Health Policy 112 (2013) 163–171

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Budget-makers and health care systems

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ARTICLE INFO

Article history:
Received 6 March 2013
Received in revised form 25 June 2013
Accepted 29 July 2013

Keywords:
Policy development
Health care spending
Budgeting
Rationalization

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.

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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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http://dx.doi.org/10.1016/j.healthpol.2013.07.024

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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