APPLYING PLANNED MARKET LOGIC TO DEVELOPING COUNTRIES’ HEALTH SYSTEMS: AN INITIAL EXPLORATION

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INTRODUCTION

The relationship between health system reform in developing as against in developed countries is a complicated one. On the one hand, arguing for a positive linkage, health systems in all countries - developing or developed - have essentially the same components (finance, production, allocation mechanism), with similar service needs (preventive and acute; primary, secondary, tertiary), drawing upon at least partially similar categories of personnel (physicians, nurses, health education workers). Further, these components typically interact similarly in terms of their clinical, epidemiological, financial, and sociological characteristics. Based on this perspective, knowledge gained through study of health system behaviour in developed countries - where there are more scholars engaged in analytic work - should be broadly relevant to health systems in developing countries as well.

Conversely, it is possible to make an equally strong case that there are few if any similarities between developing and developing country health systems. In advancing this thesis, one would argue that the economic base in developing societies provides a much lower level of per capita expenditures, the human and institutional resource base is less developed, the health needs of the population are different, and the appropriate balance among types of health workers is different. Moreover, one would argue that in this structurally different context, major health system components will not interact in the same manner as in a developed country framework.

To move the discussion beyond these two essentially opposite perspectives, one might argue that the interesting issue is to identify behavioral and/or organizational linkages despite or perhaps even within the differences. For instance, when are issues of public as against private ownership of health institutions similar in both developing and developed countries? To what extent can the same tool box of behavioral and economic mechanisms be appropriately utilized in a developing as well as developed context? Most importantly, what reform mechanisms from current experiences in developed countries can be adapted and successfully introduced in developing country health systems? In particular, can planned markets, designed by public planners to achieve public purposes, play a useful role in developing as well as developed country contexts?

In approaching these questions, this paper begins by discussing two key pairs of definitions. A brief review follows of recent experience with planned market mechanisms in developed countries, particularly in Northern Europe. The paper then concludes with a consideration of the ways that the conceptual framework utilized in recent developed country reforms might be applicable in a developing country context.
PART 1
DEFINING TERMS

A central pre-condition to any analysis is a consistent set of definitions for the phenomena under study. In the health sector, consistent definitions can sometimes be rather difficult to achieve. Thus, this section will lay out a general definition of two pairs of terms - **public** vs **private** and **competition** vs **privatization** - as well as define what is meant by the term **planned market**.

**Public versus Private**

A central distinction for an understanding of health system reform is that between the terms **public** and **private** (Saltman, 1993). On its face, this may seem to have an obvious response: **public** is what is owned by the government while **private** is everything else. In practice, the health care world in developed countries has become decidedly more complicated with regard to this issue.

Consider, first, the term **public**. In Northern European countries, there are in fact a wide variety of different arrangements of both ownership and operation of health care facilities that nonetheless are characterized as public. These public arrangements include ownership not only just by the State - by the national government - but also by regional and municipal levels of government. Health care facilities may be accountable to either elected public officials - as in the Nordic Region - or to appointed officials - as in the United Kingdom. In addition, beyond level of government, there are considerable differences in the type of supervision exercised by a public authority. Health care institutions can be directly managed, in a hierarchical or bureaucratic framework - as in the pre-1991 British National Health Service. Alternatively, they can be given substantial entrepreneurial freedom as quasi-independent agencies -- that is to say, entities that are publicly capitalized but then autonomously managed. Managed upon the basis of the objectives they are expected to achieve, managed in a strategic sense by the public authority, rather than managed on a day-by-day basis in terms of operations and inputs. A number of nationally owned airlines in industrialized countries are operated in this way. Port authorities have traditionally been operated in this manner. There is a rich literature and considerable information on how one structures quasi-independent public entities (Osborne and Gaebler, 1992). Thus, within the category of public, there is a sub-category of quasi-independent agencies which can be called public firms. Overall, the public sector has in fact a wide range of different structural options.

The term **private** is even more imprecise than the term **public**. First, there is the distinction between for-profit as against non-for-profit ownership. For-profit status indicates that private individuals have put up (or borrowed) the institutions' equity capital, and, having risked these funds in the business, expect to keep any accrued earnings. (It does not help definitional matters that precisely this type of for-profit enterprise, should it grow large
enough to issue stock, is subsequently termed a "public company". Not-for-profit, conversely, is an umbrella category that contains a number of different organizational formats (Weisbrod, 1989). The formal term refers only to ownership of capital: no group of individuals (or lenders) has contributed risk capital on which they expect to earn a profit. Instead, the funds remaining at the end of the budget year are referred to as "surplus." Definitional matters are complicated here too, in this case by the assertion of so-called "public choice" economists, who argue that senior executives inside not-for-profits typically appropriate a substantial proportion of their organization's "surplus" for their own personal use in the form of higher salaries and fringe benefits, in effect "privatizing" that surplus (Buchanan and Tullock, 1962). In practice, not-for-profit organizations can be religious, community, or geographical in character, from local to international in scope, and can run the gamut from amateur to professional in their management style and capacity.

Within both for-profit and particularly not-for-profit categories, there are a variety of different organizational options among health care providers. For instance, there is now an emerging group of small, worker-owned firms that have sprung up, particularly in Sweden, but in some areas in the UK as well. These are employees who formerly worked for the public system, but who, for various reasons, have pulled out and established their own activities. They can be not-for-profit, sometimes they are for-profit, but typically they have a close working relationship with the institutions that they previously worked for, and they still work for those institutions but they now do so on a limited contract basis rather than on a permanent salary basis. While technically, this type of endeavour can be either not-for-profit or for-profit in structure, in practice, it has a unique situation in that — as will be discussed later in the paper — such small firms often have a shared fate with the institution they work for. This makes them similar to what now occurs in certain manufacturing industries, where component makers have their fate linked to the success of, for example, the large car manufacturers that they supply. Of course, in the United States, at the other end of the for-profit spectrum, there are privately capitalized stock-issuing corporations that operate 150 or 200 hospitals across a 3000-mile distance. From one end of this spectrum to the other is the range of what can be termed private.

