In any political system, budgeting creates a second policy-process, parallel to and in some ways dominating the normal processes that create and amend programs.

Budgeting involves distinctive tasks, responsibilities, organizations, personnel, and attitudes. Hence there are national and international budgeting communities. The budgeting professionals in these communities develop distinctive norms and attitudes. Yet they serve the political authorities – mostly. What I call the budgeteers will push for their professional perspectives, and may have significant influence. But ultimately the elected political authorities also must worry about other influences. These include the voters in general; party colleagues; coalition partners; and societal interests. The latter will include a different set of players than the specifically health policy interests. For example, investment bankers and “the markets” (whatever that actually means) are constituencies that politicians believe they have to satisfy with their budget decisions. Political actors may have beliefs about budget totals that trump (or reinforce) leanings about health policy. In the United States debate of 2009-10, for example, the swing legislators were conservative Democrats for whom the budget was the most important concern.

---

1 This paper is prepared in search of feedback from health policy scholars that might help me contribute to a project on budgeting for health care that has been initiated within the Senior Budget Officers Network of the OECD. I am especially interested in how members of the EHPG perceive the relationship between budget policy-making and health policy-making in their own countries. I came into health policy research from studying budgeting in the United States. See, for example, “Markets, Budgets, and Health Care Cost Control,” Health Affairs 12(3), 1993. As a result, this paper is essentially an attempt to systematize how my own work on budgeting might (readers will judge) inform understanding of the topic of this meeting. Please pardon the fact that this leads me to refer to my own work in many of the footnotes.


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. This point is discussed at more length in Joseph White and Aaron Wildavsky, The Deficit and the Public Interest: The Search for Responsible Budgeting in the 1980s (Berkeley and New York: The University of California Press and The Russell Sage Foundation, 1991).

In this paper I will offer a broad-brush overview of the budgeting challenge as it normally appears to the two major groups of budgeting participants: budgeting professionals such as the civil servants who are members of the OECD’s Senior Budget Officers network, and political authorities. I look forward to feedback about how well this description fits health care budgeting that members of this group have observed.

* * *

**The Goals of Budgeting**

The basic task of budgeting is to resolve a conflict 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 increment (or occasionally decrement) to the public debt – otherwise known as the deficit or surplus. The budget-maker has two basic problems. First, her own preferences about details may not add up to her own preferences about totals. Second, the voters’ perceived preferences about details may not match their perceived preferences about totals.

The nature of the conflict at any time therefore depends on beliefs about totals. Consider the challenge of responding to the economic stress that began around 2008. From some economic perspectives, the conditions that increased deficits beginning in 2008 were certainly a bad thing, but large deficits were a necessary response. Hence the economic stress should not have had any particular effects on health care policy. If anything, health care spending should have been maintained as part of maintaining aggregate demand. From other perspectives, the economic stress required new constraint on spending totals, or reinforced existing beliefs about the need to constrain spending so as to limit debt.\(^5\) And from a third perspective, particularly common within the Anglo-Saxon right wing, the economic crisis did not change preferences but was viewed as confirming a view that spending and taxes were both evil.

Budget professionals tend to believe that the most important total is the balance between spending and taxes, and prefer having no deficit or modest deficits. This view follows from a series of professional beliefs. For example, they tend to view interest payments as reducing their flexibility to address future challenges. 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,

---

\(^5\) Benedict Clements, David Coady and Sanjeev Gupta eds., *The Economics of Public Health Reform in Advanced and Emerging Economies* (Washington, DC: International Monetary Fund, 2012), e.g. chapter 1.
and that they act as “guardians” against the more narrowly interested “claimants” in the rest of the political system.

Political authorities’ preferences vary more, according to ideologies about the role of government or beliefs about either the economy or public pressures. All other things being equal, however, 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.

The conflict between preferences about details and totals applies to all parts of the budget. Health care programs are especially challenging for both budget professionals and politicians, however, both because these programs are a very large share of budgets, and the demand for spending is especially intense.

Traditional Budget Norms

The process of matching baselines to totals has generated a series of norms and routines, promoted especially by the budget profession. These norms may be abandoned in the name of budget control during times of elite panic about deficits. Normally, however, these routines do influence budgeting for health care.

