

Welfare states in all advanced industrialized countries are under severe financial stress. Many observers argue that in responding to such pressures, governments are converging on a path of marketization and privatization of social risks, which ultimately leads to the unraveling of solidarity. Recent health care reforms in Britain, Germany, and the United States serve as case studies that challenge this argument. Far from converging on a market path, each country has pursued a distinctive reform response combining markets with other policy instruments. Moreover, where state actors lead the way in constructing health care markets, the extent of desolidarity is limited. The structure of each nation's health care system shapes the policy preferences and reform strategies of key actors, and thereby helps explain the distinctiveness of health care reform patterns.

## ADAPTING THE WELFARE STATE

### The Case of Health Care Reform in Britain, Germany, and the United States

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**W**elfare states in all advanced industrialized societies are facing enormous pressures, ranging from economic globalization to the aging of national populations, that simultaneously place new demands on them and strain their finances. The common wisdom is that these pressures have

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rendered current levels of collective social provision unsustainable. Therefore, governments everywhere are trying to improve welfare state efficiency and achieve budgetary savings. Some observers argue that countries are converging toward the privatization of social risks, the introduction of market competition into their systems of social provision, and the removal of government protections and regulations that safeguard people against market-generated inequities.<sup>1</sup>

To assess the effects of new pressures on the welfare state, we examine the health care reform experiences of Britain, Germany, and the United States. Health care is an instructive case study because it comprises a major part of social spending. As a result, all three countries have attempted major health care reforms in recent years. Moreover, the three countries' health care systems correspond to Esping-Andersen's (1990) three ideal-type welfare regimes. Although Britain has often been termed a liberal welfare state, its National Health Service (NHS), with its tax financing, state provision, and claims to benefits based on social citizenship, corresponds closely to Esping-Andersen's social democratic model. Germany's health care system exemplifies Esping-Andersen's corporative regime, in which benefits are provided on the basis of membership in an occupational or regional sickness fund, and corporatist actors administer the system on the state's behalf. The United States has a liberal health care system in which the majority of the population receives insurance through the workplace on the basis of a voluntary decision by employers. Public programs are limited to certain categories of population.<sup>2</sup> Thus, our country sample comprises a state-led, a corporatist-governed, and a market-driven health care system, respectively. The case selection thus offers the opportunity to investigate whether distinct types of welfare states are adjusting differently to today's more unfavorable political and economic environment.

Our findings do not bear out a commonly assumed downward spiral toward the privatization of risks in health care. First, far from converging on a market path, the three countries have taken distinctive roads to reform that reflect different mixes of market forces and other policy instruments: Britain imposed a market into its state-administered health care system. Germany opted for a more mixed menu of cost containment policies, including a cautious use of market forces and greater state intervention, but also adjusting the tried and true framework of associational self-governance. In the United

1. See Pfaller, Gough, and Therborn (1991, pp. 1-14). For an example of this argument as it applies to European Union countries, see Rhodes (1995).

2. Zysman (1983) emphasizes the linkages between the state and the financial sector, but his argument can apply to other sectors as well.

States, the Clinton administration's failed attempt to shape market forces within a framework of national health insurance was superseded by a reform process consisting of largely unregulated market developments led by private actors.

Second, just as the three countries have varied in their use of market competition and other cost-containment instruments in their health care systems, they have also varied in the extent to which their reform strategies have eroded or preserved solidarity. Britain and Germany have been far more successful than the United States in safeguarding solidarity and equitable access to care. Indeed, although the Clinton plan was an attempt to harness state power to extend the scope of the "residual" American welfare state in the direction of universalism, the United States has subsequently moved further in the direction of greater "desolidarity."

In seeking to explain these particular reform paths, we take issue with theories that seek to explain policy change primarily in terms of formal political institutions and partisan politics (Evans, Rueschemeyer, & Skocpol, 1985; Garrett & Lange, 1996; Immergut, 1992; Steinmo & Watts, 1995). We do not deny the importance of explanations focused on the political arena, but we find that they tell only part of the story of policy change. In particular, such explanations tend to focus on the legislative process and thus can only answer the question of whether a policy was enacted or not. They give only a partial explanation for why policy makers settled on the particular content of reforms and often fail to consider events within a given sector at the implementation stage.

Our explanation, by contrast, stresses the role of sectoral actors and institutions in accounting for different reform paths. This highlights the importance of "policy feedback" effects (Pierson, 1993) and the ways in which sectoral institutions and past policies shape policy makers' current reform strategies. First, our cases demonstrate that the particular linkages between state actors and the health care system shape policy makers' reform strategies and provide them with different abilities to lead the way in reform. The policy sector represents an "ensemble of opportunities and constraints" that policy makers have to take seriously if their reform strategies are to succeed. Second, important sectoral actors—particularly payers—have exerted enormous influence on the political debate around health care reform, especially with their emphasis on cost containment. But the particular institutional configuration of each nation's health care system provides payers (as well as policy makers) with different strategies to solve the problems of the health care system. Third, the sectoral perspective allows us to view the course of policy development over time rather than confining us to a snapshot view of legislative enactment or failure. Consideration of sectoral developments highlights

the ways in which policy implementation shapes subsequent policy formulation. More important, it provides a window to observe significant transformations that are occurring in the health sector even when a legislative initiative fails.

In presenting our three cases below, we begin with a brief description of the health care systems, the roles they have accorded different actors in financing and providing care, and how these actors have defined the health care problem. Next, we examine the different ways each country pursued health care cost containment and reconciled them with solidarity. We conclude by considering what the health care reform paths suggest for the future evolution of the welfare state in our three countries.

## BRITAIN

The National Health Service (NHS) provides health care to all members of society, without regard to income or employment status. The state is the main payer of services; hence, benefits are public and financed out of general taxation and the central government sets the NHS budget. The state also delivers health care through its ownership and administration of the hospital sector, through tiers of health authorities emanating from the Department of Health (DOH) at the center, and through its employment of hospital doctors on a salaried basis. However, within the state-administered configuration, the organized medical profession, particularly the British Medical Association (BMA), enjoyed a privileged role in formulating and implementing health policy and shared these tasks with ministerial bureaucrats and NHS managers. In short, the NHS was governed by a hybrid of statism and corporatism (Giaino, 1994, 1995).

In contrast to the German and American cases, employers in Britain were not the main actors in debates about health care costs. This is because the British NHS accorded the state, rather than employers, the responsibility for financing health care. Thus, the health care debate in the 1980s and 1990s was not explicitly conducted in terms of the relationship between the health service and economic competitiveness, though the public sector's effect on economic performance was a concern of the Thatcher government (see Gamble, 1994, chap. 2; Harrison, 1988, chap. 5; Jenkins, 1987; Kavanagh, 1990). Rather, this debate, and the Thatcher government's reform solution, focused more on the internal performance failures of the NHS, and the proper role of the state, market, and the professions in the welfare state.

### THE REFORMS: THE INTERNAL MARKET AND CENTRALIZED STATE CONTROL

In the battle over the NHS, Thatcher defined the problem as one of health care system inefficiency as attested by politically embarrassing waiting lists for elective (nonemergency) surgery. In her view, the problem lay with the NHS bureaucracy (the health authorities) that provided care but had little incentive to ensure its cost-effectiveness, and with senior hospital doctors (consultants) who wielded enormous influence over NHS resources by virtue of their dominant position in hospitals and their decisions on whom and when to treat but who offered little in the way of accountability in how such resources were used. For Thatcher, the solution to the NHS's perennial financial woes was to use market competition to goad health authorities and doctors toward more efficient behavior.

