are continuing to escalate, even if less rapidly than in the past.

Thus when ‘managed care’ is offered in other countries as a ‘compromise between public regulation and private action’, it looks rather more like a compromise between success and failure. Nobody pretends that other countries do not have substantial problems with their health care systems. But they are typically problems that most Americans would be very relieved to have to face! (Most, but not all. Those who work in the private insurance industry, or the rapidly

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growing managed care industry, know that in any other country their costs/incomes would not exist.)

So there is a puzzle. The record of the last forty years seems to show that the United States took the wrong road in trying to rely on private action to organise and finance health care. The rest of us groped our way to what now seems to be a reasonably satisfactory road, albeit one needing a good deal of further work. Alain Enthoven, one of the most prominent advocates of competitive managed care, declared flatly in 1989 that: 'It would be, quite frankly, ridiculous... to suggest that we in the United States have achieved a satisfactory system that our European friends would be wise to emulate.'²⁰ The fundamental problems of cost and coverage, efficiency and equity, that motivated his comment have become worse since then. Why then would anyone want to re-run the ancient 'state versus market' debates of the 1950's? And why in particular would we in other countries be thinking of expanding the role of the private market, and importing American ideas?

A good part of the answer, I think, lies in the loose use of the word 'we'. It implies a commonality of interest, suppressing the rather obvious fact that choices with respect to health care finance – as with any other aspect of public policy – have significant distributional consequences. Some gain, and some lose, and the gains and losses can be very large.

The persistence of the same old arguments over health care finance, the resilience of ancient policy proposals in the face of contrary experience, is rooted in the fact that the broad pattern of gainers and losers resulting from particular policy choices in health care has changed little, if at all, over the decades.²¹ The relative size of the particular interest groups is now very different, in different countries, and the stakes are much larger. But the interests are the same.

Figure 3 and Equation 1 provide an accounting framework – a stripped down sectoral version of the national income accounts – within which to represent the different interests involved. Abstracting from both international trade and changes in asset stocks, there is a fundamental identity linking total expenditures on health goods and services, total revenues raised to pay for those services, and total incomes earned from the provision of services.

$$T + C + R \equiv P \times Q \equiv W \times Z \quad (1)$$

The definition of what does or does not constitute a health service, the basket of commodities included in this sector, is in principle arbitrary, though in practice there is good agreement on the broad categories of ‘medically necessary’ hospital, medical, and pharmaceutical services. The grey areas are many, but quantitatively pretty small (with the exception of institutional care of the frail elderly or otherwise disabled).

Revenues may be raised through three main channels – taxation (T), direct charges (C), and private insurance premiums (R). (Following national income accounting practice, social insurance premiums are treated as taxes.) Total expenditure can be factored into the unit prices of the various health care commodities, and the quantities of each. P and Q are thus vectors whose elements refer to all the different types of commodities provided in the system. These in turn are produced by combining various inputs or resources Z that are paid at a rate per unit W . An element of the vector W might be a wage rate, for example, corresponding to a type of labour input measured in hours and making up an element of Z .

Health care goods and services are provided by various kinds of firms – professional practices, hospitals, government agencies, private corporations. A ‘real’ exchange takes place between these firms and

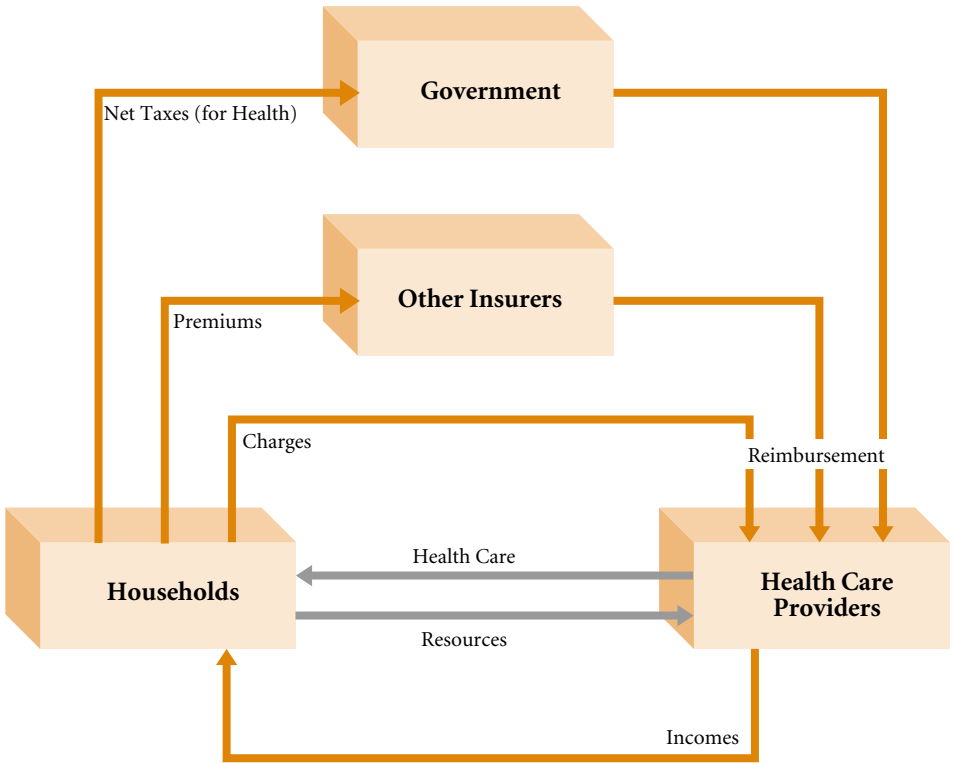
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households, as the latter both receive and consume the products of the former, and supply the resource inputs that firms combine – ‘transform’ – into commodities. The revenues received by firms for their products then all flow back to households as incomes, in payment for the resources provided.

‘Provider incomes’ is a convenient shorthand, but also introduces a potent source of semantic confusion. ‘Providers’ refers to professional persons or institutions that actually give care – doctors and nurses, or hospitals and nursing homes. But the W and Z in equation (1) include all the resources that are reimbursed out of health care expenditures. Total incomes earned from the provision of health care include but are not restricted to the incomes of ‘providers’ in the usual sense.

They include, for example, the fees of the lawyer reimbursed by the insurer to whom the physician pays premiums for malpractice insurance. They would also include the dividends received (and retained earnings ‘owned’) by shareholders in a for-profit managed care firm that contracted with physicians and collects premiums from patients. To the extent that managed care results in lower fees, salaries, or workloads for particular caregivers, it lowers the incomes of ‘providers’ as commonly defined. But if total costs continue upwards, then the flow of funds through the health care system will have been re-directed to benefit a different group of households – suppliers of managerial services and investment capital, marketers, accountants, and the whole administrative overhead of business enterprise. The components of W and Z will be rearranged – less for some, more for others, but taken in total, incomes earned from the provision of health care continue to increase.