First, budgeting proceeds in a series of iterations, with agencies being given guidance about totals, responding, and then the central budget authority accepting or rejecting details while perhaps reconsidering its guidance about totals. How much budget professionals will pay attention to the details varies with the times and pressures; but the budgeting role clearly includes such attention. Even if there were no beliefs about totals, political authorities would still not want to give agencies more than they “need.” They would 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. But they may rationalize situations in which they impose totals that are not

---

6 See White and Wildavsky, The Deficit and the Public Interest, op. cit., especially chapter 19 on the Gramm-Rudman-Hollings legislation. Recent attempts to hold the federal debt ceiling hostage also have been encouraged by the supposed apostles of budget responsibility; see Committee for a Responsible Federal Budget, “Responsible Increases to the Federal Debt Limit” (2/8/11) at http://crfb.org/document/responsible-approaches-increasing-debt-limit.

7 This also includes making sure agencies spend money in the manner and at the rate promised. So traditional budget systems were created in part to control budget execution: to make sure agencies did not try to spend more money than was allocated to them. This too requires detailed oversight – and attention to details in budget-making, so as to know if agencies are misbehaving in execution.
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. The thinking as expressed to me in interviews is essentially, “we raise questions but, faithful to the death, we pass it on.” Second, budget professionals may think that the agencies have an overwhelming information advantage; that the budget staff can’t get at all the flaws in the agency estimates; that there always are such flaws; and so that it is fair to just cap the spending and make the agency figure out the most efficient way to meet the target. This view may have become more common over time, as part of the “New Public Management.”

Third, concern about totals may just trump concern about details. If the deficit is viewed to be a big enough crisis, then “hard choices” are no longer really hard, to the budget professionals. Any pain on the details can be justified.

The budget professionals therefore are certainly rivals of the agencies. But under some circumstances the norms of budget analysis lead the professionals to pay attention to agencies’ legitimate concerns about the effects of budget restraint – and sometimes they do not.

Traditional budget theory identifies norms for proper budgeting. Control normally involves limits on spending but that is within a broader context: spending the amount that is intended, with intended effects. The norm of comprehensiveness means that all aspects of the budget plan are considered. In general, budget professionals do not like dedicated funds because they believe these constrain choices and inhibit pursuing a certain kind of efficiency (discussed below).

Budgets are supposed to be accurate and honest. Honest budgeting means that all choices are made visible and all consequences are considered. 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. In general, budgeteers would rather be conservative – that is, err by underestimating savings or revenues. Program advocates are the opposite.

---

8 One approach is to create “envelopes,” targets for spending, and leave the agencies to determine how to hit the targets. This approach shares with New Public Management a belief 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. It also absolves political authorities of responsibility for knowing whether the goals made sense in the first place.

9 See for example David M. Cutler, Karen Davis, and Kristof Stremekis, “Why Health Reform Will Bend the Cost Curve,” Commonwealth Fund Issue Brief (Dec 2009) p10, [http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Dec/1351_Cutler_Davis_Health_Reform_129_CAPAF.pdf](http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Dec/1351_Cutler_Davis_Health_Reform_129_CAPAF.pdf). The authors explain that budget and actuarial estimators “rely largely on peer-reviewed studies utilizing carefully controlled comparison groups” and that “there is not much evidence in the published literature on policy reforms short of severe constraints that save large amounts of money.” So they dismiss skeptical estimates by the budget authorities, arguing that, “(t)here is, however, a less formal, but no less important, literature that sees the world differently.” Indeed...
Budgets also are normally made annually, 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. Annual budgeting also provides the basis by which everyone keeps score. As a result, budget-makers 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 among budget professionals; in fact they tend to dislike the incremental nature of the process. Yet it remains incremental for both political and analytic reasons.

Budgeting, incrementalism means a process in which decisions about each year normally take the “base,” what was done last year, as given. Analysis and political combat then focus on the increments, so on much less than the total amount of spending. The base is not only an amount of spending but a distribution of shares: 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. The balance may change because an election changes the government, or because of dramatic new events. The collapse of the Soviet Union was not good for military budgets. But such events are rare, and fiscal stress itself is not enough to change notions of fairness, or objections to various innovations. Incrementalism in this sense occurs 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. For radical change to occur, it must be driven by events outside the budget process.

