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Budget-makers and health care systems

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ABSTRACT

Health programs are shaped by the decisions made in budget processes, so how budget-makers view health programs is an important part of making health policy. Budgeting in any country involves its own policy community, with key players including budgeting professionals and political authorities. This article reviews the typical pressures on and attitudes of these actors when they address health policy choices. The worldview of budget professionals includes attitudes that are congenial to particular policy perspectives, such as the desire to select packages of programs that maximize population health. The pressures on political authorities, however, are very different: most importantly, public demand for health care services is stronger than for virtually any other government activity. The norms and procedures of budgeting also tend to discourage adoption of some of the more enthusiastically promoted health policy reforms. Therefore talk about rationalizing systems is not matched by action; and action is better explained by the need to minimize blame. The budget-maker's perspective provides insight about key controversies in healthcare policy such as decentralization, competition, health service systems as opposed to health insurance systems, and dedicated vs. general revenue finance. It also explains the frequency of various "gaming" behaviors.

Health programs are shaped by the decisions made in budget processes. In order to understand the politics of health care, therefore, it is important to understand how budget-makers view health care systems.

This paper offers an overview of the budgeting challenge as it normally appears to the two institutionalized groups of budgeting participants: budgeting professionals and political authorities.[1] Methods for financing health care vary in well-known ways, such as the degree of direct control by governments as opposed to semi-public sickness funds; reliance on insurance or direct provision of services; or use of dedicated as opposed to general revenue finance.[2] Nevertheless, budgeting tasks, responsibilities and organizations tend to create an "epistemic community" [6] of participants who broadly share attitudes based on common training and challenges. Hence there are national and international budgeting communities [7–9]. The professionals in these communities develop distinctive norms and

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[1] Discussions of budgeting for health care per se, as a generic problem, are relatively rare. Two exceptions are based on U.S. experience [1,2]. A larger literature focuses on budgeting for "entitlements" [3] but, as discussed below, health care programs often are not designed as entitlements. This essay is based on research about government budgeting done over the course of three decades for a variety of purposes. The characterizations of norms and attitudes among budget-makers are based on that research, which includes both secondary sources about budgeting around the world and over 200 open-ended interviews about U.S. budget processes. A more extensive analysis was presented to the meeting of the OECD Senior Budget Officials-Health Joint Network on the Fiscal Sustainability of Health Care Systems in Paris November 21–22, 2011. None of the organizers of or participants in that network shares any responsibility for the contents of this essay, save for ways in which it improves on my original draft.

[2] Among the many discussions of varieties of health care systems, see Moran [4] and Rothgang et al. [5].

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attitudes, and push for these perspectives. Yet they also serve political authorities, who must worry about other influences.

The political influences on budgeting include societal interests and attitudes beyond those connected to health issues. For example, investment bankers and "the markets" are constituencies that politicians believe they have to satisfy with their budget decisions.[3] Political actors may have beliefs about budget totals that trump (or reinforce) leanings about health policy. Yet they also must cope with the fact that pressures to provide and spend (which are not quite the same thing) on medical care are especially strong.

1. Budgetary attitudes, roles, and norms

Budget processes must resolve inherent conflicts between preferences about details and preferences about totals. Details include who pays how much and which purposes receive how much funding. Totals include overall spending, overall revenue, and the year's deficit or surplus. The budget-maker has two basic problems. Her own preferences about details may not add up to her preferences about totals, and the voters' perceived preferences about details may not match their perceived preferences about totals.

Budget professionals tend to believe that the most important total is the balance between spending and taxes, and prefer having no or modest deficits. They tend to think of the government budget as their household, which they wish to manage in a prudent way. At a perhaps unthinking level, the deficit or surplus is a way to keep score on their own performance: bigger deficits mean they're losing. Budget professionals believe restraining deficits is their special responsibility, and that they act as "guardians" against the more narrowly interested "claimants" in the rest of the political system. By reducing interest payments, they expect, lower deficits also improve the government's ability to address future challenges.