FIGURE 3: Alternative Ways of Paying for Health Care
Total Revenues equal Total Expenditures equal Total Incomes



The fundamental point, however, is that the relationship depicted in Figure 3 and written out in Equation 1 is an identity, and must hold, as a matter of logic and mathematical consistency. Any change to one component must be either offset or balanced by corresponding changes elsewhere in the equation.

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To this identity, we can annex various ‘side equations,’ or additional relationships that are postulated to involve components of the basic identity. At a minimum these would include:

- (i) A health ‘production function’ that links the outputs of health services Q to the health status of the members of the population. This relationship is both complex and controversial, but the very definition of health services implies that they bear a special relationship to health. Absent that relationship, and most of us would much prefer to forego the service themselves. ‘Consuming’ health care is not in itself a source of satisfaction.
- (ii) A health *care* production function, that links the outputs of services Q to the levels of inputs Z . Dollars do not produce services, but people, know-how, capital, and raw materials do. One cannot make bricks (at least not very good ones) without straw.
- (iii) A ‘demand’ relationship linking the level of direct charges paid by users, C , to the level of utilisation, Q . The typical assumption from the economics textbooks is that as C goes up, Q goes down, and indeed *ceteris paribus* that appears to be true. But the *ceteris* are rarely, if ever, *paribus*, which is why this relationship must be considered in the context of the overall identity.
- (iv) A ‘capacity’ relation linking levels of service provided Q to some maximum available stock of inputs Z . The inputs used and paid for at any point in time do not necessarily represent the full capacity of the health care system. There

is, however, a strong tendency for patterns of care to adapt so as to use up the resources available – ‘supply creates its own demand’.

The ‘production functions’ need not hold as equalities; they are boundary conditions placing limits on the possible. But providers of care routinely assert and often sincerely believe that both of these boundaries have been reached, and also that there would be a high payoff in improved health from further increasing (the right form of) health care. The system is underfunded! Needs are not being met! Send more resources, and especially more money!

Such claims are part of the political theatre in which struggles over income shares are played out. Occasionally they may be supported with actual examples of unmet needs; rarely are the boundary assumptions made explicit, let alone supported. But whatever its relation to ‘unmet needs’, more expenditure always yields an increase in incomes. ($W \times Z$ goes up, although the split between W and Z will depend on other factors). This is the driving force behind Wildavsky’s Law.

Providers, naturally enough, prefer to talk about the ‘infinite demand’ of ‘consumers’. Patient demands may in fact escalate pretty rapidly in response to *perceived* threats to life and limb, or health and function. But this ‘demand’ is endogenous; it depends upon the behaviour of providers themselves.

The ‘cholesterol industry’ in the United States, for example, has done a remarkable job of creating ‘demand’ for testing of blood lipids, in complete defiance of the experimental evidence. Those who undergo the tests believe that their life expectancy will be increased by detection and treatment of the elevated blood lipids. Understandably enough, they ‘demand’ the test. Unfortunately, for most of them (the

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asymptomatic ones) the experimental evidence does not support this belief. Ditto mammography in the under fifty population, ditto PSA testing, ditto routine ultrasound in normal pregnancy, ditto... But there is too much money being made, not only from testing but from all the associated services of interpretation, monitoring, and therapy, to let lack of evidence impede medical progress.

There is likewise a great deal more assertion about the strength – and normative significance – of the ‘demand’ relationship than ever shows up in actual system experience. In fact providers in publicly funded systems commonly advocate the expansion of direct charges as a way of *increasing* the total flow of funds into health care, implying that if there is any net negative effect on Q , it will be more than offset by corresponding increases in P . And the evidence seems to be consistent with this view.

Studies of individual responses may show the conventional ‘demand’ response, but these findings do not aggregate to the system-wide level. Globally, increases in user charges serve to *shift* costs from one payer to another, while *increasing* the total. Providers, and especially their representatives, are not economically naïve; they do not advocate policies that will reduce their own incomes!

On the other hand the direct impact of capacity on use is one of the most solidly grounded empirical relationships in health economics. It has been observed for hospital beds, physicians, and new drug products or types of technical equipment. But it is conditional on the availability of payment. ‘Roemer’s Law’, that a built bed is a filled bed, abruptly ceased to hold in the United States when Medicare shifted to case-based reimbursement. And fund-holding general practitioners in the United Kingdom, who have to bear the resulting costs, seem much less willing than previously to hospitalise their patients.

The ‘side equations’, however, remind us that we are dealing with individual people (or households) as well as with commodities and units of currency. ‘Money is fungible’, but people are not. If we simply rewrite Equation 1 in notation that provides labels for each of the persons, commodities, and inputs involved, it becomes obvious that the identity holds in aggregate, but not for any one individual. Thus:

$$\sum_i \{tY_i + \sum_j (C_j \times q_{ij}) + R_i\} \equiv \sum_{ij} [P_j \times q_{ij}] \equiv \sum_{ik} \{W_k \times z_{ik}\} \quad (1A)$$

Here persons are indexed by i , health care services by j , factor inputs by k . In addition, the taxes paid by any individual that are directed towards health care are assumed to be a constant proportion t of that person’s income. The user charges paid by an individual are the product of that person’s level of use of a particular service, q_{ij} , multiplied by the level of charge, C_j , applicable to that service, and summed over all services. The user charge will typically lie between zero and the actual price/cost P_j of that service, although there is no logical reason why it could not be outside that range.

Stripping off the summations across individuals, the relationships in Equation 1A divide the population into two groups according to whether $W \times Z$ for a particular individual exceeds or falls short of both $T + C + R$ and $P \times Q$. The group for whom $W \times Z$ is higher are (net) recipients of health spending; they receive more in income from health care than they contribute to its financing or receive in services. The remainder, with low $W \times Z$, are (net) users of/payers for care – the rest of us.