**Economy and Efficiency:**

Both budget professionals and political authorities tend to value both economy and efficiency. These values, however, are not the same. Economy is more ideologically controversial; and efficiency has its own ambiguities.

---

10 Some systems have biennial budgets, but that often includes a revision process during the second year. For a discussion of why being unable to budget for a full year is not good for governing, see Naomi Caiden and Aaron Wildavsky, *Planning and Budgeting in Poor Countries* (New York: John Wiley and Sons, 1974).


12 Reinhard Busse has noted that budget pressures alone do not appear to have encouraged systematic reforms; see “Health reform monitor: The impact of the financial crisis,” *Health Policy* 106 (2012) p.2.
By economy I mean simply limiting spending. When traditional budget theory describes central budget-makers as “guardians” of the public purse and agencies or interest groups as “claimants,” it defines economy as the primary responsibility of senior budget officials.

But does the value of economy mean to limit spending just for the sake of limiting spending? Or is the goal to make spending fit some constraint about revenues? The answer depends on the political authorities’ ideology. Budget professionals tend to seek lower spending because that is their role in the budgeting script, but can prefer efficiency instead.

Economy might be achieved by making programs more efficient, but efficiency is not only useful to reduce spending. As one OMB senior civil servant explained to me, he was trained to be a neutrally competent budget analyst. And that meant, “if it was a Republican administration, telling them how to get the same output for less money, and if it was a Democratic administration, how to get more output for the same money.”

Hence efficiency is not economy. In many cases, cutting spending reduces output more than input, and spending more can increase value for money. But that brings up a second issue about efficiency that is especially important for how budgeters deal with health care. Efficiency can be pursued at two different levels.

The first is efficiency within a program or agency. Budget processes force each agency to explain how it would spend its funds, and then “scrub the estimates” to eliminate waste. The second kind of efficiency is the goal of many budget reforms and of many health system reformers. I call it comparative efficiency, and it is the goal of “performance budgeting” or the field of welfare economics. The basic idea is that programs or agencies should be compared, and resources distributed across them in a way that maximizes total value for money.

Large segments of the budgeting world desire to pursue the second type of efficiency, so are deeply attracted to health reform ideas which claim spending on different things would both limit spending and improve value. Unfortunately, efforts to budget for performance have barely ever worked, for many of the same reasons that reallocation of health policy effort has little success. First, there is no agreement on how to measure program outputs in common ways. Second, measures are easily questioned even if there is belief that they might in theory be plausible. Third, reallocation means winners and losers, and the losers are normally angrier than the winners are happy. Fourth, reallocation can be technically difficult: to take a health policy example, one can’t simply decide to have more or less surgical intervention for cardiac care in a region, and less or more medical management.

---

13 And more – after all, if a program is failing that may mean it needs more money, not less.
Capacity and organizations are sticky. Fifth and perhaps most important, some of the standard ideas about reallocation make much more sense to analysts than to voters.

As a result, health system reformers may receive sympathetic attention or even encouragement from budget professionals, but practical budgeters and political authorities tend to abandon grand plans to reallocate among policies.

This is especially true of the arguments that less should be spent on medical care and more on some other set of activities which, it is argued, produce more health for the money. So more should be spent on pollution control, or early childhood education, or measures to prevent obesity or smoking, and less on knee replacements for the elderly. Budget professionals share with health economists, public health professionals, and health services researchers a focus on averages and population aggregates. All are attracted to the idea that programs should be compared and funding allocated according to the ratio of measures like quality-adjusted life years to inputs. But what the voters want from health care systems is not health, but care. Not health, but rescue.

Within budgetary debate (as in health policy-making more generally), therefore, reallocation from medical care to other supposedly health-enhancing activities tends to have the attributes of what I call a zombie idea. It can’t die because it keeps being put on the agenda by institutional actors who want it to live; but it can’t live because the political environment in the form of public preferences is quite hostile.

The search for efficiency within medical care programs is particularly intense because the demand for services is so strong. That makes it especially important to argue that spending control methods are ways to make the system more efficient, rather than simply ways to control spending. Health policy analysts reveal that in their own language, bending to the political wind, as “value for money” seems to have replaced “controlling spending” in the health policy literature.