How does this analysis affect the decisions of policy makers? First, it suggests that there are a variety of ways to structure publicly owned institutions. There are a variety of decisions that can be made; it is not sufficient just to wave a verbal wand and say "we'll make these public". Alternatively, as has been the recent case (for well-understood historical reasons) in Central and Eastern Europe, it is equally insufficient to wave a different wand and say "we'll make all these private". Neither statement is informative about the wide range of options that exist within each category. It is important to underscore here that the options available in the public sector are equally varied, perhaps even more varied, than the options that are available in the private sector. While this is not how the relationship between public and private is commonly understood, it is what the process of reform in Northern European countries now teaches us.
One further point about the public/private mix draws on recent experience from the United States, although a similar phenomenon may be beginning to develop in certain health service sub-sectors in the U.K. (Higgins, 1988; Whitehead, 1994), and some commentators worry that recent reforms could trigger such a transformation in The Netherlands (de Roo, 1995). This issue involves not only the range of options — between public and private — but recent experience that, in certain contexts with certain pressures and forces let loose, private not-for-profit organizations may not behave very differently from private for-profit ones. In effect, after laying out the formal distinction between not-for-profit and for-profit, it becomes important to ask, "When do these organizational forms not behave as differently as we expect them to?" For example, the majority of hospitals in the United States still call themselves not-for-profit institutions. Many of them are still run by religious organizations - by the Catholic Church, by boards related to Protestant churches, or by community groups. In practice, however, as a result of the competitive forces now re-structuring the U.S. hospital sector, these not-for-profit hospitals have become all but indistinguishable from for-profit hospitals in many of their management and financial practices, particularly regarding patients who lack adequate insurance coverage.

To be sure, this profit-oriented competitive market has developed in the context of specific structural conditions in the U.S. hospital sector: overcapacity of beds; oversupply of certain medical specialties, and selective contracting by multiple private insurers. While some of these characteristics may be unique to the United States' health care system, the key point is that, over the last 10 years, in that country most distinctions in behaviour between a not-for-profit hospital and a for-profit hospital have essentially disappeared. This convergence has resulted in not-for-profit hospitals engaging in a number of unpleasant activities, including the so-called "dumping" of unstabilized emergency room patients onto public hospitals (Kellerman et al, 1988). Moreover, it suggests that, at least in the industrialized world, allowing one's health system to be dominated by not-for-profit provider institutions may set the stage, under certain circumstances, for the transformation of not-for-profit into the equivalent of for-profit providers.

**Competition versus Privatization**

The second key definition is the distinction between competition on the one hand and privatization on the other. If one thinks about these two terms logically, competition is a particular process through which to allocate resources. This method can employ a variety of operating mechanisms, of different tools that exist within a competitive market, including "consumer choice" or "consumer sovereignty" or "demand control"; "open bidding" or "closed bidding"; and "competitive contracts" or "non-competitive contracts". The central element of competition is that it is a method of allocating scarce resources in which the performance of different participants is compared in some fashion. After this comparison, decisions are made in which some participants win and some participants lose.
Privatization, quite differently, refers to the ownership of capital resources invested in actual facilities and institutions. In addition, at least implicitly, there is the assumption that the objective for which these funds will be deployed is also private. There is in fact a fiduciary — a legal — responsibility in most capitalist societies that require managers of a company to maximize the value of shareholders’ return.

The confusion of a process for allocating resources — competition — with a particular form of ownership of certain capital resources — privatization — and/or the assumption that the two are necessarily linked, has created some unnecessary dilemmas in a number of national policy contexts. Some policy makers have assumed that the only way to have the benefits of competition is to create a private market (Young, 1986). In reality, there is no necessary connection, in either a practical or an intellectual sense, between competitive mechanisms on the one hand and private ownership of institutions on the other.

There is now considerable experience in the health sector in Northern Europe that demonstrates that it is not necessary to have private ownership in order to have competitive incentives. There can be public ownership of institutions — as in the health sector in Sweden or Britain — and intense competition. Conversely, in other sectors of the economy, there are well-known instances in which private ownership of capital resources has led to monopoly or oligopoly rather than to open-market competition. A traditional example is the public utilities model, which can refer to gas, electric, water, and recently, in some countries, the telephone industry, all of which typically are operated as private monopolies. In these sectors, there often is private ownership of institutions but no competition.

Concrete experience thus suggests that it is valuable to separate these two concepts. In terms of designing tools, of deciding how one wants to resolve particular problems in health systems, these two concepts represent two different options that are not necessarily linked, and which need to be assessed independently. National health policymakers can in fact choose to have competitive incentives without necessarily choosing to have private ownership.

_Planned Markets_

The concept of a _planned market_ is sometimes confused with what has been labelled an _internal market_. The notion of an internal market, as put forward in the UK in 1985 by a United States economist named Alain Enthoven (Enthoven, 1985), and subsequently picked up by Mrs. Thatcher and her cabinet review in 1988, had an internal contradiction in its very definition. Both Enthoven and Thatcher referred to what they called an internal market, and then described a market arrangement that involved private as well as public institutions competing with each other. Internal, of course, should mean "inside the National Health Service." Formally, what Enthoven and Thatcher were describing should have been termed a "mixed market" — mixed public and private — similar to a mixed economy. In the event, history had its revenge. The United Kingdom now has in practice an internal market — its
health-care market being almost completely internal to the National Health Service. Thus, what was set up as a mixed market but misnamed as an internal market has become in fact an internal market.