Hence, the internal market lay at the heart of the Thatcher government's reform program as presented in its 1989 White Paper, *Working for Patients*. The market redefined the roles and relations among existing health care actors by transforming them into separate purchasers and providers. Prior to this, each district health authority (DHA) had directly managed the hospitals in its area and had thereby provided care to the district's population. Under the internal market, however, DHAs were transformed into purchasers of health care for their populations and were given the freedom to buy services from NHS or private-sector hospitals, while NHS hospitals secured the freedom to opt out of health authority control and manage their own affairs as self-governing trusts. The internal market also granted general practitioners (GPs) a role in purchasing. Large practices could become GP fund holders and receive budgets to use in purchasing diagnostic hospital services and elective surgical procedures for which long waiting lists existed. Like DHAs, fund holders could purchase services from either the public or private sectors. Through the purchaser-provider split, the government hoped to curb what it saw as excessive power of consultants by forcing them to be more responsive to GPs and DHAs—or else risk losing their business—and to shift the emphasis of the NHS away from acute hospital care toward outpatient and primary care. The reforms also included a number of measures designed to strengthen the hand of NHS managers over doctors and to encourage medical practitioners to consider more explicitly the efficiency and costs of their treatment decisions and of the ways they structured their work (NHS Management Executive, 1990; U.K. Department of Health, 1989).<sup>3</sup>

3. For a discussion of the policy proposals surrounding NHS reforms, see Giaino (1994, chap. 4); Glennerster, Matsaganis, and Owens (1992); Klein (1995); and Timmins (1995).

At the same time, a strong dose of central state control accompanied the internal market. For example, the reforms granted the health minister the power to appoint chief executives of health authorities and hospitals, thereby stripping local governments and professions their influence in this domain (U.K. Department of Health, 1989). The government also subsequently streamlined and further centralized the NHS's administrative tiers. But in doing so, the NHS central executive found itself enmeshed in the day-to-day administrative decisions of the health service. Instead of using the market to devolve controversial battles over scarce resources away from ministers and Parliament to lay managers at lower levels, the administrative changes actually enhanced the control and interference of ministers and managers at the center. Moreover, centralized state control appears to be a permanent fixture in the NHS landscape. It is not merely a temporary intervention to vanquish the government's opponents. Nor has it been a short-term intrusion of the state to set up the market and then beat a retreat and allow free competition to take over.

#### **THE LIMITS OF LIBERALIZATION IN A UNIVERSAL HEALTH CARE SYSTEM**

How can we account for this seemingly paradoxical reform strategy combining more state and more market in the NHS? The institutional configuration of the health care sector goes a long way in providing explanation of the reform path. The institutions of the NHS allowed for a state-imposed reform strategy, but at the same time, set limits to the government's market strategy.

First, because the British health care system placed the state and the medical profession in high relief, they were the targets of the neoliberal critique of the welfare state. For neoliberals inside and outside the Conservative Party, the NHS epitomized all of the worst elements that had caused Britain's decline in the postwar period. In their view, rampant statism and collectivism caused economic rigidities, whereas powerful professions ruled the welfare state with impunity and with little regard for public accountability. Indeed, the BMA's inability to control its members—especially hospital consultants—demonstrated to Thatcher the medical profession's irresponsible power and lack of discipline, and its inability to assume the duty to carry out public policy on behalf of the government that corporatism required (Giaimo, 1994; Klein, 1995). Thus, Thatcher's market strategy aimed to both destroy the corporatist bases of medical power and to provide doctors and NHS managers

with the incentives to deliver more efficient health care.<sup>4</sup> But taming the power of the medical profession required Thatcher to use the central state machinery to impose the market on recalcitrant doctors.<sup>5</sup>

Second, the institutional and political legacies of the NHS made the “market-plus-state” strategy more attractive than other, more radical neoliberal alternatives. Although neoliberals abhorred the idea of a “big state,” the fact remained that the state’s overwhelming presence as payer and provider in the NHS had crowded out a larger intermediate network of corporatist actors—such as insurance companies, providers, employers, and unions—to whom tasks of health care administration might have been delegated. Likewise, the government rejected radical proposals for compulsory national insurance or private insurance on the grounds that the former would have been far less able to control costs than the centralized financing and provision under the NHS, whereas the latter would have been political dynamite (Klein, 1995; Timmins, 1995, pp. 392-394, 453-465). Thus, Thatcher decided that if she could not turn health care over to the market, she would bring the market into the NHS.

However, as we have seen, the internal market has been striking in the extent to which it has been accompanied by enduring state centralization. Institutional legacies and technical imperatives have accounted for this mixture. The hierarchical chain of command in the NHS, from the Executive down through the tiers of health authorities, served as an ideal vehicle through which the government created and shaped the market in the NHS.<sup>6</sup> At the same time, the creation of a market from scratch posed formidable technical problems that provided a rationale for vigorous state intervention and guidance. Among these problems were the lack of computers and information on prices and costs of services, and the dearth of managerial know-how

4. The irony, however, is that the government committed an enormous amount of resources in creating the internal market. Most conspicuous were the soaring costs associated with the swelling of the ranks of NHS managers. The number of managers soared from 700 in 1987 to more than 13,000 in 1991, while between 1991 and 1992, there was an almost 25% increase in managerial personnel but only a 1% rise in hospital medical staff (Pike, Rise of 25% in NHS managers, *Financial Times*, December 11, 1993, 6). Moreover, the government provided general practitioners (GPs) with a number of financial “sweeteners” to encourage them to sign up as fund holders (Giaino, 1994, chap. 6; Klein, 1995, p. 209).

5. On the use of central state power to overcome opponents of liberalization, see Gamble (1994) and Richardson (1994).

6. The trend toward greater managerialism and upward accountability actually began in the early 1980s. The 1989 reforms only continued this process (interviews; Klein, 1995, chaps. 5, 7).

to engage in contracting, all of which entailed detailed support and intervention from the NHS Executive.

But perhaps the most important constraints on the market, and the necessity for stronger central control, have been political. The NHS embodied principles of solidarity and equity that were widely shared by the public. Public attachments to the NHS—both among the electorate and even within the elements of the Conservative Party—limited the amount of market competition that the government could introduce.<sup>7</sup> More than any other branch of the British welfare state, the NHS has epitomized—or has at least aspired to—a comprehensive notion of community based on Marshall's (1963) idea of social citizenship. The NHS expresses this solidarity as the right of all to a comprehensive level of care, (nearly) free of charge, on the basis of clinical need rather than on ability to pay (Klein, 1995, chap. 1; Ministry of Health, n.d.; Speller, 1948; Titmuss, 1974, 1987). And the public continued to expect the state to act as the guarantor of this right. Such considerations prevented Thatcher from moving toward outright privatization of health care financing and also compelled her and Major to carefully craft and constrain the workings of the internal market to avert the most egregious inequities and chaos that unbridled competition would have unleashed. The clearest example of this was Major's decision to pursue a "steady state" policy that amounted to a centrally controlled, cautious introduction of the internal market in the NHS prior to the 1992 election. Even in the aftermath of the election, Major continued to limit the play of competition. In some cases this required overriding market forces, as with his decision to pursue a central state-directed rationalization for London hospitals (James, 1995). Less spectacular—although no less important—limits to the play of market forces by Thatcher and Major alike included limiting fund holders' financial liability and the hospital services they could purchase for their patients, restricting the freedom of hospitals and fund holders to dispense with their "profits," and mandating the development of a capitation system for purchasers that would adjust for inequities based on the health status of patients (Maynard, 1991; UK Department of Health, 1989).