From a budget-maker’s perspective, proposals to pursue efficiency either within medical care activities or across them tend to share a basic difficulty. They tend to call for “investments” – that is, more spending now, accompanied by a promise that it will enable less spending later. Maybe that will work – but whoever is making the budget has to worry that maybe it won’t, and spending more now does not help with this year’s budget challenge. The alternative is to cut something now and promise other services will make up for what is lost. For very good reasons, this promise meets great skepticism from the public.

To summarize: budget professionals and political authorities endlessly seek ways to make the health care system more efficient. It would solve all sorts of problems for them if they could do so (except for the problem of the angry losers of income). They are interested in
hearing ideas from the health policy community about how to get more bang for the same or fewer bucks. Budget professionals tend to be attracted to many of the approaches generated by the health policy community. The challenges they face, however, generally lead to them adopting much blunter, less “innovative” approaches.  

There is a wide gap between what is discussed and what is done.

* * *

Demands for Spending and to Limit Spending

Two aspects of health care make the goal of economy, in particular, especially difficult. First, the good or service is especially salient to citizens or voters. Therefore demand for whatever is socially defined as necessary is particularly strong. Second, ideas about the necessary level of service continually expand. The second factor receives more attention, but the first is at least as fundamental.

Salience and Intensity of Demand for the Benefit

Medical care is a good consumed by individuals. We can argue that it has community benefits, but any collective good it provides is neither its most essential nature nor the main reason for political demand. There is no other good that seems so central to individual lives, that is such a necessity of life, for which modern mixed economies socialize finance or provision so broadly. When needed, medical care is as important to people as 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. It is so strong that voters might be convinced to pay extra for extra spending, if they trust the policy-makers who say new revenue will go for more health spending. This is not a policy illusion, or created by advocacy groups, or a desire that is easily traded off against other desires.

Education is important, expensive, and personal. But it is not as expensive and the voters themselves are not the consumers. The most similar program to health care, as an individual benefit of great importance to virtually all voters, is pensions. Pensions are the largest other public expense, and in some countries a larger share of what OECD defines as

14 It would be hard to get less innovative than Busse’s (op. cit. p2) summary of choices in southern Europe.

15 This section only seeks to explain why the challenge is difficult even in countries that have used measures that control spending and increase efficiency and equity significantly compared to the baseline country that does none of the above: namely, the United States. It is not meant to be read as suggesting that “excess demand” is the variable that should receive the most attention.
public spending. Yet the extent and generosity of public pension commitments varies more than for public health care spending. In the past two decades, public spending on pensions has also grown more slowly than public spending on medical care. It has grown more slowly in part 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.

**Expanding Definitions of “Need” for Care**

All government programs have operators and advocates, who believe in the activity, make their living from it, or both. Conflict between what their operators think is needed and what the budget office wants to pay is the most basic pattern of budgeting. When possible, the program operators make their case in public, whether that is for new weapons, more teachers per student, or more funding for research.

Health expenditure is unusual because advocacy to the public extends far beyond the normal political processes. It includes “provider-induced demand” in the medical office, but goes well beyond that process as well. “Need” is created in the media through continual promotion of supposed medical progress. Individual and social difficulties are continually medicalized, as in the redefinition of students who do not pay attention in school, as victims of Attention Deficit Hyperactivity Disorder. Advertising seeks to spread “awareness” of medical problems. Campaigns for prevention, even though prevention is often presented as a way to save money, often justify and induce more services, such as anti-cholesterol medication.

**Government Responsibility for Totals.**

I have been writing as if health care is funded by government budgets, and so government budget officials naturally are concerned with spending as part of the overall management of details and totals. Yet 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. So this raises a question: why should, or do, budget officials worry about spending that is not part of the budget?

---

16 For example, among 23 plausibly similar countries, public social spending on pensions in 2007 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. The set consists of European OECD countries that were not part of the Soviet Union; Australia, Canada, Japan, New Zealand and the United States. Data is from the OECD Economic, Environmental and Social Statistics website.
In fact, there was a time when 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. We should remember that the French legislature did not vote on total spending for the French system until 1996, and that was seen as a major reform. I think there are three main reasons why public spending on health care is a budgeting concern even in sickness fund systems – and why sickness fund systems, in general, are steadily subjected to more direct government control.