A change in the funding arrangements for health care that increases expenditure (relative to what it would otherwise be) will typically be advantageous for the first group, and costly for the second. Most obviously, an increase in expenditure that takes the form of

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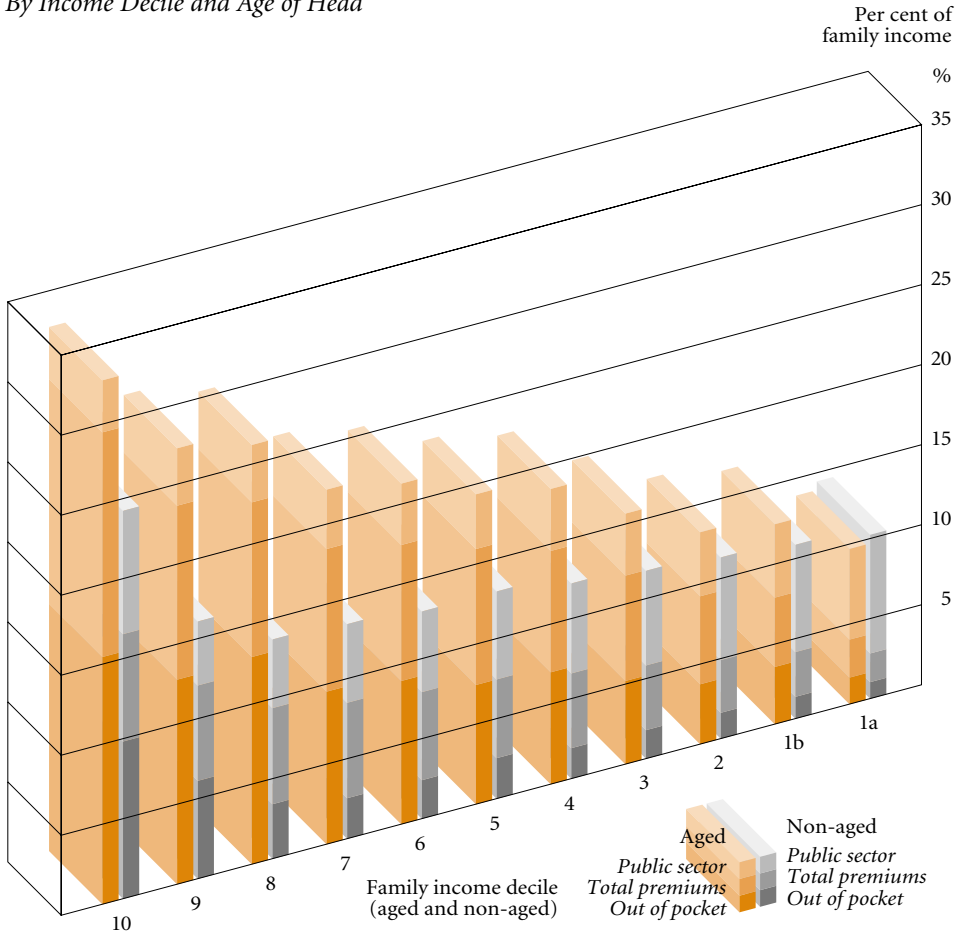
rising P and W , however it is financed, unambiguously transfers income from payers/users to providers – no surprises there.

But the user/payer group is not homogeneous; it can in turn be subdivided according to whether $T + C + R$ exceeds or falls short of $P \times Q$. The former can be labelled as the healthy and/or wealthy, contributing more to the financing of the system than the value of the services they receive from it. Conversely those for whom $P \times Q$ exceeds $T + C + R$ are net beneficiaries, at least financially. Again, any change in the sources of funding for a health care system will transfer income between the members of these two groups.

Thus one finds, for example, that people with higher incomes are more likely to favour greater reliance on user charges as a source of system finance, and less use of general public revenues. *A priori* it should be pretty obvious that while tax liabilities tend to be more or less proportionate to income, illness is not. For any given level of expenditure on health, more will come out of the pockets of the wealthier individuals if the system is tax-financed, and less if it is user-paid. Private insurance premiums, being based on expected use of care, not on income level, also take a bigger share of the incomes of people at lower incomes.

There are, however, two aspects to the regressivity of private insurance financing, as compared with tax financing. Because private insurance premiums are independent of income, lower income people will have to pay a larger share of their incomes for the same coverage. This will be true even of a 'community-rated' private plan, or a plan covering a large employee group, in which the covered pool is large enough that an individual's premium does not depend upon his/her own illness experience. Tax-financed coverage charges people in some proportion to their incomes.

FIGURE 4: Family Expenditure for Health Care
By Income Decile and Age of Head



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In small employee groups, however, experience rating by the insurer will imply that the amount of the premium will also be sensitive to extreme individual experiences. Insofar as today's 'insured' outlays are recouped by the insurer in the form of higher premiums tomorrow, insurance becomes in part a delayed user charge. This will increase the *variance* of health care costs as a share of income; to the extent that illness is correlated with low income it will also increase the regressivity of the financing system. And if and as the labour market evolves away from large employee groups toward more small firms and individual contractors, this aspect of regressivity will become more pronounced.

Empirical confirmation comes from studies in the United States.^{22,23} As shown in Figure 4, the share of health spending that comes through public budgets is progressively distributed, taking a larger share of the incomes of people at higher income levels. But both user fees and private insurance are strikingly regressive, taking a much larger share of the incomes of lower income people.

Moreover this pattern is particularly apparent among those over sixty-five, who are virtually all enrolled in the national Medicare program for the elderly. The various deductibles, coinsurance rates, and exclusions in that program, and the corresponding private 'Medigap' insurance market, produces a highly regressive financing structure even for this universal public program.

The identity provides the algebra underlying proposals for reform. Suppose one holds total expenditure constant in Equation 1A, but makes offsetting changes in t (down) and C (up). Those whose share of total income exceeds their share of total health expenditures (either because their incomes are large, or because their expenditures are small) will gain more from tax reductions than they lose from

increased user charges.²⁴ And these are the people who then advocate on various grounds and through a multitude of channels, increased reliance on ‘private’ funding.²¹

Several attempts have been made over the years to confuse this essentially straight-forward distributional issue. Proposals for integration of user charges with the income tax, or the creation of medical savings accounts, are financing gimmicks that obscure or appear to change the direction of the income transfer. But when one works through the details, at their core is health insurance with greatly increased deductibles and rates of coinsurance – more user pay and less tax finance. So long as tax liability is related to income, and service use is not, any such charges *must* transfer income from the less to the more healthy and wealthy (unless, of course, income-related barriers to access are so high that lower-income people have virtually no access to services anyway). Thus debates over public or private financing, whatever other issues they may draw in, are always and inevitably about who pays what share of the bill.

The standard claim by market advocates has always been that placing more of the cost burden on individual users will lead to lower utilisation and more careful purchasing by consumers/patients, more competitive behaviour by providers, and thus to a less costly, more responsive, and more efficient health care system. If this does not occur, it must be because the user charges are not high enough.