Finally, Thatcher's decision to continue financing health care centrally made it difficult for the government to "let go" once the market was in place.

7. Opinion polls have consistently shown that the public remains strongly committed to the principles of tax-financed, universalistic, and publicly provided health care and is willing to pay higher taxes for the NHS (Klein, 1995, pp. 135-136, 240). Likewise, NHS managers have been unwilling to part with a "public service ethos" of purchasing or providing care based on medical need. Many district health authorities (DHAs) have preferred a more cooperative strategy of joint purchasing to adversarial relations with providers or other purchasers (Light, 1997).



Centralized financing meant that the government had to be able to respond to the Treasury's perennial concerns over costs. Parliamentary accountability likewise required that government ministers remained responsible for NHS performance as a whole. Conservative governments thus found it difficult to separate operational from strategic political decisions. And they deemed it intolerable to devolve decisions to lower level managers or to impersonal market forces, while still being held to account for performance failures over which they had little or no control (Klein, 1995, chaps. 6-7).

Thus, explaining the peculiar mixture of "market and state" requires that we look beyond formal political institutions. Undoubtedly, Britain's political institutions—which centralize power in the cabinet, promote party discipline, and expand electoral majorities—allowed Thatcher to enact the internal market reforms with relative ease. But political institutions cannot account for the particular reform strategy that Thatcher and Major settled on. And even with a large parliamentary majority, Thatcher found her freedom of action in health politics constrained by the policy legacies of the health sector and the political and technical barriers they erected. As a result of these constraints, both Thatcher and Major found it necessary to temper the market in the NHS.

This being said, the NHS market reforms contained some radical elements that should not be minimized. The internal market was an attempt by Conservative governments to reshape the welfare state from within and redefine the reach of the state and the market in social provision. Instead of the welfare state delineating areas of life shielded from the reach of competition, the NHS reforms imported market forces into these areas, even if they were tempered in actual practice. For all the government's unwillingness to admit it, the internal market challenged the equity of the NHS from a new direction. GP fund holding imported into the NHS the inequality of access based on ability to pay that had been only grudgingly tolerated between the private and public sectors.<sup>8</sup> With the advent of fund holding, the wait for elective surgery in some cases was no longer based solely on medical need but also on the ability of one's purchaser to pay. This was particularly true for patients of larger fund-holding practices that possess the budgets, as well as the business savvy, to act as more assertive purchasers. Although their patients clearly benefited,

8. Class-based inequalities in access to care have long been a feature of British health care, with private-paying patients having been able to obtain faster service through private beds in NHS hospitals than those who accepted rationing by the queue. There have also been long-standing regional inequalities (Klein, 1995, chap. 6) and rationing according to social criteria, although justified on clinical grounds (Aaron & Schwartz, 1984). Nonetheless, the goal of the NHS has always been to provide the same standard of good care to all of its citizens, regardless of their ability to pay, even if the health service has fallen short of this standard in practice.

evidence suggests that such improved access was gained at the expense of patients in non-fund-holding practices. The extent of this inequity, however, remains contested.<sup>9</sup>

On balance, then, the reforms represent only a partial challenge to the solidarity of the NHS. Support for the NHS remains both broad and deep among the general public and among key elements within the major political parties. The core principles and institutions of the NHS have largely weathered the changes of Conservative governments: The state remains the guarantor in financing and providing universal health care, and has preserved the broad pooling of health risks among the entire population through a tax-financed national system. Policy makers have taken great care to limit the play of market forces in the NHS. The NHS of the 1990s, then, represents an uneasy compromise between the visions of solidarity and liberalism. It thus serves as a microcosm of the broader debate in Britain about the future contours of the welfare state, a debate that remains far from settled.

## GERMANY

German social insurance is employment based, with employers and employees paying equal shares of insurance contributions. In health care, the main actors are insurance funds (known as sickness funds) based on occupational or status groups, corporate actors such as the organized medical profession, and employers' associations and trade unions who jointly staff the administrative bodies of social insurance. Insurance funds and physicians' associations have the status of public-law bodies (*Körperschaften öffentlichen Rechts*), which grants them a privileged legal status and a (near) monopoly in social welfare provision but, at the same time, constrains their freedom of action by requiring that they fulfill certain public functions (Katzenstein, 1987; Streeck & Schmitter, 1985). Within this framework, the state normally confines itself to setting the procedural rules and the goals of social policy in framework legislation, while relying on these societal actors to administer the social insurance system with a comparatively high degree of autonomy (through the principles and practices of self-administration, or *Selbstverwaltung*).

9. Because the contract arrangements between fund holders and hospitals differed from those of DHAs and hospitals, patients in some fund-holding practices enjoyed quicker access to hospitals than patients of non-fund-holders (*British Medical Journal*, December 12, 1992, p. 1451; January 23, 1993, pp. 227-229; Whitehead, 1993). However, an alternative view maintains that non-fund-holders benefited from "spillover effects" from fund holding, with some DHAs consulting non-fund-holding GPs in their purchasing decisions or devolving purchasing decisions to them (Klein, 1995, pp. 241-242).

The employment-based nature of social insurance has meant that the problem of high labor costs has become especially prominent in the German reform debates. In recent years, employers have argued that their social insurance contributions are so high that they have rendered German industry uncompetitive in the global economy and have made Germany a hostile place to invest (the *Standort* debate). Employers have therefore urged a decrease in the growth of social insurance contributions, or at least the share paid by firms. But although calling for some relief in financing health insurance, employers have been unwilling to surrender their influence in the health care system or, for that matter, in the entire system of social insurance that the corporatist framework of social insurance affords them.

#### GERMAN HEALTH CARE REFORM: COST CUTTING AND CORPORATIST REGULATION

Since the mid-1970s, a plethora of laws has tried to cope with the problem of the “cost explosion” in the German health sector.<sup>10</sup> That costs continued to increase despite the intense political efforts to contain them is often taken as proof of the futility of state action vis-à-vis the strategic sophistication and the political power of sectoral interest groups. However, a closer look reveals that cost containment in health care has been successful, especially when viewed in comparative perspective (Alber, 1988; Organization for Economic Cooperation and Development [OECD], 1992). But opposing trends in recent years, notably the severe economic recession of the 1990s and German unification, have undercut cost-containment efforts.<sup>11</sup>

Although health care reform has been generally one of incremental change over two decades, the last major reform, the Health Care Structural Reform Law (*Gesundheitsstrukturgesetz*, or GSG) of 1992, stands out as an exception. The GSG has been classified as a “victory over pressure group politics” (Blanke & Perschke-Hartmann, 1994) and as a clear break with the “stalemate of opposed interests and consequent immobility of policy” (Dyson, 1982, 34) that has been characteristic for German health policy since the 1950s. The GSG introduced a multiplicity of structural reforms to the health sector: a change in the financing mode of the hospital sector from the principle of retrospective cost coverage (*Selbstkostendeckungsprinzip*) to

10. Between 1975 and 1992 alone, 13 health policy laws aimed primarily at cost reduction were enacted. The trend continues or even accelerates: 1996 saw the enactment of four laws with a clear orientation toward cost containment. Two more are currently in the parliamentary process.

11. Between 1991 and 1994, contributors to the social insurance system—namely, employers and employees—have borne a transfer of DM 106.5 billion from west to east.

forms of prospective and case payment, supported by broadened planning competencies of the sickness funds in the hospital sector. A nationwide and interfund risk-adjustment scheme (*Risikostrukturausgleich*), which equalizes differences in the sickness funds' membership with respect to age, sex, income, and number of dependents (who are insured for free), now compensates for that part of the variation in insurance premiums that is due to differences in these four dimensions. Since 1996, all insured persons have been granted the freedom to choose among the different sickness funds for the first time since the establishment of statutory health insurance in 1883. Before 1996, the choice of fund was a privilege of white-collar workers alone. Between 1993 and 1996, fixed budgets set a ceiling on expenses for physicians' fees, pharmaceutical treatments, hospital stays, and administrative costs of the sickness funds. These could not rise faster than the general development of insurance contributions. The GSG also significantly restricted physicians' freedom to set up their practices.