Political authorities' preferences vary more, according to ideologies about the role of government or beliefs about either the economy or public pressures. Consider the challenge of responding to the economic stress that began around 2008. From a Keynesian perspective, the conditions that increased deficits beginning in 2008 made large deficits necessary. Hence the slump should not have caused health policy cutbacks; indeed, health care spending should have been maintained to prop up aggregate demand. From a fiscally conservative perspective, the economic stress required new constraint on spending totals, or reinforced existing beliefs about the need to constrain spending so as to limit debt [11]. From a third perspective, particularly common within the Anglo-Saxon right wing, the economic crisis simply confirmed that spending and taxes were both evil.

Nevertheless, under normal circumstances, politicians would like to have lower deficits or a balanced budget, for much the same reasons as the professionals would. They believe the voters and elites also keep score, and bigger deficits are targets for criticism. Yet in many situations spending more on health care fits policy-makers' goals or offers political rewards – and being blamed for cuts is particularly unattractive. This is more of a direct concern for the political authorities than for the budget professionals.

In many countries a large share of health care spending is funded by contributions that are mandated by law, but that are not taxes paid to the government. Instead, they are payments made to sickness funds that are not part of the government, though the government may significantly influence their management. One might expect that government budget officials would be less concerned with health care costs in these systems than in systems with more direct government spending. This is, however, becoming less and less true.

At one time spending on these sickness funds could be seen as *mainly* an issue to be dealt with by the social partners, business and labor, which managed the sickness funds. The French legislature did not vote on total spending for the French system until 1996, and that was seen as a major reform. Yet health care spending has been a budgeting concern even in traditional sickness fund systems – and over time has been subjected to more direct government control. One reason is that the level of mandated social security contributions can affect willingness to pay taxes for the rest of government's activities. In addition, policy-makers have been influenced by theories that payroll contributions raise the cost of hiring new workers, so reduce employment.[4] Third, precisely because health care is so intensely desired by voters, political authorities feel pressured to ensure that sickness funds are viable. As payroll contributions have, for economic reasons, become a less adequate source of revenue, governments have tended to shift general revenue toward funding previously Bismarckian systems – in spite of the continual pressures on public budgets.

The process of matching details to totals has generated norms and routines. These norms may be abandoned during times of elite panic about deficits, or under pressure from outside powers (e.g. the IMF or European Union). Normally, however, these routines do influence budgeting for health care.

First, budgeting proceeds in iterations, with agencies being given guidance about totals, responding with information about the details that would fit the totals (or why they "need" more), and then the central budget authority accepting or rejecting details while perhaps reconsidering its guidance about totals. Information about details should influence preferences about totals, and v.v., through these exchanges.

[3] I do not mean to suggest that efforts to satisfy "the markets" are intelligent or wise. In many cases beliefs about what "the markets" want are projections from policy-makers' own beliefs, or manipulations by advocates [10].

[4] These theories may well be misguided, for reasons the German Advisory Council on the Concerted Action in Health Care summarized in 1998 [12]. Moreover, economists commonly argue that employee benefits are mainly financed by reduced wages; if this were true the payroll contributions would increase the cost of hiring only for individuals close enough to the minimum wage to prevent offsetting wage reductions.

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Budget overseers would want to review proposed details even if they had no beliefs about totals. Political authorities suspect that, absent some oversight, agencies would pad their budgets with fat or slack, and so give less value for money than they could. Budgeteers view agencies as untrustworthy, and part of the job of the budget shop is to "scrub" the agency estimates to make sure they are clean. Thus the budget professionals' claim to legitimate authority is based in part on expertise about details. Yet they may rationalize situations in which they impose totals that are not justified by plausible analysis of the details. First, they may believe that ultimately they serve the political authorities, and if the political authorities make a decision, their job is to support it. Second, budget professionals may think that the agencies have an overwhelming information advantage; that the budget staff cannot get at all the flaws in the agency proposals; and so that it is fair to just cap the spending and force the agency to do its best to serve clients within the cap.[5] Third, concern about totals may just trump concern about details. If the deficit is considered a big enough crisis, then "hard choices" are no longer really hard, to the budget professionals, who may believe any pain on the details can be justified. Thus the norms of budget analysis usually lead the professionals to pay attention to agencies' legitimate concerns about the effects of budget restraint – but sometimes they do not.