There are, of course, other names which have been applied to these new arrangements. These included "provider market", which is to say a market among providers on the production side of the system (IHSM, 1988), as well as "regulated competition" (van de Ven, 1995) and "managed markets" (Ham and Maynard, 1994). Another concept was "public competition," in which there would be competition but only among publicly capitalized institutions (Saltman and von Otter, 1992). This list of terms reflects varying ways to describe the use of market mechanisms inside what were wholly publicly capitalized, wholly publicly operated health systems in Northern European countries.

The above-noted terms can be summarized with the phrase planned markets, in that they all attempt to use market mechanisms inside what remain entirely (or, in the case of mixed markets, predominantly) publicly planned structures. A planned market can be defined as an intentionally constructed market which is designed by public sector officials in order to achieve public sector objectives.

Some economists have difficulty with the concept of a planned market. They argue it can not be a market if it is designed intentionally by public planners to serve public objectives. Yet, what is emerging in Northern European health systems are markets of exactly this character. What a planned market seeks to do is to harness market mechanisms -- specific market mechanisms taken from neoclassical economic models but stripped of their connection of private capital -- by injecting those market mechanisms into an existing public system in such a way that they achieve the same public goals, but through decidedly different means. In effect, a planned market is merely a different means to achieve the same public end.

PART 2
RECENT EXPERIENCE WITH PLANNED MARKETS IN DEVELOPED COUNTRIES

The current reform process in European and indeed health systems in all OECD countries reflects a fairly consistent set of pressures. There are three basic forms of external pressure (external to the health systems): first, demography, specifically the aging of populations; second, technology, which involves the development of both less-invasive procedures like laparoscopy and endoscopy as well as more intensive, heroic body part transplants. The third pressure is that of the economy. This third pressure is reflected in two different linked processes. One is the regionalization of economies -- the integrated internal market within the countries of the European Union is one example of that process of regionalization. At the same time, there is a globalization of production, with companies looking for "offshore platforms" for manufacturing and assembly. Both economic pressures have led economists to argue that the size of the public sector generally has to be reduced in
order to free up capital to invest in the private sector, thereby enabling private sector
companies to become more competitive in these evolving regional and global economies.

Beyond these three external pressures, there are three internal pressures that have
been heightened by the computer revolution and the vast potential of computerized
information in the health sector. One is the need for increased efficiency, e.g. more
productivity from existing resources in health systems. The second is pressure for increased
effectiveness, which can be defined as achieving better outcomes. This pressure is expressed
across a continuum from a growing number of clinical studies that analyze the outcomes
achieved by particular procedures to the increasing emphasis upon primary and preventive
health services. The third is responsiveness to patients: trying to meet the logistical and
treatment preferences of patients as well as the broader epidemiologically defined needs of
populations.

Assessing Health Sector Tensions

In response to these external and internal pressures, a series of tensions have emerged
within policymaking circles in developed countries. A central tension concerns the definition
of health care itself. Is it a social good, which means that all members of society benefit
when a single individual receives care? The classic example is immunization, which not
only protects the individual immunized but which simultaneously removes the potential that
an epidemic could spread across the entire population. Or, alternatively, is health care just a
commodity, something to be bought and sold on the open market? In this view, health
services only benefit the individual who receives them, and there is no broader interest of
society in whether an individual does or does not receive a given service. A further question
is how one responds in policy terms to the distinction between these two?

A second policymaking tension concerns the objective or goal that a health care
system should strive to achieve. Should it be solidarity, in which everyone is in the same
situation? Or should it be efficiency, such that the purpose of a health system is to maximize
efficient utilization of productive resources? Further, is there some way to link efficiency to
solidarity, such that greater productivity reinforces rather than undercuts solidarity?

A third tension within developed country health systems concerns who decides the
appropriate level of services to be provided. Should it be the public planner and the
epidemiologist? The health economist? The individual citizen? The politician? The
Corporate strategic planning executive? This tension is currently reflected in health reform
debates about priority setting and rationing in a number of countries (Ministry of Welfare,

A fourth policymaking tension has to do with the role of individual provider
institutions, particularly hospitals. What should their institutional objective be? Should it be
community-based mission, which is to say, serving the needs of the citizenry in the
community around them? Or should it be market share and competitive advantage, e.g. attracting a larger patient volume and/or a larger income?

Lastly, what ought to be the central mechanism to steer the system, to determine its basic direction? This debate raises once again the dichotomy between public sector regulation as against market oriented mechanisms of authority.

Designing Competitive Markets

Once a policymaker has decided to use competitive mechanisms in a health care system, there are a number of different options among which to choose — just as when deciding whether to take a private or public sector approach. Adopting a competitive approach to health policy is thus the beginning of a decision process, not its end.

First, there are a variety of different ways to design competitive markets for the health sector. Markets can be based on price, on quality, or on market share (Saltman, 1996 forthcoming). The example of a market based on price would be the United States airlines industry, in which it is the price of the ticket -- not the quality of the service -- that is the basis of corporate strategy. The European airline industry, by contrast (at least until recently) typically based corporate strategy on quality rather than price. A market constructed on market share can be defined as combining price and quality but at the level of each competing organization. There are now health sector markets in countries that utilize price as the predominant basis for decision (the UK), as well as others that are based on quality (Sweden). A market designed on quality recently began to emerge in the city of Vienna, Austria, as the result of an experiment within its publicly operated hospital system (Koeck and Neugaard, 1995).