Despite being an exceptional success, the GSG shares with preceding reforms the reliance on a corporatist strategy. A common characteristic of all past health reforms—successful or otherwise—has been the state's attempt to strengthen the power and responsibility of the joint self-administration of doctors and sickness funds or of funds and hospital associations, and the GSG was no exception in this respect.<sup>12</sup> This was achieved, among other things, by strengthening the binding force of collective contracts on the members of the contracting parties (e.g., on the individual physician as a member of the physicians' association or on the individual hospital as a member of a *Landeskrankenhausgesellschaft*, the regional association of hospitals). At the same time, the state expanded the scope of the collective bargaining system between physicians and funds or between hospitals and the funds (Döhler & Manow, 1995; Döhler & Manow-Borgwardt, 1992).

Corporatist governance in the German health sector has been remarkably durable for a number of reasons. First, it allows for the reduction of uncertainty and can minimize political transaction costs (Moe, 1990; Shepsle, 1989). In addition, corporatist governance corresponds to the long-standing and highly legitimized tradition of self-administration in Germany and is also compatible with the subsidiarity principle of Catholic social doctrine (*Soziallehre*), as well as with Social Democratic concepts of codetermination and democratization of societal sectors. Thus, corporatism fits the programmatic orientation of the major political parties—the Christian Democratic

12. This had already been the predominant orientation of the first major health reform in postwar Germany, the *Krankenversicherungs-Neuordnungsgesetz* (KVNG) from 1958 to 1961. See the excellent account by Safran (1967); also see Döhler and Manow (1997).

Union/Christian Social Union (CDU/CSU) and the Social Democrats (SPD)—and the regulative preferences of the ministerial bureaucracy (Döhler & Manow-Borgwardt, 1992). This restricts their receptiveness to the neoliberal critique of the welfare state, which proposes to substitute the corporatist governance with “free-contracting” between patients and providers. Indeed, neoliberalism has found expression in the small Free Democratic Party (FDP), which usually garners only 5% to 10% of the federal vote. Thus, German neoliberals have faced a more daunting political task in critiquing the corporatist governance mode in the German health system against the neoliberal notion of the “ideal market” than their counterparts in Britain. This is also because the system of associational self-governance has proven itself adaptable and able to make incremental adjustments involving both greater state intervention as well as an infusion of competitive elements within the sectoral governance structure (see below). This adaptability has meant that requests for radical reform steps appear less convincing.

Another reason for the limited attractiveness of the market as a principal alternative to the corporatist status quo is that corporatism provides an “area of interest overlap” between the sectoral actors. Although the state on occasion will tightly regulate the corporate associations within this framework, they nonetheless continue to play an important role in sectoral governance that serves their organizational self-interest. Furthermore, the sickness funds have strong linkages to unions and employers’ organizations, and the corporatist framework grants organized labor and capital a voice in health care administration through their joint representation on the administrative bodies of the sickness funds. Not surprisingly, employers and unions are not eager to replace the corporatist framework and the influence over social policy it affords them with a more arm’s-length market relationship (Manow, 1997). So, although highly critical of rising health care costs, German employers have never been proponents of a radical system transformation.

Last but not least, corporatist governance has proven quite satisfactory in depoliticizing difficult health policy issues and in containing health care costs. Because it allows politicians to delegate responsibility for the financial regulation of the sector to the partners of the joint self-administration, they can avoid blame for unpopular cost cutting.<sup>13</sup> Moreover, experiences with the politics of retrenchment since the late 1970s have shown that cost containment was most successful in the ambulatory care sector. This convinced politicians and ministerial bureaucrats that persistent cost pressures in health care were not proof of the failure of the “corporatist” strategy, because the collective bargaining regime was most highly developed between funds and

13. This follows the argument by Weaver (1988).

doctors. On the contrary, politicians and bureaucrats attributed the cost problem to the lack of appropriate corporatist structures in other sectors, especially in the areas of hospitals and pharmaceuticals. As a consequence, health policy has sought to create the preconditions for corporatist regulation in these sectors as well (Döhler & Manow-Borgwardt, 1992).

**STABILITY OF CONTRIBUTION RATES  
AND "LEVELING THE PLAYING FIELD"  
IN THE GERMAN HEALTH SECTOR**

State actors' cost-containment strategies in the health care system have followed a distinct pattern that comprises four main elements: the pooling of once-fragmented risk communities, indirect governance via the system of collective bargaining, sectoral budgeting, and the externalization of costs through higher co-payments or through the exclusion of certain treatments from reimbursement. Let us discuss each of these elements in turn.

The government has advanced the risk-pooling strategy within the context of the corporate institutions of the German health care system. The prominence of these corporate public law bodies in the health sector is a structural legacy of the fundamental principle undergirding the Bismarckian model of social insurance, which grants social rights to certain socioeconomic groups (blue- and white-collar workers, farmers, civil servants, craftsmen, miners). This setting offers not only an institutionally rich environment to state actors in their cost-containment strategies but offers them also the opportunity to "pool" different risks. Whereas fragmentation encouraged the different risk communities to compete with each other for more generous welfare packages and thus induced a "race to the top" in economic good times, a reverse mechanism comes into effect in periods of "contraction" or economic crises. In such times, the fragmentation between the different *Versorgungsklassen* (welfare classes) makes it possible for political reformers to reduce financial pressures on the welfare state through a strategy of pooling "bad" with "good" risks, financially "healthy" with deficit-ridden funds, and the better-off with the poorer. Pooling is attractive to policy makers because it can potentially diminish state responsibility for budget deficits of social insurance schemes. The GSG's risk-adjustment equalization scheme (*Risikostrukturausgleich*) is a good example for the importance of this strategy in health insurance (see below).<sup>14</sup> The introduction of the risk-adjustment scheme in the German health sector is a strong (but not the only) counterexample to Esping-

14. For an overview, see Mackscheidt (1990) and Nullmeier (1992).

Andersen's thesis that "it is virtually impossible to amalgamate occupationally exclusive social insurance schemes."<sup>15</sup>

The second prong of the cost-containment strategy involves the state manipulating and setting the terms of the collective bargaining system in health care. In governing the health sector and ensuring cost containment, the state sets out general policy goals in framework legislation that the corporate bodies are expected to observe in their collective bargaining. The most general and important state-set objective in recent decades has been Beitragsatzstabilität (stability of contribution rates, *Social Law Book V*, §§ 71 and 141 para. 2). The state has operationalized this goal by tying sickness funds' expenditures to the development of their revenues, which in turn, are linked to the development of wages and employment.

As an alternative to administrative review, fixed budgeting has been a third strategy to stabilize contribution rates. In recent years, the Kohl government has repeatedly resorted to the instrument of *sectoral* budgeting. As the latest example, the GSG guaranteed stability of contributions' rates through budgeting of all major subsectors of the health care system from 1993 through 1995. Given the lack of a political consensus about alternative indicators and government and employers' concerns about the effects of social insurance costs on labor costs, the stability of contributions has been and remains the first objective of German health policy. However, cost containment by budgeting was viable only as a short-term strategy because it ran counter to the ideological commitment of the Christian-Liberal coalition to avoid state *dirigisme* and to instead rely on corporatist self-governance in health care.