As observed above, the international comparative experience of the last forty years is flatly in contradiction to this claim. But the point emphasised here is that, whether or not the claim were true, it must be the case, from the basic accounting, that shifting the cost burden from taxpayers to users will on average redistribute wealth from lower

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to higher income individuals. When people persistently advocate a particular policy by making a claim *A*, which (I believe) the evidence rejects, while consistently avoiding discussion of effect *B*, which the policy *must* bring about, one should at least consider that *B* may be the real objective.

Interestingly, Hsiao²⁵ provides a recent evaluation of the Singaporean experience with medical savings accounts, as part of a more general reform based on precisely the claims of the market advocates. He concludes that, on the contrary, increasing the role of private financing has led to more rapid cost escalation, an over-capitalised system of duplicated and under-utilised facilities, and rapid increases in physician incomes. Even when patients are paying prices in nominally ‘free’ markets, hospitals do not compete on price, but on technology, in order to attract physicians who will bring in the paying patients. Nor can this be blamed on mis-management; he describes the Singaporean funding system as carefully planned and well-administered. It was the fundamental theory that was in error.

In 1993 the Singaporean authorities concluded that “The health care system is an example of market failure. The government has to intervene directly to structure and regulate the health system”,²⁵ Their observation is a bit late to be original; indeed one does wonder, given the accumulation of international experience, how they could ever have imagined otherwise. But it is significant because it follows a decade-long effort, under the most favourable circumstances, to make ‘the market’ work.

Massaro and Wong²⁶ offer a much more favourable commentary on the Singaporean experience, though drawing upon many of the same observations as Hsiao. Where he points to health care costs outrunning a national income that was itself growing rapidly, Massaro and Wong

state that nations ‘rationally invest’ (p.269) a larger share of their income in health care as they become wealthier. On the other hand they note that costs rose less rapidly than in some other rapidly growing economies, perhaps restrained by medical saving accounts. It is thus unclear whether they consider cost control to be an appropriate objective. In any case, “Hospitals are profitable and physicians are well paid” (p.269) and high technology services are readily available. But that is exactly Hsiao’s point. The system is over-capitalised, and (some) providers have made out like bandits.

Massaro and Wong share Hsiao’s view that Singapore provided the most favourable environment for competitive markets in health care; and they emphasise the necessary interplay between market mechanisms and detailed public regulation. But they seem to miss Hsiao’s fundamental point. The increasing regulation of physician supply, hospital budgets, and prices/fees in both the public and the private sector, is an explicit response by the Singaporean authorities to what they regard as failure of the private market system to control costs and promote efficiency. Consequently they have now adopted the cost control measures that are common in public insurance systems all over the developed world.

The profitable hospitals and well-paid physicians in Singapore, however, remind us that contributors at different income levels are not the only participants in the conversation over ‘the state versus the market’. The split between those who pay, and those who are paid, has had an even more powerful and long-term impact on the evolution of health care policy. It has always fuelled the conflicting perceptions of ‘system underfunding’ versus ‘excessive costs’ that seem to emerge in all systems, whatever the evidentiary base.

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The comparative success of governments in developing mechanisms for cost control – though not always in deploying them – has led to increasing efforts by providers to enhance their incomes by drawing in more private funds. These efforts underlie the peculiar ‘conversation of the deaf’ between those who are trying to limit public responsibility for payment by defining ‘core services’, and turning the rest over to some ‘private market’, however defined, and those who are trying to improve system management by elimination of ineffective services.

The root of the problem is that people, however remunerated, get paid for doing things, whether or not these are effective. If the movement for ‘evidence-based health care’ leads to a slimmed-down health care system, with fewer ineffective services and lower costs, then as the identity makes obvious, there will be fewer and/or lower income streams generated. Population health status may be maintained, or even increase, but Q , Z , and T , C , and/or R all fall.

On the other hand, the ‘core services’ approach finesses the question of ‘Does the service do any good?’ – health drops out of consideration – and splits Q into two components, ‘core’ paid for from the public budget, and ‘non-core’ paid for through direct charges or private insurance. The original bundle of services – or rather types of services – now draws in more money in total. Private funding (C and/or R) increased; unless there are equal or greater reductions in public funding the health care system as a whole expands. Prices, incomes, and perhaps jobs are up.

Are the ‘non-core’ services effective in improving health? Well, once they are out in the private market, who cares? Containing the exuberance of private medicine (or drugs, or dentistry, or...) is

technically difficult and politically expensive, unless there is some egregious public scandal (thalidomide, for example). Governments – or employers – will only take on the task if they must bear the financial consequences of not doing so. And even then success is not guaranteed. But if someone else is paying, the prudent response is to hide behind the rhetoric of the ‘sovereign consumer’ – who is after all ‘freely choosing’ to spend his/her own money – and perhaps try to promote a voluntary code of ethical conduct by providers.

The key distinction is that the evidence-based approach to classifying services identifies activities that ‘do no good’ and thus should not be provided *by anybody, in any setting*. In aiming to reduce total system costs while maintaining or improving population health status, it threatens provider incomes. The ‘core services’ approach is instead a program for tapping more private funds to supplement those provided by increasingly tough-minded governments – cost-shifting rather than cost control. In this way advocates hope to expand total system cost while limiting or reducing public outlays. Different objectives, different constraints; but again, the debate about private funding turns out to be about incomes.

Not all providers, however, believe that they can successfully draw in private funds. Those who offer well-defined and easily marketable procedures to anxious middle-aged businessmen may do very well; but those whose clientele have complex problems and minimal personal resources would gain little from an opportunity to market their services privately. From them, one hears support for the ‘evidence-based’ approach, but with the proviso that any savings should be put back into other forms of care, to meet other needs. Resources (and incomes) would then be redirected within the health care sector, while blunting the threat to total expenditures/incomes. Unlike the ‘core

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services' approach, however, this does not offer governments a way to limit *their* outlays.