First, when the government mandates social security contributions, that affects citizens’ and companies’ willingness to pay taxes for the rest of government’s activities. Second, the required contributions for health care, and for pensions, have normally been percentages of payroll. That means that, by some theories, those contributions raise the costs of hiring new workers. Policy-makers in much of Europe therefore have blamed those costs, rightly or wrongly, for persistently high unemployment. 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 towards funding previously Bismarckian systems – in spite of the continual pressures on public budgets.

From a budgetary perspective, therefore, the revenue side of the equation is more clearly in play for health care than for most other programs (pensions excepted). We know from how many systems are financed that voters can be induced to pay dedicated contributions for health care programs. When there are already such contributions, the benefits of keeping the system intact may seem very large compared to even the costs of providing some extra general revenue.

**Excessive Advice**

Budget-makers might feel better about their difficulties dealing with health care if there weren’t an endless array of experts telling them there are good solutions. Instead, there may be far more ideas about how to make health care more efficient than about any other field of human endeavor.

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 so on. All are promoted by experts with impressive credentials.
There is little evidence that most of these ideas would save money. Yet that doesn’t affect the fervor of the advocacy, at all. We had a beautiful example in the United States. Peter Orszag, as Director of the Congressional Budget Office, organized a massive analysis of health care spending control options.\textsuperscript{17} By the time it came out, Orszag had been chosen as Director of the Office of Management and Budget for President Obama, and proceeded to ignore the strong evidence, from staff he had managed in a report he commissioned, that the ideas he favored would not save money anytime soon, if ever.

The health policy community not only generates ideas, or at least re-labels ideas, at an overwhelming rate. It also is divided by deep ideological disputes. The best-known involves insurance and cost-sharing. The level of insurance coverage that is normal for citizens of every advanced industrial democracy except for some Americans is, according to some of the most distinguished American health economists, so inefficient as to be “lavish.” Other analysts – some economists and many non-economists – do not accept this argument. But that means budgeters are going to face conflicting claims about efficiency, from highly-credentialed experts, for as long as health care budgeting exists.

The world of expert advice about health care is, as William James described an infant’s perceptions of the world, one of “blooming, buzzing confusion.” Budget-makers might have an easier time if they had fewer alternatives.

* * * * *

Policy Responses\textsuperscript{18}

To recapitulate:

* Both budget professionals and political authorities who have budget responsibilities tend to have related worldviews that follow from the tasks of budgeting, their roles, and the pressures they face.

* Budget professionals tend to share many of the attitudes of expert health policy reformers. However, both the practical pressures they face and the attitudes of the political authorities tend to mean this empathy is not reflected in budget policies.

* Budget professionals, and to some extent political authorities, face contradictory pressures to pay attention to details or to totals.

\textsuperscript{17} Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals (Dec 2008), at \url{http://cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9924/12-18-keyissues.pdf}.

\textsuperscript{18} The discussion that follows emphasizes perspectives among budget-makers and the politics of choice, rather than what works best (except in passing). Participants in the EHPG likely encountered as much of my perspective on the latter issue as they could possibly desire at our April, 2010 meeting.
* “Efficiency,” at least within programs, appears to offer a way to square the circle – that is, to meet public demands for services while keeping spending within some bounds. Easier said than done, of course.

* Budget-makers lean towards favoring economy, even if not through efficiency. But the extent of that bias varies greatly with the policy preferences of the political authorities.

* Voters intensely desire access to medical services (and not government policies focused on population health).

* Modern medical care is extremely costly (in aggregate) everywhere, compared to any other government program, so has to be a major factor in efforts to control budget totals.

* Budget-makers get an endless supply of advice from health policy expert communities; unfortunately most of it doesn’t help them with their problem. Their problem is how to keep spending within some target next year, while not forfeiting too much political support by making the public angry.

So what can budget-makers do about all this?

**Blame Avoidance**

The main thing they do is seek ways to avoid blame.