Nevertheless, the difficulty in getting the powerful self-governing actors to adhere to the principle of stable contributions has led the Kohl government to employ market-like mechanisms to achieve cost containment. Politicians granted all patients free choice of fund in 1996 in the hope of introducing

15. Esping-Andersen (1996, p. 28, Note 5). Other examples are the financial balancing scheme (*Wanderungsausgleich*) between the notoriously deficit-ridden miners' insurance fund (*Knappschaft*) and the blue- and white-collar worker pension funds, which was introduced in 1968 during the first economic recession in postwar Germany. Likewise, in 1969, a financial balancing scheme between blue- and white-collar worker pension funds was introduced, which led to an enormous redistribution of wealth from the comparatively well-off white-collar funds to the deficit-ridden blue-collar funds. Also in that year, any income ceiling for compulsory insurance (*Pflichtversicherungsgrenze*) for white-collar workers was abolished, which was another important example of the tendency to expand significantly the membership of the pension insurance in periods of financial strain. In health politics, the collective financing of all expenses of pensioners' health insurance (*Krankenversicherung der Rentner*), enacted in 1977, represents the most important example of interfund risk pooling, which, in the beginning of the 1990s, comprised more than 40% of overall health care spending (see Enquete-Kommission, 1990).

competition into the health sector. And to strengthen competition further, the government enacted legislation in 1997 that would link the level of a fund's insurance premium to the level of co-payment for its members. If a sickness fund raises its contribution rate, such action will automatically trigger a drastic increase in patient copayments for its members: Each contribution hike of a 0.1% increment would lead to a co-payment increase of DM 1 for pharmaceuticals or of 1%, respectively, for other co-payments.<sup>16</sup> At the same time, the law has eliminated waiting periods before moving to different funds and now allows members to immediately switch their membership out of a fund that increases its contribution rates. These provisions thus give the sickness funds strong incentives to avoid any hike in contributions for fear of the resultant loss of members.

But policy makers deemed the increased possibilities for funds to compete for members too risky without first carefully laying the groundwork and instituting safeguards. As a result, the financial risk-adjustment scheme preceded the extension of free choice of fund. Without such equalization among sickness funds, the government and the opposition Social Democrats worried that those funds with high contribution rates as a result of the lower incomes and poorer health status of their members—namely, the local funds that served as insurers of last resort—would have been driven into bankruptcy. Since its installment in 1993, the *Risikostrukturausgleich* has succeeded in significantly narrowing the differences in contribution rates among funds. In 1993, roughly 32% of all funds had a contribution rate of more than 1% above or below the average, whereas in 1996, less than 10% of the funds did. In addition, the intensified competition among sickness funds since the GSG led to a wave of mergers, so that the number of funds dropped significantly from 1,221 in 1993 to 498 as of 1997.<sup>17</sup> Thus, the risk-adjustment scheme appears to have fulfilled its primary purpose: Funds have become more similar in critical respects, and differences in their risk communities have not been allowed to give some funds an unjustified competitive advantage.

Although it is too early to draw firm conclusions about the effects of the most recent health reforms, it is certain that up to today, German health policy of the past two decades has not gone in the direction of greater inequality. Instead, it has significantly reduced the fragmentation on the payers' side, broadened the "risk pool," and distributed more equally the financial burdens

16. This provision has been revoked in 1998 due to the upcoming national elections.

17. Ministry of Health, *Daten des Gesundheitswesens* (1997).



associated with providing the population with medical services. These achievements are the product of the state's tight administrative regulation of the health sector and close monitoring and adjustment of corporatist self-governance. Even where market-like elements have been introduced, the "regulative embeddedness" of the health care system has worked to preserve and even extend solidarity. Indeed, the free choice of fund, along with the risk-adjustment scheme, rectifies long-standing inequities among blue- and white-collar workers. Both competition and the safeguards against market failures are embedded within a broader regulatory regime in which the state exerts a strong presence in regulating public-law bodies; mandates a broad menu of statutory benefits, universally provided, on which competition is not permitted; and has long relied on a strategy of risk pooling to compensate for "poor risks." In short, up to now, adapting the German health sector to harsher economic conditions and unfavorable demographic trends has not eroded solidarity in either access to, or financing of, care.

### THE UNITED STATES

The American health care system is part of a liberal welfare state in which social provision is made through the private market or through limited social insurance programs (Esping-Andersen, 1990). In health care, state leverage over private actors historically has been limited. Most Americans obtain health care coverage through their employer on a voluntary basis: either as a fringe benefit negotiated by their labor union or as a result of a firm's unilateral decision to offer insurance. The employer's risk pool often extends no further than its own employees. Those unable to obtain insurance through an employer have the option to buy individual policies in the private market, although these tend to be prohibitively expensive. Public insurance programs, in which the federal government acts as payer, cover only certain defined categories, such as Medicare for the elderly and disabled and Medicaid for the poor. State governments have significant jurisdiction over Medicaid and have been the primary regulators of private insurance. As a result, the federal government has had at best an arm's-length relationship to the employer-based, private insurance market. It has exerted influence over that sector largely by issuing regulations and specifying payment procedures for Medicare and Medicaid, which employers and private insurers may choose to adopt for their own plans.

**FREE RIDING AND COST SHIFTING IN A  
VOLUNTARY HEALTH INSURANCE REGIME**

In the United States, policy makers faced the twin problem of cost containment and severe gaps in coverage. Those without insurance found their access to treatment for nonacute conditions rationed by price and ability to pay. But they had limited access to emergency care because those employers who provided insurance cross-subsidized the care of the un- or underinsured. Providers who received low reimbursements from government insurance programs or who cared for the uninsured were able to recoup their losses by charging patients with private insurance higher fees. Insurers, in turn, passed on their cost increases to employers by charging them higher premiums for insurance for their employees. Thus, an elaborate but largely hidden cost-shifting game was being played, but with only some employers footing the bill. This cost-shifting game did not arouse too much complaint from employers as long as the economy kept growing and American businesses were shielded from the effects of competition.

However, broader changes in the American labor market, in combination with the voluntarism of employment-based insurance, aggravated the problems of cost and access to health care. With the decline of the manufacturing sector (characterized by unionized jobs that provided fringe benefits), many of the new jobs created in the United States since the 1970s offered only part-time, temporary, or subcontracted work. Such contingent labor enabled employers to refuse to provide fringe benefits as a way to keep their labor costs down (Freeman, 1994). This situation placed firms that provided insurance coverage at a disadvantageous position relative to those that did not or relative to foreign competitors with lower labor costs. The end result was that firms that did provide insurance became less willing to shoulder the high insurance premiums that cross-subsidized the care of the uninsured. Some employers began to look to government for relief from their cross-subsidy burden through a national health insurance program (Martin, 1995a), for this would have forced all employers to pay their fair share of health care costs of their workforce.

**THE REFORM PATH: FROM SOCIAL INSURANCE  
AND REGULATED COMPETITION TO  
“UNMANAGED COMPETITION”**

The Clinton administration's Health Security Plan, unveiled in the autumn of 1993, tried to correct these shortcomings while building on the existing foundation of employment-based insurance. The reasons for this were twofold: First, the legacy of Reagan budget deficits ruled out a state-administered

system like Britain's and the higher taxes or government spending it would have required. Second, a state-administered system would have likely met the implacable opposition of existing health care stakeholders, particularly private insurers and employers who already provided insurance and wished to retain control over its contents (Skocpol, 1996).