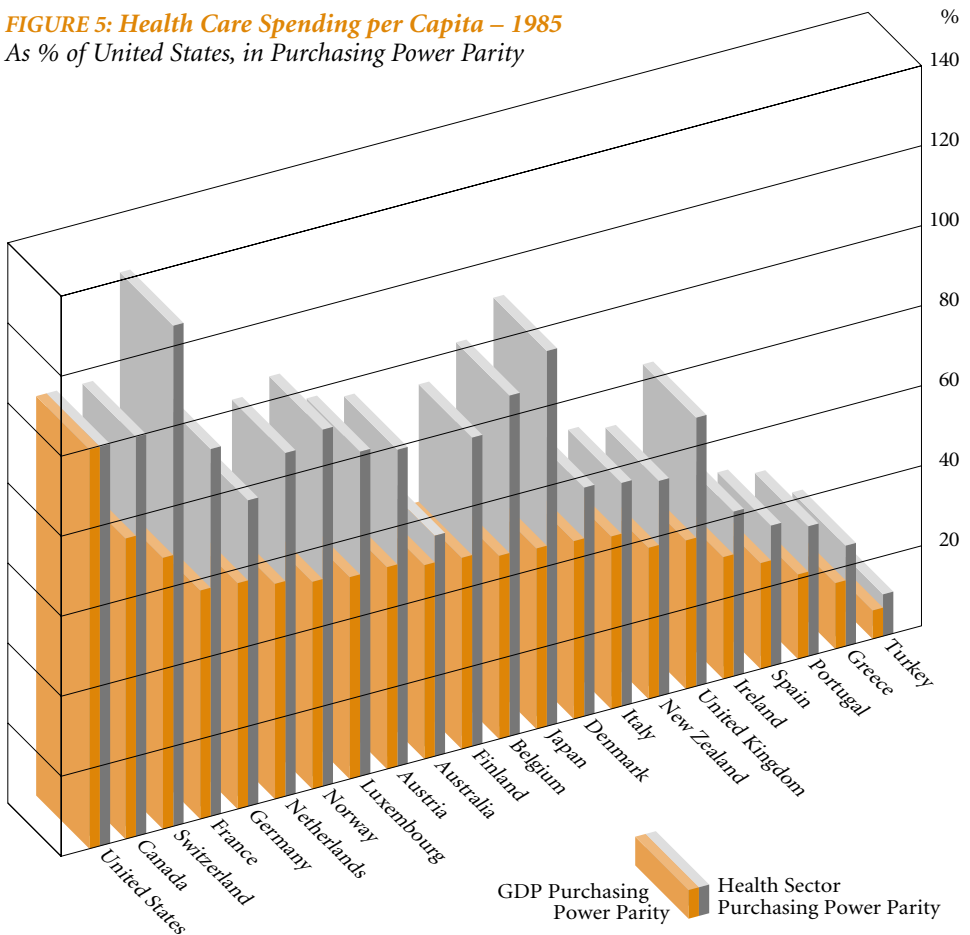
Proposals to expand the role of private insurance link the interests of both providers and upper-income contributors. Governments have proven to be quite tough as budgetary negotiators, and are imposing increasingly stringent controls on health care expenditures as their own fiscal positions weaken. Private insurers, on the other hand, have no particular incentive to limit cost escalation – if anything the contrary – and in any case have never done so. ('Managed care', whatever one thinks of it, is quite different from traditional health insurance.) From the point of view of providers the optimal situation is to have complete freedom to set prices and choose treatment patterns, but to have a high level of insurance coverage in the population so that the resulting bills will get paid.

American experience indicates that a high level of coverage requires very large public subsidies, both directly for the elderly and poor, and through tax expenditures for those with private insurance. But the tax expenditure subsidies for private insurance can be, and in the United States are, structured so as to yield the greatest benefits for people in higher income brackets. At the same time the tax supported public programme for the elderly has extensive user charges built into it, deductibles and coinsurance, in the name of cost control. But these charges are in turn covered, in whole or in part, by private 'medigap' insurance policies or through extensions of employer coverage as a retirement benefit. Such private coverage is highly correlated with income.

Thus increases in Medicare user charges serve primarily to shift costs from a funding source that is related to income – taxes – to one that is

not – private insurance premiums. Their ‘deterrent effect’ – which as argued above has no effect on aggregate system cost anyway – is faced only by those whose employers did not provide (or can no longer sustain) post-retirement coverage, or those who cannot afford private

FIGURE 5: Health Care Spending per Capita – 1985
As % of United States, in Purchasing Power Parity



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medigap coverage (or were sold a bad policy), or those who are not poor enough to qualify for Medicaid coverage.

Viewed in aggregate, the combination of Medicare user charges ‘to control costs’, plus private insurance to cover those charges, plus tax expenditure subsidies for private insurance, all overlaid with the capricious effects of highly imperfect markets, makes no sense at all. Indeed, it borders on lunacy. But if we look at the combination instead as a (non-transparent) way of keeping health care expenditures and incomes *up* by fragmenting funding sources, while shifting the burden of contributions down the income scale, then it begins to make sense. The whole system produces much higher costs, and a much more regressive contribution structure, than would be politically acceptable in any single-payer public system funded out of general revenue. A cover story is provided by the economic rhetoric in which the ill are to be held accountable for their ‘choices’ to ‘consume’ health care.

But all this administrative apparatus does not come cheap. This point emerged very clearly from an analysis of OECD data by Gerdtham and Jönsson,²⁷ in which they identified the effects of differences in the *relative* prices of health care services, from one country to another, on international comparisons of health care costs. They found, as displayed in Figure 5, that a large proportion of the differences in *per capita* expenditure between the United States and all other countries of the OECD was a result of higher relative prices of health care in the United States.

Americans received, (on average, and at the time of their study), no more care than Canadians, very little more than Japanese, and much less than Swedes. But they paid much more, relatively, for what they got. In terms of the identity above, P (the price) is higher in the

United States than anywhere else. A number of other studies have reached similar conclusions.²⁸⁻³¹

Defenders of the American health care system may claim – and even believe – that this price differential corresponds to some unmeasured difference in ‘quality’, but the discussion rapidly becomes circular. It is in fact a natural extension of the ‘American exceptionalism’ claim:

“American health care costs more because Americans face greater threats to their health, and need more care”.

“But they do not get much more care, they just pay much more for it”.

“Well, then the care they get must be of higher quality”.

In effect expenditure is *defined* as quality. The only way out of this (il)logical trap is to place the burden of proof on the apologist. Let him find some evidence of benefit – not just for the wealthy but population-wide, not just inferred from some theory but actually documented – to correspond to the extra cost of the system as a whole.

The extreme case frames the general issue. The expansion of private insurance, within a public system of health care finance, offers benefits to both providers (higher prices) and upper income payers (a more regressive financing structure). It thus supports a potent political alliance. If in addition providers are able (selectively) to recruit people into private insurance by offering them the reality, or even just the perception, of superior services, this reinforces the financial advantage.

But the complex administrative mechanisms for achieving these redistributive objectives are themselves costly. They result not only in higher incomes for (some) providers, but also in an increasing flow

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of real resources into the ‘overhead costs’ of managing the health care system. And this is inevitable. The inherent instability of private health care financing – Wildavsky’s Law again – leads to uncontrolled cost escalation. This in turn generates an ‘administrative arms race’ as each payer struggles to shift the ever-increasing costs onto others. Such efforts are highly rational, indeed necessary for survival, at the level of the individual institution. From the perspective of the society as a whole, they generate an ever-increasing level of pure waste motion.