Budgeting norms also include control, comprehensiveness, accuracy, and being conservative. *Control* involves not only limiting spending but ensuring that funds are used as intended, with the intended effects. This oversight of budget execution also requires attention to budget details. *Comprehensiveness* requires that all aspects of the budget plan be considered together. Therefore, budget professionals tend to dislike dedicated funds, on the grounds that the "mix and level of public spending may be distorted by the connections of particular types of spending to specific sources of funding," and that the mix of taxes may reduce the tax system's efficiency [14].

Accuracy and honesty mean that all choices are made visible and all consequences are considered.[6] Budgeting involves projections of effects of policies, and the budget shop prefers evidence to guesswork, if at all possible. This can be particularly frustrating to advocates [16]. In general, budgeteers would rather *be conservative* – that is, err by underestimating savings or revenues. Program advocates are the opposite.

Most government budgets are for a single year, so that some accounts describe "annularity" as a budgeting norm. Some period has to be used to guide the adjustment of details to totals, and to provide a standard frame for evaluating totals. A longer time period may make it harder to have accurate projections; a shorter period may leave agencies unable to manage their activities because of uncertainty about resources.[7] Annual budgeting also provides the basis by which everyone keeps score. As a result, budget-makers normally care far more about effects next year than about effects in the long-run (though see the discussion below).

Budgeting is also normally *incremental*. This is *more a pattern than a norm*; budget professionals tend to dislike the incremental nature of the process.[8] Budgeting decisions about each year normally take the "base," what was done last year, as given. The base is not only an amount of spending but a distribution of shares. Incrementalism develops partly as a way to limit calculation and partly because it reflects a normally stable balance of political power. Even if budget-makers *want* to revisit the base, they normally have neither the time nor the power to do so. Analysis and political combat then focus on the increments, so on much less than the total amount of spending.

Radical change must be driven by events outside the budget process. The shares that were considered "fair" (or at least politically acceptable) one year are not likely to change unless the political balance has changed so that different preferences are favored in this year's budget process than in last year's. This may occur because an election changes the government, or because of dramatic new events that change priorities. The collapse of the Soviet Union was not good for military budgets. Fiscal stress itself, however, is not enough to change notions of fairness, or objections to various innovations.[9]

Budget professionals and political authorities tend to value both *economy*, defined as spending less, and *efficiency*, getting more value for the money spent. Increasing efficiency can serve the goal of spending less, but can also be valued for its own sake. Budgeting professionals whom I have interviewed tend to see efficiency as a politically neutral value, on the grounds that even politicians who want to spend on programs should want to maximize the return for their spending.[10] Politicians naturally would rather claim that they have saved money through making programs do the same thing for less money than admit that they are cutting benefits. However, political authorities will disagree greatly about the goal of economy if it means cutting benefits.

Arguments about efficiency involve two dimensions. The first is *program efficiency*, a given program's value for money. Budget processes force each agency to explain how

[5] One approach is to create "envelopes," targets for spending, and leave the agencies to determine how to hit the targets. Such versions of New Public Management are awkward for the budget professionals, who are expected to interfere less with agencies but fear losing "the discipline on which all budgeting rests" [13]. But the view that goals should be determined by political authorities and then the bureaucrats should be given the "autonomy" to figure out how to achieve the goals has distinct political advantages: it absolves political authorities of responsibility for knowing whether the goals made sense in the first place.

[6] Related but not quite as ubiquitous is pursuit of "transparency" on the grounds that, in a representative government, the budget should help make decision-makers accountable to citizens [15].

[7] If budgets are biennial, that often includes a revision process during the second year. For a discussion of why being unable to budget for a full year is debilitating, see [17].

[8] For the classic description of and in some ways advocacy for budgetary incrementalism see [8]. On both dissatisfaction with and inevitability of incrementalism see [18].

[9] Reinhard Busse [19] has noted that budget pressures from the recent financial crash alone do not appear to have encouraged systematic reforms. Changes imposed from outside are an exception; see [20].

[10] In this they reflect Herbert Simon's [21] argument that efficiency is a particularly administrative concern, as opposed to being a contentious value premise.

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it would spend its funds, and staff then "scrub the estimates." They might, for example, reject purchase of new equipment; or adjust projections of savings from a fee constraint in order to include provider response that could increase volume.