Thus, the Clinton plan proposed both national health insurance and government-regulated market competition to expand access, to replace cost shifting with cost containment, and to halt the free riding by many firms. First, the Clinton plan mandated all firms to provide insurance, with government subsidizing the costs to small firms or those individuals unable to obtain insurance through the workplace. By pooling all risks within a national insurance system, Clinton hoped to solve the access problem and eliminate cost shifting by firms that did not provide insurance to those that did.

Second, the Clinton plan promoted the use of market forces to rein in health care costs. Thus, the Clinton plan permitted competition among different types of insurance plans but pinned its hopes for cost containment on managed care organizations (particularly the most restrictive plans, known as health maintenance organizations, or HMOs).<sup>18</sup> HMOs would have been the lowest cost plan offered to patients, whereas traditional indemnity plans would have been forced to keep their costs in line or else charge higher premiums to patients in exchange for such "extras" as choice of provider and additional benefits. But employees, not employers, would have had to assume the greater cost sharing that went with greater choice.

Third, government would have been a crucial player in regulating market forces in a system of "managed competition."<sup>19</sup> Indeed, the Clinton plan envisioned government actors to take the lead in reconfiguring the health care market to give weaker market players the requisite power in negotiations with large providers and plans. Thus, the president's plan required states to establish health alliances on a regional basis to organize the insurance market and ensure that small businesses and individuals would have access to affordable insurance. Large firms, however, could constitute their own alliances. The alliances would "manage" the competition in the health insurance marketplace, for example, by monitoring plans to prevent them from cream skimming. In short, managed competition required the government to design and

18. HMOs have reduced costs through a variety of measures, including fewer hospital admissions and shorter lengths of hospital stays than traditional insurers; limiting patients' choice of doctors to those on an approved list and restricting their access to specialists; and paying provider groups on a fixed, prospective capitation basis rather than open-ended fee-for-service reimbursement.

19. Like the British, the president's plan borrowed heavily from Enthoven's theory of "managed competition." See Enthoven (1985, 1988, 1993).

enforce a framework of rules to delineate the permissible areas of competition.

The president's plan would have also expanded the powers of the federal government in the new health care system. The Health Security Act would have legislated a minimum comprehensive benefits package for all plans to offer under national health insurance. Furthermore, a National Health Board, with members appointed by the president, would have possessed wide-ranging powers to regulate alliances and health plans, and to mandate additional benefits. Indeed, because the Clinton administration doubted that market forces alone could control costs, it provided the federal government with the means to enforce a global budget cap: The National Health Board was given the authority to limit premium increases to the rate of inflation (Starr, 1994; White House Domestic Policy Council, 1993, pp. 82, 105-109).<sup>20</sup>

Although Clinton's effort to introduce national health insurance came to an inglorious end, the government's failed effort to lead the way in reform and to create and shape the market in health care did not spell the end of health care reform. On the contrary, transformation of the health care system has continued apace at a breathtaking scope and speed. But rather than the federal government leading the charge in actively shaping and regulating the market, employers have decided to "go it alone" by using market forces in health care. Many employers have sought to contain their health insurance costs by encouraging competition among managed care plans and providers and requiring or inducing their employees to enroll in HMOs. Under pressure from employers to hold the line on premiums, managed care plans have become increasingly aggressive with doctors and hospitals, forcing them to slash their costs by negotiating steep price discounts or capitation arrangements.<sup>21</sup>

The go-it-alone approach, however, is a broad canopy that provides employers with a range of cost-cutting strategies beyond promoting competition among providers. Thus, employers have shifted the costs of insurance onto their employees through a range of strategies such as higher co-

20. Both Enthoven and the Clinton administration believed that government had to set the rules of competition within a framework of universal health insurance to prevent plans from denying coverage to vulnerable individuals or groups. But they parted company on the role of government in ensuring cost containment. Enthoven believed that competition alone could have ensured cost containment and that a budget cap was unnecessary.

21. By 1997, 85% of employees were in some type of managed care plan, up from slightly more than 28% in 1988 (Freudenheim, 1994, 1998). For an excellent survey of recent managed care developments, see Wilkerson, Devers, and Given (1997, esp. chap. 1 and conclusion chapter). The editors point out that intensified price competition among managed care plans is a recent development. For an earlier discussion of employers' go-it-alone strategies of cost containment, see Giaimo (1996).

payments or having workers bear a greater share of premiums, limiting the range of benefits in health insurance plans they provide, banding together in voluntary purchasing cooperatives (much like the health alliances envisioned in the Clinton plan) to gain leverage over providers and insurers, self-insuring their own immediate workforce to avoid co-optation into states' risk pools for the uninsured, or refusing to provide coverage at all (Giaino, 1996).

What these strategies amount to is nothing less than a process of "unmanaged competition." That is, employers' efforts to use market forces to achieve cost containment have proceeded in the absence of an effective regulatory framework that would prohibit or compensate for market failures, particularly continued market segmentation and shrinking insurance coverage as a result of insurers' cream-skimming practices or firms' decision to drop insurance. And as competition heats up among HMOs and providers in an effort to reduce costs, comprehensive oversight or consumer-protection measures for those subject to the rationing decisions by managed care plans is lacking.<sup>22</sup>

Where government action has occurred, it has largely taken the form of incremental regulation of the insurance market to foster competition—as with federal and state oversight of mergers (Given, 1997)—and only piecemeal consumer protections and regulation of employers' and insurers' practices. Likewise, efforts to expand access have faced severe obstacles and have been piecemeal at best.<sup>23</sup> The Health Insurance Portability and Accountability Act of 1996 (or Kassebaum-Kennedy law) best illustrates the government's market-promoting action. The law sought to respond to employer concerns with "job lock" by barring insurers from denying coverage to new employees who have preexisting medical conditions. But because the law made no provision that premiums will be affordable and allowed insurers to require a waiting period, the law has fallen far short of its goal of enhancing labor mobility. Moreover, because the law only addressed those already in the

22. Although HMOs tend to have a good track record in providing appropriate care for those who are younger and healthier, evidence is mixed as to whether they provide appropriate care for those with chronic conditions (Miller & Luft, 1994). In a highly competitive market, some HMOs might be tempted to engage in hidden rationing of expensive care or otherwise discourage patients with chronic conditions to enroll to keep costs down. Because quality-of-care indicators are not well developed, rationing by HMOs is a very uncertain exercise that has become a politically charged issue.

23. As an example of incremental widening of access, the federal government in 1997 expanded state public insurance to poor children. In doing so, it followed past precedents in social policy of creating a new entitlement program that targets a "deserving" category of the population. But the law is expected to cover only half of the uninsured poor. An example of piecemeal consumer regulation is the 1996 federal law requiring all insurers to provide a 48-hour hospital stay for women who give birth (see U.S. Department of Labor, n.d., pp. 17-18).

labor market rather than extending to those outside it who lack insurance, it did not approach anything like universal coverage.<sup>24</sup>

#### THE DILEMMAS OF REFORM IN A VOLUNTARY HEALTH CARE REGIME

How can one explain the American reform path, which began as an ambitious attempt to create a new branch of social insurance but which ended up as an atomistic, "every-firm-for-itself" strategy? Explanations of the Clinton plan's failure abound,<sup>25</sup> and it is not our intention to provide another detailed analysis. Instead, we highlight the importance of the nature of the American health care system. In brief, a voluntary, employment-based health care system influenced Clinton's reform calculations, shaped firms' definitions of the health care cost problem and their attitudes toward the Clinton plan, granted employers enormous latitude to pursue a range of go-it-alone cost-containment strategies, and limited the capacity of government actors to regulate or otherwise shape market forces in health care.