Some have challenged the identification of excessive administrative costs with waste (e.g. Redelmeier and Fuchs).³² They point to the extraordinarily sophisticated management techniques in the United States, the extent and detail of data generated, and the leading-edge research in health services. And of course such claims are valid; in these areas, the United States clearly does lead the world.

Such responses, however, miss the point. Managerial (and even research) activities are not ends in themselves. They are only valuable insofar as they contribute to the ultimate ends of a more efficient and effective health care system, and a healthier and more satisfied population. Since the United States achieves much worse results than systems that spend much less, the extra administrative expenditure is wasted, regardless of how much sophisticated management it may buy. It appears to support a vast negative-sum game of inter-institutional competition over cost transfer and benefit appropriation.

The whole is not merely the sum of the parts. Activities that are critical to the survival of individuals and organisations add up to a massive drag on the performance of the system as a whole – as in an arms race.

The dynamics of the relationship between public and private insurance depends upon a number of institutional characteristics that

are quite system-specific. God and the devil are both in the details. The point emphasised here is a more general one, that distributional conflicts are central to all arguments *pro* and *con* private insurance – the relative balance of state and private action. Depending upon how it is structured, expanding private insurance offers opportunities for transfer of incomes both from payers to providers, and from the less to the more healthy and wealthy payers. Conversely, the historic shift to public coverage moved incomes the other way, though the amounts were not so large in earlier decades. Associated with these inherently political choices over distribution, however, are significant differences in the real resource costs of system administration – and corresponding income opportunities in the financial services industries.

If governments, and behind them electorates, can be induced to focus their attention on public budgets alone, rather than the balance of costs and benefits from the health care system as a whole, then the stage is set for an ‘unholy alliance’. Providers, wealthy taxpayers, and private insurers can all gain by (i) lowering public expenditures, but (ii) increasing overall expenditures, and (iii) shifting a larger share of costs onto the relatively less healthy and wealthy. A perfectly reasonable public objective of reforming and improving the effectiveness of the health care sector can be deflected and perverted into a programme for regressive income redistribution and protection of health sector revenues, all under the ideological cover of shrinking ‘Big Government’.

All of which is rather banal and obvious – Political Economy 1A – and one might reasonably ask whether the whole excursion was necessary. The justification, I think, is that so much of the debate over health care policy, particularly among economists, and particularly over the relative role of ‘the state’ and ‘the market’, continues to be carried on as

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if it were possible to abstract from distributional issues. Out in the real world, by contrast, the conflicts are about very little else.

The tone of economic discourse was set about twenty-five years ago; and Arrow³³ sounded a warning at the time that was generally ignored. In an analysis of the welfare effects of coinsurance rates, originally written in 1973, he declares at the outset that: “I ignore distributional considerations and assume a single person in the economy”. On the next page, however, “To avoid distributional considerations I assume that all individuals have identical endowments and identical utility functions. I further assume a very large population....”

The confusion is understandable. In a single-person economy, who buys insurance, and from whom? But in an economy of *differentiated* individuals it is impossible to derive general *a priori* conclusions about ‘aggregate’ welfare. Arrow therefore assumes that the economy consists of many identical individuals. They vary in their actual health experience – or why buy insurance? – but they are identical in their *expectation* of illness, so have equal access to insurance coverage as well as equal incomes. Moreover they all work for the same proportion of their time in the ‘medical’ industry. Thus there is no distinction between ‘providers’ and ‘users’ – everyone is both, and to an equivalent degree. Under Arrow’s assumptions Equation 1A does hold for each of the individuals *i*, not just for the aggregate. One need only substitute an expected value for the actual quantities of services used by each person.

As an approximation to the real world, Arrow’s assumptions were ridiculous – as he very well knew. What he was showing is that *without* such assumptions, one cannot, at the theoretical level, ‘ignore distributional considerations’ and still generate any conclusions at all about the desirability or otherwise of any particular policy.

Of course one can do so if one is prepared to make interpersonal comparisons of well-being, balancing one person's loss against another's gain, and this happens every day in the real world of public policy. But as a number of leading theorists, Arrow included, have pointed out, one cannot do so on the basis of 'value-neutral' economic theory. Theory by itself does not and logically cannot provide a normative basis for policy prescriptions. Rice provides a more detailed discussion,³³ see also.³⁴⁻³⁶ Normative judgements, in or out of economics, cannot be derived from positive propositions alone, or in Archibald's paraphrase of Hume: 'No ethics in, no ethics out'.

Yet respected economic analysts do so routinely, making firm declarations as to the 'efficiency' or 'optimality' of particular arrangements, or their 'welfare costs' or benefits. In doing so they are making value judgements about the relative deservingness of different individuals, and approving or disapproving the transfer of substantial funds from one set of people to another. But these judgements are implicit, unaccountable, and typically unconfessed – sometimes even denied. There is also some reason to believe that the values implicit in proposals for more reliance on private markets in health care are quite unrepresentative of the views of the populations who use and support health care systems. Yet such proposals are confidently offered as guides for public policy.

Economists who serve as market advocates will sometimes reply that they are simply taking as given whatever distributional outcomes have been generated by the wider society/economy, and are implicit in current arrangements. This argument slides over the fact that changes in health care organisation and finance will *change* the pattern of burdens and benefits that the analyst claims to take as given. Preserving the *status quo* would require offsetting policy changes that are not

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identified, let alone advocated. In fact, however, their work typically shows little interest in redistributive effects, and even less in the social and political processes determining underlying patterns.

So what is going on? Well, the suppression of ‘distributional considerations’ through the (implicit) assumption of identical individuals *can* provide an analytic cloak for what would otherwise be a naked redistributive agenda. Deliberately redistributive policies can be promoted as ‘optimal’ on *a priori* grounds, allegedly on the basis of value-free economic theory. The essential feature of all such policies is a shift in funding sources so as to link individual contributions more closely to either care use or risk status, while weakening the link to ability to pay. Often they will also give providers greater discretion in price setting, which may include offering patients various forms of preferential treatment in return for additional private payments.

Policies of this form may be described as making more use of ‘the market’, and of ‘competitive forces’, to determine the allocation of resources to and within the health care sector. In practice, however, they are always embedded within pseudo-markets, hedged about with extensive regulation and formal or informal collaboration by providers. Much of the regulation may be privately administered, but nowhere outside theoretical analyses does one find anything approximating the free competitive markets of the economics textbooks.