Budget professionals also, however, tend to be very interested in claims that funds can be saved by reallocating among programs. This *comparative efficiency* is the goal of "performance budgeting" reforms that have been ubiquitous for decades. Budget analysts, much like health economists, public health professionals, and health services researchers, tend to focus on averages and population aggregates, and want to quantify output. Budgeters therefore may seem like natural allies for health policy reformers who wish, for instance, to shift funds from hospitals to primary care, or from medical care to public health measures.

The budget community's fascination with such approaches is matched, however, by a history of failure [22–24]. The reasons may appear familiar to health policy analysts. There is disagreement about how to measure program outputs in common ways. Measures are easily questioned when applied even if they might be plausible in theory. Reallocation means winners and losers, and the losers are normally angrier than the winners are happy. Capacity and organizations are sticky, so reallocation may be hard to implement or have major transaction costs.

Both budget professionals and political authorities find also that the demands of annual budget scorekeeping fit poorly with proposals to save on care by promoting public health. These ideas tend to require "investments" – that is, more spending now, accompanied by a promise that it will enable less spending later. *Maybe* that will work – but maybe it won't, and spending more now does not help with this year's budget challenge. At the same time, if a program is performing poorly, cutting it means abandoning its goal. If the goal is important, then poor performance might call for spending more, not less.

Last but not least, some of the standard ideas about reallocation make much more sense to analysts than to voters. Voters appear to be more interested in being rescued if they get sick than in the government spending in ways that increase the odds they will be healthy. Therefore reallocations away from rescue – whether from hospitals to primary care or medical care to public health – tend to be politically unpopular.

For all these reasons, budget professionals' sympathetic attention to and encouragement of proposals to reallocate from medical care to other supposedly health-enhancing activities rarely results in policy change. These ideas resemble policy zombies: they cannot die because they are promoted by permanent institutional actors, but cannot live because the political environment, especially the need for more certain savings and public distrust of cuts to medical services, is quite hostile [25].

The challenges of budgeting therefore usually lead budget-makers to adopt much blunter, less "innovative" approaches [19]. Health policy advocates should expect a wide gap between policy discourse and budgeting outputs.

2. The budgetary environment

Medical services are especially salient to citizens or voters. Therefore mass demand for whatever is socially defined as necessary is particularly strong. Moreover, ideas about the necessary level of service continually expand. As a result, the usual conflict between demands to limit totals and to spend on details is especially intense when budgeting for health care.[11]

In emphasizing these factors I do not mean to suggest that the medical lobbies, and especially physicians, are unimportant. All publicly funded programs have operators and advocates, who believe in the activity, make their living from it, or both. Conflict between what operators think is needed and what the budget office wants to pay is the most basic pattern of budgeting. The health care industry is no exception.

Yet the form and influence of provider lobbies varies greatly across countries. They are by no means unified: the interests of drug companies, physicians or hospitals, for example, may be set against each other in budgetary competition [2,26]. A particular interest may be fragmented either by subset (such as medical specialty or ownership of hospitals) or along the lines of other national political divisions – as with French physicians, whose organization mirrors France's fragmented union structure as well as generalists vs. specialists [27]. The substantial part of the health economy that may be owned by government, or at least formally nonprofit, will be less able to influence through methods like campaign contributions that are available to other provider interests, such as military contractors.

Nations vary also in the nature of interest group relationships in general – such as whether there is a culture and practice of corporate bargaining. They vary as to the autonomy of the civil service vis-a-vis politicians; the autonomy of political authorities vis-a-vis voters; and the mobilization of interest groups that might counter the provider interests. Therefore, while physicians and other providers will lobby extensively to enhance their incomes, the results depend on far too many factors to allow easy generalization. German physicians are more strongly organized than French, but that does not appear to have made them more successful at protecting their incomes. The British government may be more autonomous than most other states, but British GPs are doing just fine. The details of a case study may suggest that, as in a study of Sweden, "the physicians' union was clearly one of the winners" [28]; yet Swedish health care spending as a share of GDP fell dramatically in spite of the physicians' supposed power. Political authorities may manage to set up the budgeting dynamic so that physicians or other groups turn on each other – "shooting inward as the circle closes" [29].