A few common approaches are:

* **Reducing spending without cutting services:** that is the advantage of limiting prices and having simpler systems of insurance or for paying for services. Of course this does not reduce blame from the medical industry.

* **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 for a long while.

Much of the “competition” agenda can be understood as another way to distance the budget-maker from the results of spending constraint. So can decentralization. In each case these are also efforts to avoid responsibility for details. The market closed that hospital; the government didn’t. 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.\(^{19}\) Unfortunately or fortunately (depending on your preferences) it usually doesn’t work. But we see attempt after attempt to offload the responsibility for details, and so the blame.\(^{20}\)

### Demand for Spending vs. Demand for Services

Budgeters also make use of the fact that *demand for spending and demand for services are not the same thing.* This actually cuts both ways: it’s good for dealing with voters, not so helpful in dealing with the medical care industry.

The public wants services but voters care much less about ensuring large incomes for medical providers, drug companies, hospital suppliers or anyone else who might be hurt by lower prices. That is why much of the action in budgeting for health expenditure focuses on prices, not volume.

Budget-makers, however, have to deal with the fact that while the voters care more about services than spending, the industry cares more about spending than services. Hospitals, doctors, device manufacturers and drug companies would rather get a given income from higher prices for fewer services. The industry will try to convince the patients that higher prices are needed to guarantee quality. Much of budgeting for health expenditure, therefore, involves attempts to break any possible alliance between the public and the

---

\(^{19}\) These arguments may also be made out of ideological faith, with equal disinterest in empirical reality.

\(^{20}\) Especially in England, where the current approach appears to be to just confuse the heck out of everybody. Not that, judging by the polls reported by Nick Timmins, blame avoidance was working all that well. Nicholas Timmins, *Never Again? The Story of the Health and Social Care Act of 2012* (London: The Institute for Government and The King’s Fund, 2012).
industry. Budget-makers need to be able to counter providers’ claims that spending restraint hurts patients. It helps that the public is somewhat skeptical of doctors if the issue can be defined as their income, rather than patients’ care. This is why American physicians focused their fire on “managed care” and its supposed restrictions on patient care in the 1990s, even as almost all the actual savings in that era came from lower prices.21

Although I am arguing that the desire to avoid blame suggests certain strategies, that does not mean budget-makers always follow that logic. The Obama administration is an interesting case. On the one hand, it managed as part of its health care reform effort to identify itself with the idea that the government should take steps to reduce physicians’ ability to choose services for their patients. This was not popular. On the other, in order to get savings that the CBO would score, they basically restricted prices and raised taxes.

**Timing Strategies or Games**

A third set of responses involves manipulating time frames for budgeting and advocacy. This can work in various and contradictory ways.

On the one hand, 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 short-term is what matters. 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. There are too many uncertainties about the long run. The political costs of budget decisions depend 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 Sept 30 to October 1 (so one fiscal year to the next) one year, and back the next year. 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.22

This is especially true when the government owns the supply so is fully responsible for capital expenses. It leads to a lot of deferred maintenance. Movements towards more contracting with the private sector in order to expand supply reflect a similar budgetary logic: the cost of new supply is spread over time (though also usually increased) by paying fees to

---

22 The pattern may be a bit different if there is a separate capital budget funded by borrowing. Which is the reason to have a separate capital budget funded by borrowing. For indications of the pattern in the NHS context, see Henry J. Aaron and William B. Schwartz, *Can We Say No? The Challenge of Rationing Health Care* (Washington DC: The Brookings Institution, 2005).
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, at least in advocating for 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.”23 This budgeting view has migrated into health policy as the campaign to “bend the cost curve.”24 It both complicates decision-making and creates a further disjunction between what people talk about and what they do.

A further kind of timing strategy addresses the difficulty of matching details to totals in a responsible way by announcing some form of long-term spending restraint. A government might, for example, establish five-year spending targets for health (or other) spending. Because it is simply less possible to provide detailed plans for five years, it is also less expected. Advocates for programs may tell themselves that the plans are fake anyway so can be fixed later. The pain is deferred so reaction may be less intense. Sometimes these measures include supposedly action-forcing mechanisms to enforce the targets.25 This kind of ostensibly long-term measure is above all a way to try to avoid responsibility for details. Its political dynamics are shaped by the fact that it can look better than anything more honest or immediate, and the calculations various sides will make about how binding the targets will be. For example, it is easier to accept something you oppose if you think you will have the power to fix it later. In any event, vague long-term plans with supposedly automatic enforcement mechanisms may be becoming a more common maneuver for health care budgeting.