First, the existing health sector arrangements strongly influenced Clinton's choice of reform strategy. That strategy, in turn, magnified the pivotal role of employers in the legislative process. In basing his plan for universal coverage on employer-provided insurance, Clinton allowed his plan to be held hostage to the veto of employers. And because the health care system afforded firms so many go-it-alone strategies to lower their labor costs, it made it difficult for employers' peak associations to overcome the centrifugal tendencies within their ranks to rally their members to support the Clinton plan at the legislative stage.<sup>26</sup>

Second, the employment-based nature of health insurance meant that businesses' concerns over labor costs figured prominently in the definition of the "health care problem." At the same time, the voluntary nature of employer-provided insurance profoundly colored the ways in which businesses saw the link between health insurance and labor costs, their attitude

24. On the contents of the Kassebaum-Kennedy law, see Fuchs, Lyke, Price, and Smith (1997). For early assessments of the effects of the law, see General Accounting Office (1998); and Pear (1998b).

25. Among the good, albeit fragmentary, early analyses on the Clinton Plan's failure are *Health Affairs*, 14(1) (Spring 1995); *Journal of Health Politics, Policy and Law*, 20(2) (Summer 1995); Mann and Ornstein (1995); and Aaron (1996). See also Manow and Giaimo (1995). Skocpol (1996) provides a comprehensive treatment of the politics and legislative process behind the Clinton Plan.

26. For an account of business organizations' disarray toward the Clinton plan during the legislative process, see Clymer, Pear, and Toner (1994); Judis (1995); Manow and Giaimo (1995); Martin (1994); Skocpol (1996); and Toner (1994).

toward the Clinton plan, and their strategies to lower their labor costs. In short, employers' attitudes toward Clinton's plan involved different perceptions of risk and calculations of costs based on their position in the existing health insurance system and whether it met their competitiveness strategies.<sup>27</sup> Many employers who already provided health insurance saw national health insurance as the solution to their labor cost problem because it would have spread the risks and costs of health care to all firms and leveled the competitive playing field among them. But many small firms and service-sector enterprises did not wish to part with the voluntarism of the health insurance system because their competitive strategy of low labor costs rested on their ability to not offer insurance. Indeed, small firms vehemently opposed the Clinton plan on the grounds that it would saddle them with prohibitively high labor costs that would have driven them out of business. But even among firms that provided insurance, there were those who rejected the Clinton plan because they feared it would raise their costs by forcing them to help subsidize insurance for small business, or that the larger regional alliances would be able to secure better deals from insurers than they could have as their own corporate alliances (Judis, 1995; Martin, 1995a, 1995b).

Aside from its effects on labor costs, national health insurance hit a nerve with many employers because it involved basic questions of corporate autonomy. Some employers—and not just small businesses—opposed Clinton's national insurance proposal on the ideological grounds concerning the proper reach of the state in corporate governance. They believed that the employer mandate would have encroached on their freedom to decide insurance coverage for their employees and were suspicious of national insurance as an entering wedge for further government intrusion into other areas of corporate governance (Judis, 1995).

Finally, government actors do not have the linkages to employment-based insurance that would allow them to take a lead in shaping the behavior of private actors to prevent market failures. Indeed, state and federal jurisdiction over private insurance and employer health plans often works at cross-purposes so as to block efforts to expand access or enact consumer protections. A federal pension law, the Employee Retirement and Income Security Act (ERISA) is one of the chief obstacles to effective government regulation. While ERISA allows states to regulate "the business of insurance," self-insured plans are exempt from states' benefit mandates and consumer protections that apply to other private insurers.<sup>28</sup> At the same time, however, federal

27. See Baldwin's (1990) argument on how calculations of risk shape whether different social groups favor or oppose more or less universal social insurance schemes.

28. Under the Employee Retirement and Income Security Act (ERISA), employer-based insurance plans fall under two categories. Private insurers that contract with employers to pro-

regulation of self-insured plans is quite weak.<sup>29</sup> And because ERISA places employer self-insured plans beyond the reach of state regulation, state governments have been unable to require these firms to join statewide risk pools that would expand access for the uninsured. The end result is a dual system of government regulation that shields self-insured plans—whose numbers are growing—from government regulation that applies to other types of private insurers.

The path of employer-led reform through unregulated market competition and go-it-alone strategies has ominous implications for both the equity and cost of health care. First, firms' go-it-alone approaches to contain their health care costs only segment the market further and threaten what little solidarity there is in the American health care system. The current trend shows the number of uninsured growing as employers—willingly or otherwise—exercise their exit option and refuse to offer coverage or as low-wage workers find insurance premiums beyond their reach (Cooper & Schone, 1997; EBRI, 1997). And even employees who are insured are feeling more insecure, as many employers shift onto them a greater share of health care costs. Second, it does not appear that employers' go-it-alone and market strategies have contained

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vide care or benefits are subject to state and federal regulations, whereas self-insured plans are exempt from state insurance regulations and subject to very limited federal oversight. In 1993, self-insured plans covered 17% of the U.S. population, or 44 million individuals, up from 39 million in 1989 (General Accounting Office, 1995, pp. 9, 47-50). Acs, Long, Marquis, and Short (1996) estimated that approximately 40% of the workforce was enrolled in self-insured plans (p. 275). Polzer and Butler (1997) have also noted that some courts have ruled that managed care organizations are not insurers and are therefore exempt from state regulation (p. 98). So the range of insurers shielded by ERISA may even extend beyond self-insured plans. On ERISA's constraints on the states, see Chirba-Martin and Brennan (1994), General Accounting Office (1995), O'Keefe (1995), and Polzer and Butler (1997). Grogan (1995) discusses ERISA and other limitations on states' efforts to expand coverage for the uninsured.

29. A public backlash has also been growing against HMOs' rationing practices. In an effort to address public concerns, halt the proliferation of piecemeal legislation for discrete diagnoses, and instead create a national framework of consumer protections that would cover all insurers—including managed care organizations and employers' self-insured plans—Clinton appointed the Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1996. The commission, however, agreed to only a limited number of consumer protections (such as insurer payment for reasonable emergency room visits, rights to external appeals for denied claims, and easier access to specialists) and did not call on government to enact universal coverage. Moreover, bowing to business and insurance representatives and the requirement of unanimity, the commission refused to recommend federal legislation to enforce these consumer protections. Nor did it advocate changing the ERISA law. It remains to be seen whether the federal government will enact the commission's consumer protections into legislation. On the President's commission and similar consumer protection bills before Congress, see President's Advisory Commission (1998) and Pear (1997a, 1997b, 1997c, 1997d, 1998a, 1998c, 1999).



the overall costs of the health care system. Indeed, after slowing considerably in the past few years, employers' health insurance premiums are set to rise substantially, as insurers seek to recover profits after years of belt-tightening. It is also likely that larger market players (big HMOs and employer purchasing groups) have contained their own costs by shifting the costs of uncompensated care to weaker market players.<sup>30</sup> In doing so, however, they have aggravated the problem of the uninsured, as small firms and individuals find themselves forced to shoulder the cross-subsidy and are priced out of the insurance market by exorbitant premiums. Third, the worst-case scenario predicts that employers' and managed-care plans' cost-cutting actions, combined with spending cuts in public insurance programs, will effectively destroy the cross-subsidy for the uninsured, with the disintegration of the public hospital system—the providers of “last resort” for the most vulnerable populations—the result.<sup>31</sup> Thus, absent effective public intervention, the ultimate logic of this employer-led strategy of market reform threatens to undermine not only the cost-containment efforts of firms but also the survival of the health care system itself.