Hence providers in general, and physicians in particular, exercise unusual power over health care policy less through deploying standard political resources (money, votes) than

[11] This section refers only to budgetary dynamics; I am not suggesting that "excess demand" caused by insurance is the key reason for high spending, as that would not explain why spending is highest in the United States.

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through their influence on policy implementation. In the most basic case, physicians may strike to block a reform [30]; the range of resistance techniques, however, is quite great. These methods, however, apply best to efforts to direct clinical practice; physicians have much less ability to, for example, avoid price regulation. This is another reason why successful spending constraints tend to rely on relatively blunt methods – providers have less ability to block implementation.

From a budgetary perspective, the mass demand for medical services is a more distinctive challenge.

When they need it, consuming medical care is as important to people as consuming food, shelter, and clothing. Yet only medical care is generally provided, for everyone, through some socialization of finance. *Therefore there is no other government activity for which spending restraint potentially affects all voters in such a direct and so noticeable way.*

Education is important, expensive, and personal, but is not as expensive and the voters themselves are not the consumers. Pensions are the largest other public expense in most countries, in some a larger share of what OECD defines as public spending, and are also an individual benefit of great importance to virtually all voters. Yet the extent and generosity of public pension commitments varies more than for public health care spending.[12] In the past two decades, public spending on pensions has also grown more slowly than public spending on medical care. Health care spending grows more quickly because spending per beneficiary on health care has tended to grow more quickly than per capita GDP, while pension benefits have not. This brings us to the second reason for intense demand: the tendency for ideas about necessary services to expand.

When possible, all program operators make their case to the public, whether that is for new weapons, more teachers per student, or more funding for research. In health care, however, advocacy to the public extends from explicit political advocacy, to "provider-induced demand" in the medical office, and beyond. The challenge is not simply invention of new technologies for treatment – although that can raise spending if fees for new services are higher than fees for old, or if the service induces new demand because it is easier to perform. Rather, "need" is created in the media through continual promotion of supposed medical progress. Individual and social difficulties are medicalized, as when U.S. students who do not pay attention in school were redefined as victims of attention deficit hyperactivity disorder. Advertising spreads "awareness" of medical conditions. Campaigns for prevention often justify and induce more services, such as anti-cholesterol medication.

In this context dedicated financing for medical care, as we will see below, can mean the revenue side of the equation is more clearly in play for health care than for most other programs (except pensions). Demand for spending may make raising the dedicated contribution possible, but there is a more complex interaction. If there are policy reasons not to raise those contributions, but spending cuts are impractical policy or politics, the benefits of keeping the system intact may seem very large compared to even the costs of providing some extra general revenue.

Health care budgeting is made more challenging by the fact that the health policy community generates, or at least re-labels, a bewildering array of ideas. Evidence-based medicine! Cost-effectiveness analysis! Primary care! Medical homes! Competition! Markets! Budgets! Regulate prices! Don't regulate prices! Get the cost-sharing exactly right! Electronic Medical Records! Chronic Care Management! Gatekeeping! Better integration of care! Accountable Care Organizations! And more!. Entrepreneurs promote their pet ideas, disciplines promote their worldviews about the spending "problem," and some proposals, such as higher cost-sharing, are subjects of deep ideological disputes.

To discuss the politics of ideas in health care would require a much longer article, or book.[13] Here, we need only note that there are many, all promoted by experts with impressive credentials who have jobs that allow them to keep selling. Budget analysts, if given the time to evaluate evidence, normally find that data in support of the vast majority of these policies is quite weak. Whether political authorities act on this analysis depends on their personal beliefs, political pressures as they see them, and the rules governing the budget process.[14]

3. Budget maneuvers and program forms

Even more than with other challenges, budget-makers dealing with health care face intense demands about both details and totals, desperately seek efficiency, face seemingly automatic pressures for ever-higher spending, and must sort through confusing and poorly-justified alternatives. The norms, incentives, and constraints in budgeting as described above lead to some fairly common responses. From the budget-maker's perspective, they may look a bit different than from the usual health policy point of view.