* * * *

Program Form and Budgetary Dynamics

Although some aspects of the budget-maker’s problems are ubiquitous, how they play out depends in part on the form of the health care program.

Entitlements vs. Bureaus

23 See The Economics of Public Health Care Reform op. cit. for a typical example.
25 One example in the United States is legislation that creates automatic cuts in particular categories of spending if targets are not met; the original example was the Gramm-Rudman-Hollings law of 1985, but the 2011 legislation that increased the debt ceiling included such “sequesters” as of January 2013. A more responsible (it would be hard to be less responsible) approach is the Independent Payment Advisory Board for Medicare in the 2010 health care reform.
The first dimension involves the promise to provide health care. The government may create a health service or services, and then promise the public that it can obtain the care it needs from these bureaus. So the guarantee is of access to the bureau, and in that sense the bureau is the promise. 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, these are two kinds of programs: a bureau program, or an entitlement program. The form of the promise shapes the politics of expenditure. Bureau budgeting allocates funds to an organization; the level of service that follows depends on how the organization is managed. Entitlements, however, promise to pay for specific services, as incurred; for specific categories of people, as qualified; with payments determined by law or regulation. Policies to reduce spending normally need to address these choices, and thus the promise itself, directly.

In general, it should be somewhat easier for people at the top of the budget process to limit spending for bureaus than for entitlements. 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.” Yet while politicians may try to blame managers, or claim new initiatives will increase efficiency, at some point ownership will lead to blame.

If the program is an entitlement, however, expansions tend to occur through the internal dynamics of the health care system. So constraint requires direct changes in program rules such as payment rates or benefits. Politicians must make the explicit choices about constraint. They also cannot use the “fairness” defense for economy and say the agency managers should be able to make do with the “fair” allocation.

When dealing with an entitlement program, budget-makers therefore tend to 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. In some ways the ideal situation for avoiding blame might be to control bureaus but not formally own them – perhaps like Canadian provinces and Canadian hospitals. 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.

**General Revenue vs. Dedicated Funds**

The difference between a bureau system and entitlement system is one aspect of the common health policy distinction between Beveridge and Bismarck-style systems. That distinction also involves another difference: Beveridge systems being financed from 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 a bit more like Beveridge systems. 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 could 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. In general, public finance theory and budget professionals favor this kind of competition among programs and distrust dedicated funds.

Political authorities, however, may 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 for how much health expenditure they are willing to pay. 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 probably depend on whether the goal is to cut or to restrain increases, and on the budgetary environment. 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 one 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.

* * * * *

In Conclusion...

Budget processes generate a great deal of frustration for health policy-makers or advocates. Budget-makers likely feel the same way about health policy.

Within any government, then, one of the central questions will be the relationship between the health policy officials and community, and the budgeting officials and community. It 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 situations, governments may simply decide not to be consistent – not to worry too much about whether their budget policies fit their health policies. It is hard to figure out, for example, exactly how the budget policies articulated by the present government of Great Britain are supposed to fit with the 2012 health legislation.

But often governments actually want to have health policies that fit budget goals, and budget policies that fit healthcare goals. Then the possibility that the people responsible for healthcare have different objectives than the budget-makers becomes far more important.

In general, 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 the asymmetry of expertise may come into play. So 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.

The answers to these questions may change. Patrick Hassenteufel, William Genieys, 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. Yet in his most recent work, Professor Hassenteufel suggests that during the Sarkozy government, power was presidentialized, and the President’s office favored the budget staff while paying less attention to the health policy actors who were so influential during the previous decade.

One has to suspect that both the process and outcomes of the relationship between budgeting and health care policy ultimately depend on attitudes at the highest political levels. President Obama relied mainly on his Budget Director. Prime Minister Cameron appears to have relied mainly on his Secretary of State for Health. I look forward to learning about other countries.

---