Second, it is possible to utilize different market-style mechanisms, drawn from specific instruments used in the neo-classical economic model. The core market mechanism, for example, can be a system of negotiated contracts, or it can be patient choice and consumer sovereignty. Although both mechanisms are drawn from the neo-classical model, they are conceptually contradictory approaches. A negotiated contract means that a manager decides which service provider to utilize, and then the patient follows the money to that facility. Patient choice works in precisely the opposite manner, in that it is the patient who decides where to go -- which hospital, which doctor -- and then a set payment follows the patient. Sweden is an example of a system that has been trying to use both mechanisms, despite the obvious fact that it is not possible for the money to follow the patient while simultaneously the patient follows the money. Thus far, in Sweden, patient choice has had the predominate role, somewhat to the chagrin of some county-level planners and politicians. This example demonstrates, however, that a market need not be internally consistent, which in turn suggests that policymakers ought to be clear about which specific competitive mechanism they intend to adopt.
A third aspect of designing competitive markets in health care is that they can be introduced in different sectors of the health system (Figure 1). They can be utilized on the finance side, in how revenues are raised. They can be utilized on the production side, in how services are delivered. They can be designed for what can be called the allocation mechanisms, which are the entities that distribute the finance that is raised to the institutions that produce the services e.g. the provider payment arrangements (Saltman, 1994b).

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Figure 1: Three Basic Components of Health Systems

In turn, the three different elements within this analytic framework can be constructed in a variety of ways. Concerning finance -- how funds are raised for health care -- there are a number of ways to raise the money. Funds can be generated through general tax revenues, through social insurance premiums, through private insurance premiums, and through individual (or, in the developing world, family or village) self-pay. There are health care systems in different parts of the industrialized world in which the funds come predominately from each of these three. A number of the Northern European health systems are based predominantly on taxes, while most continental European countries are based predominantly on social insurance premiums. The United States is a country in which health care funding is based primarily on private insurance premiums. Of course, in nearly every country, additional funding elements beyond the predominate one are utilized as well.

Turning to the production system, the various components are straightforward: they are the service provider units. However, there are a number of alternatives with regard to allocation mechanisms - in terms of taking the funds that have been raised and distributing them to the provider units. One traditional approach is the integrated model, involving budgets and salaries – the old British NHS being the classic example. Alternatively, finance can be distributed to the production side through contracts, or through reimbursement. Reimbursement usually is configured on a per-case basis and can be either prospective or retrospective in character. Prospective indicates that the price is set in advance; retrospective that the price is set after the service is delivered. There is thus a range of different policy options in terms of how to distribute accumulated funds to the production side of a health system.
Present Reforms in Northern Europe

Several key points can be made about the present reform process in Northern European health systems and in OECD countries generally. The first is that, even though there is some activity on the finance side, it remains rather minimal (Saltman, 1994b). There continues to be little serious interest across 23 of the now 25 OECD countries in designing competitive markets to raise funds for health systems. Of the remaining two OECD members, The Netherlands has been trying since 1987 to find a way to introduce competitive mechanisms on the finance side while still maintaining solidarity. They have been broadly unable to achieve this objective (de Roo, 1995; van de Ven and Schut, 1995). Experience in the second country - the United States - with its existing competitive market on the finance side, continues to reflect severe cost, quality and access problems. The now-defeated Clinton Plan was in substantial measure an attempt to consolidate the process of competition on the finance side, in order to mitigate its worst consequences.

What is taking place within OECD countries is substantial activity on the production side of health systems, involving different ways of organizing hospitals and doctors; and with regard to the allocation mechanism, employing different ways of paying providers (Figure 2 on page 12). Regarding the allocation mechanism - or what also can be termed the provider payment system - reimbursement systems can, as noted above, utilize different mixes of market mechanisms: patient choice, negotiated contracts, open bidding. Moreover, recent reforms in developed country health systems are not entirely competition oriented. There also has been an increase in the use of regulatory mechanisms - e.g. of State-based intervention. One example of increased regulatory efforts can be seen in Germany, with the introduction in 1993 of reference pricing for pharmaceuticals. In other OECD countries as well, recent efforts to constrain pharmaceutical expenditures have turned to regulation - not competition - as the primary mechanism of reform.

It is, further, worth noting that efforts to introduce competitive incentives into the allocation mechanism of a health system has served to illustrate a chronic structural problem. Health systems have three levels of service provision: the hospital sector, the primary and/or ambulatory care sector, and (in the industrialized world) the social care sector. Yet in publicly operated health systems in Northern Europe, there typically are only two levels of public sector responsibility or oversight. In the Nordic countries, there are two public health-related budget holders: a regional budget (for example the county budget in Sweden, or the central hospital district budget in Finland) and the municipal budget. The challenge is to devise an organizational strategy by which to obtain coordination between three levels of publicly provided services with only two levels of budget-holders (Saltman and von Otter, 1995).

One particularly pressing problem concerns the best location for primary care. The Swedes decided that primary care should be part of the county system at the regional level,
in combination with the hospitals. This arrangement creates better collaboration between these two sub-sectors of the health system, but co-ordination with social care remains more complicated. One recent reform in Sweden has been to link the public hospital/regional and social care/municipal level services through the introduction of competitive incentives (Anell, 1995). The Finns, developing an alternative model, placed primary care at the municipal level of government with social care, to create a better link between these two sub-sectors. But the issue then becomes how to link those two to the hospital. The 1993 Finnish reform adopts contract-based competitive mechanisms in an effort to try to tighten this specific budgetary link (Brommels). In part, the utilization of competitive mechanisms inside the public sector in recent Nordic reforms -- the desire to introduce planned market models -- has been an attempt to transcend this structural dilemma of having three health sub-sector components, but only two levels of budgeting in public systems.

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<td>Positive lists for pharmaceuticals</td>
<td>Improved coordination between health and social services, especially for elderly</td>
</tr>
<tr>
<td></td>
<td>Co-payment and deductibles</td>
<td>Quality improvement</td>
</tr>
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**Cross-cutting initiatives**

- Improved information systems
- Enhanced preventive services
- Patient rights

*Figure 2: Current Reform Instruments*
Assessing Finance-Side Competition

Having briefly surveyed the health reform landscape, it may be worthwhile to return to the issue of competition on the finance side of health systems, to note the dilemmas of attempting to stimulate competition among different private insurance companies. This is a particularly important issue for the discussion of health financing questions in developing countries, since the problem of identifying adequate financing tends to dominate developing countries' health debates (Creese, 1995).