The most basic response is to try to avoid blame. As Kent Weaver has argued, *blame avoidance* is likely a more common and powerful incentive, for policy-makers, than claiming credit [42]. Common approaches include:

- *Reducing spending without cutting services*: that is the advantage of limiting prices and having simpler systems of insurance. Of course this does not reduce blame from the medical industry. Hospital managers, doctors, device

[12] Consider a set of 23 countries that includes European OECD nations that were not part of the Soviet Union, Australia, Canada, Japan, New Zealand and the United States. In 2007 public social spending on pensions ranged from 3.36% of GDP in Australia, to 12.48% in France. Public social spending on health care ranged from 5.6% of GDP in Switzerland, to 7.49% in France. Data is from [31,32].

[13] For overviews including reports from a variety of national cases see [25,33–37,53].

[14] See, for example, the U.S. Congressional Budget Office's skeptical analysis of cost control choices for the 2010 U.S. reform [38]. In part because of deep belief in these measures, advocates inside and outside the Obama administration insisted the law's approaches would yield large savings [16,39]. Congressional budget process rules, however, required Congress to use CBO's numbers for official estimates, and opponents of the reform were happy to cite these estimates. Ironically, many analysts believe the 2010 U.S. legislation could not have passed if it had included more credible cost control measures [40,41].

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manufacturers and drug companies would rather receive higher incomes from higher prices for fewer services. So they will try to convince the patients that higher prices are needed to guarantee quality; or even claim that policies that mainly lower prices in fact are reducing services.[15]

- *Reducing the medical industry's incentive to tell people they should want services.* This is the great advantage of capitated payment and of other forms of bundling: whoever is receiving a bundled payment has strong economic incentives not to tell patients they should want more services within that bundle.
- *Getting patients to think doing without services is their own choice.* This is the preferred approach of many health economists, and the rationale for versions of higher cost-sharing. Unfortunately for budget-makers, changing policies to increase patients' cost-sharing is extremely noticeable.
- *Maximizing the distance between the budget-maker's decision that restricts services and the patient's experience of denial.* There are two main ways to do this. One is to restrict capital investment, so that the supply of facilities directly limits services. This is part of expenditure control in almost all systems. The second is to fund an agency to provide services, and then blame the managers of the agency for any shortages. Both of these approaches help to explain why the NHS was able to limit spending unusually well for many years. As that example shows, such measures may eventually be overcome by pent-up demand – but penting up demand serves the goal of economy (which may not be efficiency) for a long while.

Both competition and decentralization can be understood as ways to distance the budget-maker from the results of spending constraint. The market or local government closed that hospital; the central government did not. From a blame avoidance perspective, the arguments about whether the market actually increases efficiency, or whether local governments are "closer to the people" and so can do a better job of maximizing utility for a given sum of money, are irrelevant. If the political maneuver works, it serves its purpose.[16] Unfortunately or fortunately (depending on your preferences) the argument usually fails. Yet we see attempt after attempt to offload the responsibility for details, and so the blame.

Budgeting is also characterized by a wide variety of *timing strategies*, which budgetary actors may adopt either to protect spending or intensify pressure to reduce it. Time factors therefore shape both spending and allocation among types of spending.

Both policy logic and political pressures encourage a focus on next year (annual budgeting). If totals are based on policies for managing aggregate demand, the coming year is most important. If budgets are meant to be work plans for agencies, then the immediate future is the only period for which it is practical to budget. The political costs of budget decisions also depend most on the totals and perceived pain on details in the short run.

These incentives at their most extreme can lead to calendar manipulation: for example, moving a U.S. Medicare payment date from September 30 to October 1 (so one fiscal year to the next) in one budget cycle; moving it back in the next cycle, and so claiming savings twice. Their most important effect, however, is on the balance between operating and capital expenses. Budgeting is biased in favor of operations over capital investment, and government health expenditure is no exception.[17]

Operating expenses are especially favored when the government owns the supply so is fully responsible for capital expenses. That leads to a lot of deferred maintenance. Proposals to contract with the private sector to expand service availability reflect this budgetary logic: the cost of new supply is spread over time (though also usually increased) by paying fees to the private supplier. In essence, the next year's budget looks better due to deferred expenses.