One need not assume, however, that the provision of an analytic cloak for redistributive objectives is the deliberate intent of analysts in the tradition of neo-classical economic theory, even though their work may be useful for this purpose. There is an important distinction to be drawn between two quite different groups of participants in the debate

over the role of the state in health services; we may label them ‘fundamentalists’ and ‘instrumentalists’. The latter advocate particular structures or policies because they expect certain *consequences* to result; but the former are ‘advocates without predicates’, holding particular forms of economic organisation to be good *per se*. In an earlier day socialists regarded state control of the means of production, or at least of the ‘commanding heights’ of the economy, as good *per se*, on *a priori* grounds. At present, advocates of ‘the market’ on theoretical grounds enjoy the same absolute conviction.

Debates with fundamentalists about the proper scope of public and private action are ultimately futile. Initial impressions to the contrary, they do not in fact base their case for ‘the market’ on (testable) claims that their preferred institutions or policies will lead to lower costs, or healthier people, or better performance on any other externally defined criterion.³⁷ When pressed, fundamentalists explicitly *reject* such external standards.^{38,39} Their position is rather that *whatever* results – prices, quantities, distribution of services, health outcomes – emerge from market processes are ‘optimal’ *because* they have been generated by those processes. The private marketplace is the source of ultimate objectives rather than merely a means to their achievement. Individual willingness-to-pay for the products of private, competitive firms is not the best criterion for ‘efficient’ resource allocation; it is the only criterion.

The fundamentalist argument for private action in health care, though clothed in economic rhetoric, is in fact a form of religion. It converts side equation (iii) (see page 30) above, linking the level of use of health care services to the direct charges that users must pay, from a *positive* statement about an (in principle) observable relationship between two variables, into a *normative* statement about how the level, mix, and distribution of health care services, the *qij*, *ought* to be determined. But

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normative statements are the province of priests. (And also of politicians, but those suffer the inconvenience of having to secure public support.) The normative views of economists, qua economists, have no more (or less) significance than those of the man on the Clapham omnibus (if there still is one).

But these theoretical arguments, mostly in the economic literature, are primarily icing on the cake. Very few people (if any) share the underlying value system on which they are based. When we come to the point, most of us do *not* agree that it is a misallocation of resources when people receive life-saving care that they cannot themselves afford, and that our societies would be in some sense ‘more efficient’ – better – if this did not occur. We do not want to live in that kind of society, we do not have to, and we will not.

Accordingly most of those on the political stage who consistently advocate (or oppose) a larger role for private markets in health care do so because they anticipate particular consequences, rather than from religious conviction. These ‘instrumentalists’, however, may have very different objectives. Roughly, we may draw a distinction between those whose aims are primarily distributional, and those who are genuinely concerned with system performance.

All, of course, use the rhetoric of ‘reform’, and of public interest more generally – even the fundamentalists can sometimes be found in this camouflage. And it is a gross over-simplification to suggest that a population can be thus neatly partitioned into two distinct groups. People’s motives are usually mixed, and often far from clear even to themselves. Nevertheless it is important to recognise explicitly that debates over health policy, and particularly over the role of the state, are motivated by these two quite different classes of objectives.

This paper has emphasised the link between extension of the role of private market mechanisms, particularly in the financing of health care, and distributional objectives. The interest groups that for decades have reiterated the same arguments for private markets, regardless of the evidence accumulated against them, see their own interests clearly enough. Their members hope to earn more (providers), or to contribute less and have preferred access to services (healthy and/or wealthy users).

To the extent that they are right, there is again little to debate. The analyst's role is only to make the proposed redistributive agenda as explicit as possible. Its advocates can then compete directly for broader public support without drawing upon mis-interpretations of economic theory or other claims of general public benefit. Since in practice people as citizens do not appear to be motivated solely by perceptions of their own economic interests, greater transparency of policy effects may well lead to different, and more satisfactory, collective choices. (If it were not so, interest groups would not be so careful to disguise the full impact of their proposals.)

Moreover redistributive processes turn out to be more complex than they look, and alternative choices *do* have consequences for the overall functioning of a health care system. Quite clearly private funding mechanisms can be used to generate a more regressive distribution of contributions, if that is what one wants. But international experience indicates that the overall system will be more expensive because providers' prices will be higher, because inappropriate use will be harder to control, and especially because the complex mix of public and private financing and management mechanisms will add substantially to the administrative 'overhead costs' of providing care.

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The explosion of costs in the United States, for example, has not all gone into the pockets of providers as traditionally defined (see above). An increasing proportion has been appropriated by members of the managerial and financial services industries, who now appear to be cutting into and pushing down the incomes of caregivers. The management thus financed has, to date, involved a good deal of extra trouble and work for both caregivers and patients, not all of which is included in statistics on health care costs. But if the most recent data *do* in fact herald a new world of stable or even declining American health care expenditures, the struggle between providers of care and providers of managerial overhead is likely to become increasingly bitter.

In any case, while upper-income Americans may pay a smaller *share* of the costs of their health care system than they would if it conformed to White's 'international standard', many of them actually pay more in total because their system is so much more expensive. *Public sector* spending on health care in the United States, at \$1,599 per capita in 1994, was greater than in any other OECD country except Switzerland, even without including the American tax expenditure subsidy. Canada, for example, with universal public first dollar coverage for hospital and medical care, spent only \$1,444 (US) in public funds; most European countries spent substantially less. Americans thus pay more *in taxes* for health care, in addition to (or despite) their massive contributions through the private sector. And the gap appears to be widening.

The more interesting instrumentalist debates arise, however, after it is accepted that the public purpose of health care systems is indeed what most people in every society say it is: the maintenance and improvement of health, and the humane treatment of the ill.⁴⁰ Indeed, as van Doorslaer, Wagstaff and Rutten report⁴¹ and as public surveys

confirm, most people seem to have a rather Marxist view of health care systems: 'From each according to his ability; to each according to his needs'. Side equation (iii) then moves from the centre of the stage; and we focus instead on side equations (i) and (ii) (see page 30). Are our health care systems efficient providers of effective services? Do they respond to patients' needs in a humane and timely fashion? How can their performance be improved, while maintaining fiscal constraints?

If a health care system *were* in fact 'on the frontier' of both the health care and the health production functions above, then there would be a direct link between resource inputs, and (someone's) health status. In such circumstances 'cutbacks cost lives' – or at least put health at risk – as care is long delayed, or denied altogether. And over-strained providers may be brusque, perfunctory, uncommunicative, and inconvenient of access. Faced with such prospects, a majority of our populations might well support more resources for health care, particularly if they perceive themselves personally to be at risk. Nurturing that belief is the cornerstone of the public relations strategy of provider representatives, in all countries.

If on the other hand (as is widely if not universally believed by students of health care systems) there is a great deal of inappropriate, unnecessary, and sometimes downright harmful care being paid for in all modern health care systems, and if the process of production is none too efficient either, then the key question becomes one of moving closer to both production frontiers.