Finance-side competition creates a number of social and structural complications. The first is adverse selection. If there are a number of different competing insurers, it is easier for an insurer to make money by underwriting only healthy people, rather than by running an efficient service delivery system. Examples of this strategy can be seen in the United States, where some Health Maintenance Organizations (HMOs) and other insurers have tailored the services they offer and/or the location of their health centres, to exclude poorer, minority, and/or other high risk subscribers. For example, an HMO may offer good dental services but no service for dentures, since elderly people without teeth tend to be in worse health and are more expensive subscribers (Luft and Miller, 1988).

Selective disenrollment is a second problem. Even when a private for-profit insurer enrolls only healthy people, if a subscriber should become seriously ill, there is a strong financial incentive to convince that individual to withdraw from the plan. This can be accomplished through a number of relatively well-known techniques. The classic approach is to tell a patient that "we'd dearly like to help you, Mrs. Jones, but our specialists don't have the precise competence you need."

A third complication of competitive financing arrangements is high administrative costs. The United States has been estimated to spend between 19 and 24% of its total health care resources on administration, in considerable part due to the consequences of finance-side competition (Woolhandler and Himmelstein, 1991; Woolhandler et. al., 1993). The generally accepted figure in Britain or Sweden is from 5 to 7% for administrative costs. The United States thus spends four times more on administrative activities not related to delivering services. It is interesting to note that high administrative costs appear to be a consequence of for-profit managed care firms as well. A recent New York Times survey found that in 1994, for-profit HMOs spent up to 27.1% of their revenues on administrative costs (Freudenberg, 1995).

Fourth, in order to try to counter the social consequences of adverse selection, it becomes necessary to introduce muscular State regulation. Oddly enough, the more one uses market mechanisms on the finance side, the more regulation those market mechanisms require if they are to still achieve public sector economic and social objectives (Saltman, 1994b). This seemingly counter-intuitive need for increased State intervention is a problem in market-based health care reforms generally, reflecting both the broadly unstable character
of markets as such (Polanyi, 1944) as well as the particular social good character of health services.

Fifth, finance-side competition tends to de-emphasize preventive health and medical services. Private for-profit providers necessarily focus on achieving short-term financial results. Like other businesses, they are judged by investors in terms of their semi-annual and annual profitability. Such accounting requirements make it difficult to justify paying for health promotion and health prevention activities unless these services will have an immediate effect on the insurer’s bottom line. Immunization, for example, has a direct positive impact on costs. Smoking cessation, typically, does not. Private insurers thus tend to emphasize what is cost effective for the insurer, not necessarily what will produce the greatest health gain for the individual or the population as a whole.

A related issue is that private insurance companies can buy each other out or, on occasion, go bankrupt. This can result in disruption of health services and/or higher costs to subscribers.

Sixth and last, as the Dutch have found out, it is difficult to combine private insurance companies with solidarity (de Roo, 1995). In particular, it is hard to develop a risk-adjusted formula which is sufficiently well calibrated that chronically sick or otherwise high risk individuals will still be economically attractive to a bottom-line oriented insurance company (van de Ven and Schut, 1995). It is a matter of some irony that the Dutch, who abandoned their earlier planning model because they said the State was incompetent (Saltman and de Roo, 1989) have now spent seven years trying to put into place a model within which the State must be highly competent in order to monitor, regulate, and maintain operating stability.

There is one instance of the use of finance-side incentives which has produced positive results in Northern Europe. As noted earlier, Sweden has sought to stimulate a more efficient connection between the hospital sector and the home-care sector or social sector by using competitive incentives to link their budgets together. This approach has sought to overcome the separation of hospital (county) and social service (municipality) budgets in Sweden, by drawing on a market-style mechanism first employed in the Danish region of North Jutland. Once an elderly patient is declared to be medically ready to leave the hospital, then the municipal social service unit has five working days to accept that person and to provide the social care he or she requires. If after five days the social services have not accepted the patient, then the municipality must pay the full cost of keeping the patient in the hospital for however many additional days he or she remains there.

The assumption on the part of the counties in Sweden, when this was put in place, was that they were going to receive a considerable sum from the municipalities. In the past, the municipalities had left elderly patients people in hospital for up to 12 months. Indeed, such patients had come to be termed "bed blockers," and they were one reason that Swedish
hospital capacity had grown so large, particularly in medicine departments. While there was no dispute that such prolonged hospital stays were bad for patients, since they didn't receive the occupational therapy and other appropriate care that they would receive in a less intensive environment, little progress had been made through planning measures such as joint cooperation committees in resolving their situation.

When this new market-like arrangement was implemented, the actual outcome differed substantially from what the counties had anticipated. Within the first year, the municipalities took back and provided care to 85% of the patients that had previously been bed blockers (Johansson, 1996 forthcoming). As a result, the counties received only a small proportion of the additional funds they had been expecting. This example suggests that a well-targeted competitive mechanism can, in the proper circumstances, more successfully link different sectors of a public system together than can a traditional bureaucratic planning arrangement. Moreover, the benefits achieved were clinical and social - in terms of more appropriate patient care - as well as financial in nature.

Assessing Allocation and Production Side Competition

In contrast to the paucity of reform activity in industrialized countries on the finance side, there is an extraordinary amount of ferment on the allocation and productive sides of these health systems. On the allocation side, one can point to three major instances in which competitive incentives are being used to re-structure relationships inside health care systems, and particularly within publicly operated systems like those in Northern Europe.