Budget professionals and advocates for budget balance also, however, have developed a propensity to emphasize long-term budget effects, as part of advocating greater restraint of totals. They use projections of long-term budget risks from an aging society as a way to increase pressure on other political actors to accept spending constraints – the supposed "entitlement crisis" [11]. This budgeting view has migrated into health policy as the campaign to "bend the cost curve". At best this may enhance the case for investments that could lead to long-term savings; at worst it can increase a sense of crisis while also diverting attention from the merits of immediate savings [45].

Another timing strategy is to announce a long-term spending restraint, such as multi-year budget caps – usually with greater cuts in the later years, but without specifying those cuts. Since the threatened interests are not specified, it is harder for advocates to mobilize a response. Advocates for programs may tell themselves that the targets are fake anyway so can be fixed later. These approaches are ways to claim credit for "reducing the deficit" immediately while deferring blame for the pain of cuts. They pose a dilemma: if there is no enforcement then the restraint may disappear; but enforcement measures may be bad policy on the details (once the details are specified). Recent U.S. experience with the automatic cuts or "sequesters" included in the 2011 Budget Control Act shows how political actors' miscalculations can have budgetary results that are very hard to justify as policy. The rules for the sequester, however, greatly favored medical treatment over other programs, including other health programs–so even irrational budget-making confirmed the especially high political demand for medical services [46].

Budget policy-making includes a further *macropolitics of structure* [47]. Budget-making challenges from health care

[15] Thus U.S. providers in the 1990s attacked "managed care" for its restriction of services even though almost all of the savings in that era came from lower prices [43].

[16] These arguments may also be made out of ideological faith, with equal disinterest in empirical reality.

[17] For evidence of the bias against capital spending in the NHS, see [44]. A separate capital budget funded by borrowing may reduce the bias toward operating expenses.

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depend in part on the form of the health care program. Two aspects of the classic distinction between Beveridge and Bismarck approaches are part of the politics of budgetary structure.

The first involves the promise to provide health care. The government may create a *health service or services*, a bureau program. The *promise is of access to the bureau*, which is responsible for providing care. Or, the government may create and guarantee an *insurance system*, and patients then seek care from a variety of providers. Some of these (especially hospitals) might be government-owned, but many will not be. The *promise is that specific services will be paid for, as needed.* In budgetary terms, this is an entitlement program. In general, it should be somewhat easier for people at the top of the budget process to limit spending for bureaus than for entitlements.

In bureau budgeting funds are allocated to an organization, and the level of service that follows depends on how the organization is managed. Politicians will try to blame program managers – the "bureaucrats" – for any inconveniences to patients (and announce management reforms). They also can rationalize spending restraint in incrementalist terms: "we gave them four percent, that's more than other agencies received, it should be enough."

If the program is an entitlement, however, the promise is to pay for specific services, as incurred; for specific categories of people, as qualified; with payments determined by law or regulation. Expansions tend to occur through the internal dynamics of the health care system. So political authorities must say who they will hurt, by endorsing explicit changes in program rules such as payment rates or benefits, to reduce spending. They cannot hide behind agency managers or invoke comparisons to other programs.

When dealing with an entitlement program, budget-makers therefore often try to make it work more like a bureau. At one extreme, in which insurance systems fund hospital budgets by some sort of formula, the two approaches look similar. Larger bundles leave more of the choices about the details, so blame for the details, to someone other than the budget-maker. While economists seek the ideal blended way to pay physicians so as to encourage "value," budget-makers look for blends that create the best combination of control and deniability.

Some ideas for making healthcare more efficient may also be more effectively implemented within a formal organization – a bureau. The best-known implementations of electronic medical records are in large organizations, such as the U.S. VHA. Formal organizations have many tools to coordinate or integrate activities, and to influence employees. Guidelines are more easily adopted and enforced with the power of hierarchy, even though that power is relatively limited when dealing with professions. Although formal organizations certainly can develop their own pathologies and entrenched inefficiencies, it appears on average a bit easier to govern a bureau system in a way that serves budgeting values than to do the same with an entitlement system. However, blame cannot be avoided forever by claiming the health service will become more efficient.

Traditionally Beveridge systems have also been funded by government general revenue, and Bismarck systems from dedicated payroll contributions. This contribution difference in turn was associated with different governing structures: directly by government for Beveridge systems, and by the social partners, business and labor, for Bismarck systems.