The 'instrumentalist' case for systemic reform through private market mechanisms is simply that these could be structured either to embody incentives for greater efficiency in production than is possible in governmentally administered systems, or (which is not at all the same

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thing) to encourage a more appropriate mix – perhaps less in total – of services, more responsively provided. In the process, of course, these mechanisms must not result in an unacceptable (to whom?) redistribution of incomes, or a re-ignition of cost escalation.

At a very basic level this proposition does not seem particularly contentious. Opening hospital laundry or dietary services to competitive bids from private firms may raise issues in labour relations, but not for health policy. Implicitly it is assumed that the quality control problems are similar regardless of the choice of supplier.

Matters become more interesting, however, when the incomes of those making clinical or managerial decisions are linked to the choices they make. Empirically it is now well established that the therapeutic decisions of providers *are* sensitive to how they are paid, though the terrain is far from fully mapped. When the American Medicare programme introduced prospective payment in 1983, for example, and began paying hospitals a pre-determined price per inpatient case, treatment patterns promptly changed and inpatient bed use fell. Even more dramatic reductions have since taken place in response to pressures from private payers. In Germany, claims for public reimbursement of prescription drugs fell by twenty per cent in the first six months of 1993, following the government's declaration that drug billing that exceeded a pre-set target would be paid out of the fund for physician reimbursement.⁴² When doctors are financially at risk for increased drug bills, they change their prescribing habits.

In general it seems quite clear that (some) service patterns can be powerfully influenced by linking them directly (negatively) to provider incomes – making W depend on Q . Aneurin Bevan's comment in 1948

that if you want to send a message to doctors, you should write it on a cheque, has been confirmed. Furthermore, if you want to make changes in the mix and volume of health care, you *have* to send a message to doctors.

But there are a number of ways of doing this, involving different mixes of economic, regulatory, and educational messages. In the German case, for example, the economic message was combined with closer scrutiny, by professional colleagues, of the prescribing practices of individual physicians.⁴² Which intervention was critical?

Rates of performance of certain surgical procedures – extra-cranial/intra-cranial bypass grafting, carotid endarterectomy, mammary artery ligation – have been powerfully affected by the results of effectiveness trials. (But other interventions, tonsillectomy, for example, or diagnostic procedures such as PSA testing or routine EFM in childbirth, have been remarkably resistant to contrary evidence.) In Canada, the transition from inpatient to day care surgery proceeded at a slow and stately pace over nearly twenty years after the supporting evidence first became available. The process speeded up remarkably in the 1990s, when tighter hospital global budgets forced bed closures.

Economic incentives of various forms, particularly directed at providers of care, are thus only one potentially useful class of tools in the overall mix of mechanisms for health care system management. There is as yet no evidence at the system-wide level to justify a wholesale shift to decentralised decision-making based on market-type signals. Moreover, all interventions have side effects. One should never underestimate the power of economic incentives; but neither should one overestimate the ability of economists (or anyone else) to predict how people will respond.⁴³

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The British experience with GP fund-holding and hospital trusts is of particular interest in this regard; so far no close observers of that system seem willing to commit themselves as to whether or not it is 'working'. The reforms of which fund-holding is a part have been associated with a significant *increase* in system costs, and particularly in managerial overhead. There are very clear warnings from the United States that 'more management' may simply mean more money for more managers. Reported declines in waiting lists in the UK may show no more than that with more money, one can buy more services.

The test will be whether the new, more 'market-like' system can deliver better performance, for the same or less money, on meaningful outcomes measures. The down-side risk, apart from the extra cost of a managerial bureaucracy that fails to pay for its keep, is that it may simply open up new opportunities for income redistribution to providers, and among payers. GP fund-holders may find – as American managed care systems have found before them – that selecting and enrolling relatively healthy patients yields a much higher return than more carefully analysing the care they give and recommend.

More generally, if subjected to stronger economic incentives, providers will respond. But their responses will probably go beyond what is contemplated or desired by governments, and may be difficult or impossible to control through 'contracts'. This management task will be a good deal more difficult if providers come to think of themselves less as professionals with public responsibilities, and more as private businessmen 'beating the system' any way they can. In the United States that horse has already left the barn, but not elsewhere; and co-operative relationships, however grudging, should not be lightly put at risk.

In any case the notion that some sort of automatic, self-regulating market-like structure can be established that will *substitute* for public management and yet achieve public objectives is a fantasy – powdered unicorn horn. In particular, it seems very clear that no incentives at the individual or institutional level, economic or otherwise, will set an upper limit on overall system expenditures. Certainly none ever has. Ultimately governments have to set these limits and maintain them with whatever mechanisms will do the job.

The use of competition among providers, and market mechanisms generally, as simply one set of tools, among others, for the pursuit of public objectives seems quite well understood and accepted by many of those responsible for managing the health care systems of western Europe. Morone and Goggin⁴⁴ refer (p.568) to “...guarded optimism about the proposed marriage of medical markets and social welfare universalism”. “Competition ...may add efficiency and consumer control without subverting traditional collective visions”.

It may be that the confusion between market as means and market as an end, and the use of currently fashionable private sector rhetoric as cover for distributional objectives, are more characteristic of North America – at least at the moment. But these ideas *are* being energetically exported, and will find receptive audiences among the same set of potential gainers, in all countries.

DISCUSSION

The short message of this paper is:

- ◆ that there are powerful redistributive motives behind parts of the health care reform agenda, in all countries;
- ◆ that much analysis, particularly by economists, mis-directs attention by assuming these issues away; and,
- ◆ that competition, and market mechanisms generally, are particularly suited to both facilitating and concealing the process of redistribution.

Accordingly, to come back to Morone and Goggin;⁴⁴ “The great question for the future turns on whether that optimism is justified”. Keep your eyes open, and watch your back.

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The conflict over the respective role of the State and market in health care has a long history. In the last decade there has been a resurgence in the ideas of the market although most of its advocates recognise that such mechanisms have to be regulated and will not be free and fully competitive.

Evans argues that the evidence from market innovations over the last 40 years demonstrates inferior system performance. Marketisation, he argues, brings greater inequity, increased inefficiency, cost inflation and higher levels of public dissatisfaction.

So why does market advocacy continually reassert itself? Professor Evans argues that market reforms enrich providers: physicians, pharmaceutical companies and private insurers. Furthermore market reforms often facilitate cost shifting from rich (low users) to poor (high users).

The alliance of providers seeking to enrich themselves and upper-income citizens seeking to shift costs produces advocacy based on the principles rather than the practice of markets. This smoke-screen has to be seen for what it is: a programme to produce expenditure increases (to enrich providers) and inefficiency and inequity (cost shifting from the rich to the poor).