First, there has been a rapid increase in the use of various types of contracts. Typically, these new contract relationships have re-structured what were previously unitary command-and-control public bureaucracies into some form of purchaser-provider arrangements. The new contracts involve a revised distribution of responsibility within what remains a publicly owned, publicly operated health system. On the purchasing side, one or more purchasing or commissioning authorities are established. Similarly, on the provider side, hospitals and health centres are restructured as quasi-independent entrepreneurial entities which receive their funds not from a fixed budget but in direct relationship to their performance. In the United Kingdom, these new provider agencies are known as self-governing trusts; in Sweden and Finland they have been termed public firms (Smeets, 1995; Anell, 1995). The key element in this contract process inside public sector health systems is that hospitals must receive contracts from purchasing authorities if they are to have patients and incomes. In turn, the purchasing authorities can stipulate a variety of factors about hospital performance, including volume and quality characteristics, as well as price. This type of market typically leads to negotiations on the basis of price competition among providers, and can be considered to empower managers, both in the purchasing authorities and in the newly entrepreneurial public firms.
A second, quite different competitive mechanism is reliance upon patient choice as a way to steer certain acute-care public sector budgetary patterns. In these reforms, patients are given the opportunity to make the logistical choice about which hospital and which physician they will see inside the publicly operated health system (Saltman, 1994a). In turn, hospitals and sometimes physicians are paid - from public funds - in some relationship to the number of patients they attract. This patient-led form of competitive incentive mirrors the role of consumer sovereignty in market economics, however it applies only inside publicly operated facilities, and patients bring with them a fixed fee set by public planning officials. Moreover, these fees can be set to ensure that total expenditure stays within a previously fixed budget ceiling. This arrangement is thus not just a standard fee-for-service system. In this patient-based market, providers typically compete for patients on the quality of their services - indeed this type of patient-driven framework can be termed a quality-based rather than a price-based market (Saltman, 1996 forthcoming).

The degree to which health care systems have adopted patient choice as a mechanism of resource allocation varies among countries. In Northern Europe, Sweden has since 1991 allowed patient choice of both primary care and hospital site, and has backed that decision up financially by having the "money follow the patient." Indeed, patient choice can be viewed as the predominant competitive mechanism in Sweden, since purchaser-provider contracts can and have been overruled by patient preference (Saltman, 1994a). This is, of course, only logical, since managerially-let contracts would require precisely the opposite financial relationship - as it has in the UK - requiring that "the patient follow the money." Thus, at each level of service, policymakers must take a decision regarding these two antithetical types of competitive mechanisms.

The third type of reform among allocation mechanisms has been productivity payment for general practitioners. Instead of fixed salary, the reforms have emphasized a GP payment structure in which a base salary reflects educational level, to which is added some type of capitation mechanism tied to the number of patients on a list. A third component also is typically utilized: in the UK, it is fee-for-service for certain preventive acts; in Finland, the third component is fee-for-service for curative acts. Through these second and third components, a competitive incentive is created for a general practitioner to serve each patient and to keep that patient satisfied. In turn the GP feels that he or she is, in part, being paid for the volume of work done.

A related but equally important set of reforms concerns broader efforts in Northern Europe to give either part or all of hospital budgets to primary care, such that the primary care physician in effect controls payment to the hospital. In some ways, this is may be the most radical and most controversial aspect of what is taking place with market incentives in Northern Europe. In these new arrangements, the GP pays the hospital only when the GP refers a patient to it for care. It makes the hospital dependent by making specialist care dependent on primary care. This has been an objective in Sweden since 1948 (Serner, 1980), and in a number of other Northern European countries for up to 20 years. Different
countries have utilized different mechanisms in their efforts to achieve these objectives. In the UK, private GP fundholders now purchase elective and diagnostic services, while a new pilot program allows GPs to purchase all hospital care. There are two counties in Sweden that are utilizing a similar approach — Stockholm and Dalarna — but employing public political boards at the local level responsible both for all primary care and all hospital services (Anell, 1995). In Finland, this notion of giving budgets to primary care has meant that all monies for the hospitals go to municipally appointed health and social boards, which are responsible for paying the hospitals (Brommels, 1995). This had officially been the case before, but in Finland the 1993 subsidy reform has made it real. One interesting point is that while in the UK, hospital budgets have been given to private GPs, in Sweden and Finland hospital funds have been allocated to publicly accountable local political boards.

**On Constructing Contracts**

Three further points can be made about ongoing reforms in developed countries. The first concerns the notion of contracts. This bears on the ability of a public sector institution to successfully cooperate with private sector institutions, or, conversely, helps define when it will become more difficult to utilize private companies to achieve a public sector objective.

There are a variety of different ways to write a contract. A universal contract covers all people or all services; while a selective contract covers some people or some services. A hard contract fixes the price fixed in advance, incorporating an adversarial, arms-length relationship, in which if something goes wrong one goes to court. A hard contract could be re-defined as a litigable contract. Alternatively, a soft contract often involves common ownership, and typically occurs in the private sector inside large corporations between separate internal units (where it is known as "transfer pricing") as well as in the public sector, specifically in health systems. A soft contract implies a relationship in which approximate price and volume are discussed, but at the end of the year the contractees decide what the price should be, based on what both sides require to meet their obligations. In a sense, with a soft contract the price is negotiated at the end of the contract, whereas with a hard contract the price is set at the beginning. A key distinction is that, with a hard contract, one doesn’t worry about the survival of the entity one is contracting with. In a soft contract, there may be common ownership, or perhaps equally valuable (if one is contracting public money to a private firm), there can be a shared fate, e.g. the contracting partners share the same outcome. A recent U.S. study noted, however, that all forms of successful public sector contracting require the contract-letting agency to be a "smart buyer" with high administrative competence and to exercise careful monitoring of contract fulfilment (Kettl, 1993).

There are numerous ways to structure contracts. **Block contracts** are based on a fixed sum of money without being tied necessarily to specific services. **Cost-per-case contracts**, or **price and volume contracts** can have price corridors that increase based on certain agreed volumes. Whether quality is included in a contract is contingent on the specific negotiation. Lastly, the issue of security versus risk shifting can be important. Typically, a hard contract is
a way in which a public agency shifts the risk of meeting the needs for care for a specific patient group onto a private provider, with the provider accepting increased risk in return for the security of regular income.