As already mentioned, Bismarckian systems are becoming more like Beveridge systems [5]. Governments have been reducing the roles of the social partners and adding new funding sources. Nevertheless, both years of experience with health care and basic budgetary logics suggest that the difference between general revenues and dedicated funds can have important effects.

Paying from general revenues can be said to exercise a "discipline" on health expenditure because it puts the health programs in competition with other programs. Political authorities, however, may and probably should have another view – as their basic problem (unless they are ideologically opposed to spending and taxes) is how to raise money at minimum political cost. Dedicated financing forces voters and their representatives to confront directly the cost of the health care they desire. When a program is within the general budget, the choice is much less direct. One group may think health care could be paid for by cutting defense; another that health care could be funded by spending less on agriculture supports; another that it could be paid for by raising specific taxes. In short, people can agree to demand more spending even if they disagree on how to pay for it. This does not help budget-makers balance the books.

Moreover, having dedicated revenues can also discipline spending, because funds are not supposed to run deficits and any increase in spending has to fit within the specific funding source. The actual budgetary effects of dedicated vs. general revenues can be confounded by many other factors – including the bureau/entitlement distinction, the immediate budgetary conditions, and whether the goal is to cut or to restrain increases.[18] Yet it surely makes more sense to say the level of health expenditure accurately reflects public preferences if it is based on dedicated revenues.

This does not mean payroll taxes are the best form of revenue, or that the dedicated contributions should be limited to only that form. It does suggest that from a budgetary control perspective perhaps the best combination of program form and financing would be a bureau system with dedicated revenues. With control, however, comes blame–and that is not good for political authorities.

4. The budget community, health policy community, and political authorities

This essay has emphasized some aspects of health care budgeting that are common across nations due to the fact that the norms and attitudes in budget communities, basic roles in budget-making, and fundamental challenges in

[18] For a discussion that demonstrates the general uncertainty of findings about the link between program form and spending outcomes, see chapter 3 in [5]; for evidence that suggests that cutting and restraining increases are not quite the same task, see [48,49].

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funding health care are much the same across nations. Blame avoidance and timing games occur in any system, as does the pattern of encouraging but rarely adopting proposals for comparative efficiency.

The fact that there is a separate budget process and community raises one more fundamental question: power. What will be the relationship between the health policy and budgeting officials and communities?

That relationship will be shaped in part by the political views of the government of the day, and whether it is able to penetrate each bureaucracy fully. If that government has a clear ideological viewpoint, and dominates the bureaucracy, the health and budget officials may collaborate fully. Then issues of trust and expertise will not be important – because everyone is on the same side and ideology makes expertise undesirable. In other cases, of which the recent NHS reform appears to be an example, policy may be affected by only a very small circle of policy-makers, with most of each community excluded, and the budgetary logic of decisions at best obscure [50].

Yet often governments seek to link health policies to budget goals, and vice versa, in a coherent manner. Then the possibility that the people responsible for healthcare have different objectives than the budget-makers becomes far more important.

Normally, the health policy people want to spend more than the budget-makers do – or want to raise extra money that the budget-makers would prefer not to raise. In that situation the medical industry and voters may constrain the budget-makers enough that the health policy officials get at least a draw.

Often, however, political authorities at least think they want to emphasize budget restraint. Then asymmetry of expertise may come into play. One question is how much the budget-makers know, another is how much they worry about getting details right, and a third is how much they trust the health policy part of the government.

There is no general answer to these questions, because political conditions change. Hassenteufel and colleagues have provided a compelling account of how a community of experts within the health care parts of the French administrative apparatus gained control of cost control policies in the 1990s by both expressing allegiance to cost control goals and asserting superior expertise. They argue that this has occurred to some extent in other countries as well [51,52]. Yet in his most recent work, Professor Hassenteufel suggests that during the Sarkozy government, power was concentrated in the President's office, that office favored the budget staff, and the policy community that had gained power in the previous decade lost influence [53].

This review ends, therefore, with something most health policy participants likely know. Conflict between budget-makers and health policy-makers is endemic to all systems. The budget-makers normally have the upper hand. Yet the extent and form of that advantage depend in large measure on political forces that are stronger than either the budget or health policy professionals.

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