## CONCLUSION

The current political wisdom holds that welfare states in advanced industrialized societies have become too costly in a climate of slower economic growth, heightened international competition, and unfavorable demographic trends. As a result, these countries have little choice but to roll back the state from social provision, inject market forces into the welfare state, or privatize social risks—all of which destroy the solidarity of the welfare state. But our case study of health care reform in Britain, Germany, and the United States

30. Kaiser, one of the largest HMOs in the nation, asked for a 12% increase in premiums for 1999. Estimates are that 1999 premiums will rise an average of 7% nationwide (or 5 times the consumer inflation rate). Premium increases are also attributed to higher costs as a result of patients' demands for greater choice of doctor and to physicians organizing to counteract the growth of managed care organizations (Freudenheim, 1997, 1998). Real per capita health spending averaged just below 5% per year between 1970 and 1993 and 1.5% per year between 1993 and 1996, but is set to grow at 3.4% per year from 1997 to 2007 (Smith et al., 1998, 128-129).

31. For evidence of the worst-case scenario and the threat to the public hospital system, see *Los Angeles Times* series (October 1995). A more sanguine picture predicts that although public hospitals may survive, they will be chronically underfunded as large employers and insurers effectively shift the burden of cross-subsidy onto smaller insurers and firms (Reinhardt, 1995). But even under this less dire scenario, the numbers of uninsured are likely to continue to grow, as insurance premiums become unaffordable for these weaker market players.

indicates that this scenario is overly simplistic and misses important cross-national differences and counterbalancing developments. Indeed, our three countries have demonstrated versatility in their health care reforms, combining market competition with other cost control instruments. Moreover, their policy responses have had different effects on the solidarity of provision and financing.

First, our three countries have not converged on a common reform path. In Britain, Conservative governments attempted to rein in health care expenditures through a state-imposed market strategy. But they also continued to rely heavily on an overall global budget for the NHS as a way to constrain health care spending. In Germany, cost-containment reforms encompassed significant increases in patient cost sharing (particularly with the latest health care reforms), a continued reliance on public-law corporatist actors to implement cost-containment measures through their collective agreements (and even moving to extend such corporatist arrangements in other sectors), and allowed carefully controlled competition among sickness funds for members. In the United States, Clinton attempted to introduce national health insurance and harness market forces to address both access and cost problems in the health care system. However, the president's failure to secure passage of national health insurance legislation has left private actors to carry out reform through market strategies whose rules have not been adequately specified.

Second, the employment of competitive market forces in the health care system does not necessarily entail a rollback of the state (Giaino, 1996; Richardson, 1994; Vogel, 1996). Indeed, Britain and Germany are cases in which governments have vigorously intervened in their health care systems, leading the reform process and actively shaping market forces in health care. Britain, moreover, has seen more enduring state centralization of its administrative structures alongside market forces within the NHS. State intervention in the market in both countries has been necessary not only to overcome opponents of reform but to set the permissible boundaries of competition to prevent socially unacceptable market failures. The United States is a contrasting case of an abortive effort at state-led reform, with private actors subsequently shaping markets in much of the health care system. Government action has been largely reactive, incremental, and as often as not, market promoting rather than market hindering.

Thus, our cases should encourage scholars to rethink the assumption that economic globalization inevitably implies the retreat of the state from social provision. True, the political calculus of "blame avoidance" provides policy makers with strong incentives to delegate responsibility for cutbacks in welfare either to anonymous market mechanisms, to automatic indexing

formulas, or to negotiated self-governance by corporate actors. Yet, although the politics of welfare retrenchment may be highly unpopular (Pierson, 1994), it is also true that non-reform may be just as unpopular, particularly when state actors face a shrinking financial base for social spending. Inexorably rising social insurance premiums or taxes may not translate into electoral success. Thus, state actors may find it politically profitable to reform the welfare state by reducing its perceived inefficiencies and by restricting some of the profit opportunities for welfare state providers. Such a task often requires an active policy and an interventionist state to overcome the opposition of entrenched welfare state professionals.

Third, welfare state researchers commonly conceive of social policy as “politics against markets” (Esping-Andersen, 1985) and assume that the infusion of market mechanisms into the welfare state automatically results in the erosion of the solidarity of universal programs and harms core constituencies. But because our three countries have shown important variations in the purposes and design of market experiments in health care, the consequences for solidarity have been different. Indeed, policy makers may use markets not only to enhance efficiency but also equity, as the Kohl government’s decision to grant blue-collar workers free choice of fund suggests (Giaino, 1996). Moreover, to the extent that the reform projects encourage providers and payers to be more responsive to patients, the British and German market experiments may actually benefit core welfare state constituencies. At the same time, policy makers in both countries have taken great care to constrain the play of market forces to prevent socially unacceptable inequities in health care financing and access, and have preserved their statutory commitment to universal coverage. In the United States, by contrast, the federal government’s failure to create a framework of universal health care with comprehensive rules over the workings of market forces has meant that it has not adequately addressed the serious problems of market segmentation in insurance and inequities in coverage and access.

Fourth, in explaining the different patterns of health care reform, we have highlighted the importance of the institutions and actors in each country’s health care system. In doing so, we have concentrated on *sectoral* configurations rather than the more general “formal public institutions” (Garrett & Lange, 1996) in analyzing the “relationship between changes in economic structure and public policies” (Garrett & Lange, 1996, p. 56). Although the structures of formal public institutions are important in shaping the general probabilities of success or failure in enacting welfare reforms (Immergut, 1992), they do not tell us much about the concrete direction of reforms. Rather, sectoral institutions influence actions and calculations of political actors. Policy makers have had to anticipate the views of key health care

actors in the reform debates and have tailored their reform policies to fit the existing institutional configuration of their given health care system. In addition, sectoral institutions may provide or deny government actors leverage over, and links to, health care providers and payers. These linkages, in turn, affect state capacity to intervene in the health sector, to shape market forces in health care, and to take a leading role in the project of reform. Moreover, the health sector has designated different actors as payers and embedded them in sectoral arrangements in particular ways. As a consequence, they may define the health care problem differently, and the health sector may allow them different ways to achieve their reform goals. Finally, formal political institutions cannot tell us much about the course of reform or transformation within the health sector itself. But what occurs at the implementation stage may provide "policy feedback" (Pierson, 1993) that prompts subsequent reform efforts (as in Germany) or may alter the course of reform (as with the slowdown of the market in Britain). And as the United States demonstrates, sectoral change may be considerable, despite policy makers' failure to enact a major reform program.

Fifth, welfare states are as much instruments of economic adjustment or industrial restructuring (Manow, 1997) as they are instruments of redistribution and social equity. In the current era of heightened international competition, this industrial restructuring role is becoming even more pronounced. But because welfare states serve multiple purposes, current welfare state reform projects have been hotly contested struggles between forces advocating cost containment and those championing solidarity. In health care reform, some actors—employers in particular—saw health care reform primarily as a project to reduce their labor costs in a more competitive economic environment. But although interested in cost containment, policy makers have also faced competing pressures to preserve solidarity. This has been the case especially in universal health care systems in which the public expects the government to continue to safeguard universal access to a comprehensive level of care. In countries with such health care systems, pressures to preserve solidarity have acted as a counterweight to cost cutting.

If health care is any indication, national actors still have considerable freedom of choice to decide the terms and distributional burdens of welfare state adjustment (Garrett & Lange, 1996). Each nation's particular welfare state adjustments continue to be the outcome of ongoing battles—or negotiations—among state actors and social forces in search of a new settlement to (re)define the balance between state and society, and the extent of social protection of individuals against the effects of old age, illness, or the vagaries of broader market forces.

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