Decentralization Requires Increased State Regulation

A second point concerns the role of the State in planned health care markets. Regardless of how one decentralizes responsibility either inside the public sector or beyond the public sector to private entities (although all private entities need not themselves be decentralized; if they are large corporations they can be quite centralized), regardless of how one changes the structure of authority in health systems, there are certain key roles that remain or grow in terms of the responsibility of the national government (Saltman, 1994b). These responsibilities include setting and enforcing standards in the health sector, defining the appropriate package of services and/or benefits, and determining criteria for access. The State's role also should involve defining minimum quality standards, assuming there is a national health policy and all citizens are equally entitled to be treated under it.

In addition, State responsibility includes monitoring the behaviour and performance of both providers and (if they exist) insurers. The Swedes, for example, have established an effective and sophisticated set of regulatory mechanisms. These new regulatory standards are output oriented regulations, unlike old-style command-and-control or input oriented regulation (input meaning controlling the number of resources). The Swedish National Board of Health and Welfare now seeks to evaluate the outcomes from health sector activities within each county council to determine whether they meet the standards set by national policy. Further, State responsibilities also include establishing a centralized information collection system to provide data about the health sector's performance as well as to serve a credentialling function. Credentialling is necessary to ensure that patients choosing providers, or managers letting contracts, can only choose amongst those who meet minimum clinical, educational, and/or financial criteria. Credentialling should apply equally to medical professionals, providers and insurers. Although it may initially seem counter-intuitive, precisely the process of decentralization in health system structure thus requires a new and strengthened role for the State.

Renewed Interest in State Regulation

A third, related point about reform in developed countries' health systems concerns the role not of market-style competition but of traditional governmental regulation. Alongside various experiments with competitive mechanisms, national governments also are introducing more traditional regulatory measures in certain sectors of their health care systems. One area in which this has been true has been pharmaceuticals. A number of governments have now introduced various cost constraint measures such as reference-pricing and/or negative lists (e.g. drugs that cannot be purchased with health insurance funds).
In 1993 in Germany, the national government introduced Länder-specific ceilings for outpatient pharmaceuticals (Busse and Howorth, 1996 forthcoming). If these ceilings were exceeded, office-based physicians would have to make up the initial excess (up to 280 million DM) from their own insurance fund payments. This regulatory measure resulted in a drop of 8% in outpatient drug expenditures in the first eight months of operation (Financial Times, 11 November 1993). A second example from Germany comes from the finance side. As a way to better fund nursing home and home care services, in 1993 a new social insurance program was established requiring a mandatory contribution of 1% of salaries of all employees (the contribution is split equally — as is typical in the German sickness fund system — between employer and employee) (Wasem, 1996 forthcoming). Once again, regulation rather than competition was believed to provide the best solution.

As both the second and third point suggest, the current period of health system reform in developed countries is not exclusively one of reliance upon the introduction of market-style competitive incentives. Rather, there is a mix of mechanisms being deployed. Overall, however, the major distinguishing characteristic of this period of health reform in the industrialized world — beyond its near-universality across almost all countries — is the newfound reliance upon various competitive mechanisms to improve the micro-efficiency of provider institutions and professionals.

**Obstacles and Lessons**

Having described the characteristics of current health reforms in developed countries, it remains to say something about the obstacles to reform and major lessons to date. The obstacles to reform are not surprising. They include the following (Saltman, 1994b):

1) It has been harder than expected to implement reform;
2) Market-oriented reforms have required increased, although restructured, national regulation;
3) There are conflicts between different policy objectives - for example, between negotiated contracts and patient choice;
4) Transaction costs for contract-based market mechanisms have been higher than anticipated, raising questions about overall cost effectiveness.

Moving beyond obstacles, one can point toward three important lessons from current experience with reform in the developed world. First, market style mechanisms in health systems appear to have the greatest potential in the production or the allocation sectors of the health system. Conversely, they do not seem to have much potential on the finance side. Second, market mechanisms appear capable of improving short-term micro-efficiency, but their long-term financial effect is not known, nor is their long-term impact on the actual health-related effectiveness of systems. Neither financial outcome nor effectiveness has yet been adequately evaluated, reflecting the fact that the reform process is a relatively new one.
The third lesson - one worth stressing - is that context and history are important factors in the likely outcome of reform initiatives. Market mechanisms have been valuable and are seen to be valuable in Northern Europe precisely when they are introduced in publicly regulated, publicly accountable health systems. This does not necessarily mean publicly owned, but rather, systems in which there is a strong sense of public responsibility and an articulated structure of expectations that providers feel obligated to fulfil. What has succeeded has not been just the application of market mechanisms regardless of the broader environment or context. This is a crucial factor which policymakers ignore at their peril.

PART 3
PLANNED MARKET LOGIC IN DEVELOPING COUNTRIES

Questions about the appropriate public/private mix within a health care system, and related issues surrounding the structure and outcome of planned markets in the health sector, go to the very heart of the current health care debate in developed countries. Beyond pressures to improve efficiency, effectiveness, and responsiveness to patients, questions about public/private mix and the role of planned markets penetrate to the core political objectives that national health policy seeks to achieve. Given this degree of centrality, it would seem natural that a number of these issues are relevant to at least some developing countries as well. Given, however, the distinctions between developing and developed countries noted in the Introduction, it also would be unlikely for all developed country issues to be appropriate for discussion in a developing country context. Further, given differential levels of development between different groups of developing countries, as well as between regions within many countries, it may well be that some developed country issues are relevant only to part of some developing countries. One need not be seeking to impose solutions from developed onto developing countries’ health care systems to recognize where certain generic similarities exist.

The review of recent developed country issues in Part 2 suggests a number of analytic points that might well be useful to national health policymakers in developing countries. Perhaps the first policy message is that the public sector is, indeed, alive and well in countries that have adopted a planned market approach to health reform. Far from succumbing to privatization and private for-profit or not-for-profit objectives, publicly operated health systems are in the process of re-designing and strengthening their ability to achieve public sector health objectives through publicly owned and operated institutions.

This leads to the second message, which is that there are many different ways to restructure a publicly operated health system in a market-incentive-oriented direction. Such concepts as public firms, capitated general practitioners, negotiated contracts, patient choice, and intra- and inter-governmental financial incentives, as well as other similarly innovative concepts, all suggest that national policymakers have considerable latitude in how they seek to achieve official public sector health objectives. In the developing as well as the
developed world, market mechanisms, incentives, and structural innovation can be as much a characteristic of public as of privately operated health providers and health care systems.

A third related message concerns the diversity of competitive tools and formats that national health policymakers can adopt. Different competitive strategies, utilizing different market-style mechanisms, can be tailored to fit specific national circumstances and particular health policy objectives. There can be, in effect, many different types of health care markets, relying on a variety of market-style incentives (some contradictory, as already discussed).

A fourth message concerns the counter-intuitive notion that increased decentralization requires enhanced State standards, monitoring, and evaluating, in order to prevent decentralization from deteriorating into fragmentation. This is a lesson that Russia, among other countries in Central and Eastern Europe, is currently learning. Indeed, a market-oriented health policy may well require almost as much state activity - although different in focus and purpose - as did the prior governmental planning approach.

Beyond these four points of similarity, there remain important points of uncertainty if not divergence. In developed countries, for instance, market incentives appear to have the greatest potential on the production side and allocation dimensions of health care systems. This reflects, as discussed, the socially and economically deleterious consequences of competitive behaviour on the financing side of the health system. Yet, a key characteristic of many developing countries' health system is insufficient revenues from public sector sources, hence a need to attract private funds for health through private insurance, community self-insurance, self-pay, and also contributions by non-governmental organizations. It would thus appear that poorer developing countries may have considerable difficulty in following developed countries in creating single source, publicly accountable health financing systems. Alternatively, wealthier developing countries like South Korea and Tunisia may find that they have sufficient financial capacity to introduce more uniform, mandatory insurance structures similar to those in developed countries (Anderson, 1988; World Bank, 1993).

A second, similar dilemma exists on the issue of public as against private provision of health services. Some developing countries face certain health policy problems from a different perspective than do countries in the developed world. In poorer developing countries, for example, it is difficult to insist that physicians work solely for the public sector since public salary levels are so low. Indeed, if wealthier patients pay for services privately, more of what are severely limited public funds remain for use by poorer patients.

Yet there remain many concerns about the economic, social, and clinical quality consequences of allowing a multi-tier public/private delivery system. These concerns, typically focusing on the behaviour of private-office-based physicians, include lower quality of care in the public sector, and the provision of expensive, unnecessary and/or duplicative services to private patients (World Bank, 1995). In better-off developing countries, there is the possibility that private for-profit hospitals may drift toward the commodity orientation to
health services which characterizes for-profit provider institutions in developed countries like the United Kingdom and the United States (Higgins, 1988; National Institute of Medicine, 1986).

Thus, it may be difficult for developing countries to conclude that in the delivery of health services, as Deng Tsou Ping once put it about the Chinese economy in general, "It doesn't matter if the cat is black or white, but only if it catches mice." Given the debate over whether health care is a social good or an open-market commodity, the response might well be "but what type of mice are to be caught? Individual acute curative care or population-based primary and preventive activities?"

While the need for multiple sources of health care finance and provision reflect the difficult economic circumstances in many developing countries, there also can be dilemmas in developing countries of a political nature. It is not uncommon in the developing world - and in the countries of central and eastern Europe and the former Soviet Republics as well - to find that political power is fragmented among several groups and that, as a consequence, the government is not particularly stable. In these circumstances, it may be appropriate to speak of these countries as having not only an emerging market but also an "emerging State." This fragility of political as well as economic power can seriously complicate the ability of policymakers to successfully pursue innovative health sector reforms. In some countries, further, there may not be an adequate dialogue between the technical experts and the political decision-makers, compounding the ability to implement and sustain innovative reform programs.

A further structural dilemma that developing countries confront concerns the managerial and organizational infrastructure necessary to implement successful reform in the health sector. Capacity development in institution-building has been described as having three linked characteristics: knowledge, process, and practice (Paul, 1995). If countries do not have an adequate pool of trained financial and operational managers, nor an institutional culture inside the health sector that is supportive of innovative initiatives, it may be difficult to implement and sustain some of the more sophisticated incentive-oriented reforms currently being utilized in Northern Europe.

Having recognized the diversity of service providers, on the one hand, and the importance of common health-related objectives, on the other, it may be appropriate to consider whether the lessons of soft contracting might somehow be applicable in developing country health systems. Soft contracting involves, typically, common ownership, which leads to ex post facto budgeting adjustments as each of the contracting parties might require. In the developing country context, where multiple forms of provider ownership is common, perhaps a suitable mechanism could be developed to bind the fate of private providers to that of the public sector. The goal would be to simulate the characteristics of a soft contract as much as possible by creating, in effect, a shared fate among private and public providers alike. This type of relationship already occurs in the manufacturing world, for example in
the automobile industry, between assembler and supplier. One intriguing challenge would be to design incentive and/or regulatory arrangements that could establish a similar bond within the health sector in developing countries, across public and private lines.

In the last analysis, it is not feasible to presume that any specific planned market model is appropriate for any particular developing country context. The best approach is to consider, instead, the possible adaption of planned market methods and mechanisms in a way that fits the historical, social, political, and economic context involved. In this regard, planned markets are like all other health policy strategies that have emerged from comparative studies: indicative options not prescriptive solutions.
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