“Divergent Neo-Liberalism: Building Welfare States in an Era of Markets”

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From Medicare reform in the United States to school vouchers in Sweden, markets have long been on the public services reform agenda in mature welfare states. Rhetorically, this debate has often been cast in terms of markets against the state, with markets promising the slim the size of the state – for better or worse. When we turn from the OECD to the developing world we see similar arguments. Here, markets have emerged in systems that are newer or less extensive, and have been promoted as an organizational alternative to the welfare state. Markets in the OECD countries though, rarely operate in a singular manner, raising questions about the impact of markets on developing welfare states (see Gingrich 2007). This paper examines this question, building on work developed through an examination of markets in the OECD to argue that markets in public services in the developing world vary substantially and that this variation is central to understanding their effects and political implications.

This approach contrasts with much of the literature focused on market reforms. Market reform in public services takes a number of forms, including contracting, purchaser-provider splits, vouchers, public-private-partnerships, corporatization of service providers, and outright privatization. Much of the literature on markets in social programs takes this list of reforms at face value, assuming an equivalent logic behind a wide range of practices and resulting market structures. One line of literature presents markets as the 'solution' to the problems of government, promising that a range of market mechanisms – from contracting to vouchers – will improve the efficiency, quality, and responsiveness of services (Lundsgaard 2002; Osborne and Gaebler 1992; Savas 2000). When it comes to the developing world, these arguments are presented with equal force. Influential non-governmental organizations (NGOs), in particular the World Bank, expended much energy in the 1990s promoting market reforms and decentralization in the developing world (World Bank 1993; World Bank 1995). While early enthusiasm about markets has, over time, given way to more qualified advocacy of them, markets and their outcomes are still presented in relatively uniform logic which often boils down to a claim that 'all good things go together.' Private markets offer greater efficiency, choice, quality, responsiveness, and flexibility than the public sector

and market reforms can bring all these potential benefits to the state.[1] In so doing, these approaches claim markets replace the state and offer an alternative to the corrupt and poorly functioning bureaucracies of the developing world (Shleifer and Vishny 1998).

A second line of literature presents markets in an opposing light, seeing them as essentially eroding the capacity and power of the public sector, to the detriment of citizens (Leys 2003; Pollock 2004; Suleiman 2003). These critical approaches also conflate a range of market reforms, with all market reforms undermining public governance and the public's interest. In contrast to proponents of markets, these critics argue that 'all bad things go together,' presenting a range of market instruments, from vouchers to contracting, as threatening. For these scholars, markets threaten service delivery, they threaten users of services, they threaten workers, and more generally they threaten the democratic process. These arguments are made forcefully in the developing world, with critics of pro-market NGOs and domestic market reforms emerging in both academic discourse and the political sphere (Sen and Koivusalo 1998). As with market proponents, this perspective sees markets and the state as antithetical, but rather than seeing this feature as something positive it presents markets as reducing social welfare.

A third approach rejects these uniform assessments of markets, pointing to a number of nationally specific features of markets. In these analyses, markets are powerfully shaped by pre-existing institutions and do not operate in single way. Equally though, markets do not offer a way for countries – developing and developed – to radically reshape services, as they are conditioned by existing national institutions.[2]

How then do we understand markets – are they good, bad, inconsequential? This paper advances two arguments that contrast with the above approaches – first, market reforms *do matter* as they alter the way services are produced and allocated, and second, markets *vary* substantially and this variation in market structures is as important as their presence or absence. Markets can be constructed in multiple, but not infinite ways, and

[1] While early advocacy of markets in the developed world has moved to more limited advocacy of markets aimed at identifying *when* they are appropriate, the logic of *how* markets operate remains relatively undifferentiated (e.g. Preker, Harding, and Travis (2000)

[2] There is a large theoretical literature on path dependence (Mahoney 2000; Piersson 2000), application to advanced welfare states (Pierson 1996; Tuohy 1999), and market formation in transition economies (Spenner et al. 1998). While the causal mechanisms associated with these analyses vary substantially, each argues that radical change is neither possible nor effective because of the nature of pre-existing institutions. While this paper draws on some of these ideas, it breaks with the emphasis on fixed national models

these differences shape how competition operates, what this means for service delivery, and who wins and loses from reform. Consequently, far from being a universal 'bad' or 'good', markets serve the interests of different actors depending on their design. To preview the argument developed below, I argue that there are profound differences among markets built around detailed contracting that actually increase *state* control, markets built through tendering out to *producers* in ways that leave the state powerless, and markets that use *user* choice as the main vehicle for competition, and these markets are further differentiated in how they place costs on users.

The first section of the paper develops a typology of market reforms, building off an analysis of market reforms in the developed world, primarily in European public services. The paper then examines how this typology fares when we look at market creation in three non-Western cases. These cases were selected because of their prominence in the literature on market reforms. Each of the countries has been described as an exemplar of market reform, using a 'textbook' or 'blueprint' approach to building markets, and yet when we scratch below the surface we see fundamental differences in how markets were built and used.[3] In Singapore, markets in health care have shifted new costs on to individuals but have also been used as a prong of greater state intervention in the health care system. In Colombia, by contrast, markets in health have left the state powerless, funneling new benefits to the producers of services. Finally, in Chile, markets in education have created new benefits for middle class parents, reshaping the education system around their interests. The conclusion reflects on the implications of extending an argument developed with reference to OECD states to the developing world.

How do markets work?[4]

The chief feature that distinguishes markets from other forms of organization is that they influence behavior by manipulating *incentives.* This method differs from hierarchical 'command and control' systems, where a central agency defines processes and outcomes, and from a 'network system' of management where users and providers

[3] For instance, Singapore's use of Medical Savings Accounts has been suggested as a model for the United States (Massaro and Wong 1995; Pauly and Goodman 1995). Scholars looking at reforms in Colombia argue that it followed the World Bank 'blueprint' for reforms (Homedes and Ugalde 2005). Chile is described as introducing a 'textbook' voucher scheme (Hsieh and Urquiola 2003).
[4] This section draws heavily on previous work (Gingrich 2007).

operate on the basis of mutual trust. But what are market incentives? This section argues that in contrast to the polarizing rhetoric around markets, there is reason to believe that the structure of market incentives in public services is variable. Many areas of public service activity are beset by market failures or imperfections that make the incentive structure malleable and give policymakers latitude in how they construct markets.

First, in the area of funding services, it is unclear how much public spending is optimal. The most compelling economic rationale for public financing of welfare services is that many such services produce 'positive externalities', meaning that purely private markets tend to under-supply these services. In other words, the benefits of these services accrue to both the individual and society and where individuals must bear the full cost of provision there will be a less than socially optimal amount of provision and consumption (Barr 2004). While theoretically, economic analysis could offer a rationale for a particular amount of cost-sharing between public and private, in practice externalities are difficult to measure and problems of moral hazard and adverse selection mean that there is not a single perfect balance between public and private financing.[5]

Second, technical aspects of the services also mean that market-like competition in their delivery – not just financing – differs from perfect competition. There are several specific features of public services. Both the presence of information asymmetries (i.e. where the supplier of the service, such as a doctor or social worker, knows more about the cost and quality of the service than the user) and imperfect information in many services areas make it difficult for consumers to 'shop around' for producers or insurers. This means that unregulated competition can lead to non-competitive outcomes (Arrow 1963; Barr 2004). This combines with a second key feature of public services, it is hard to define their quality. What is an educational outcome? A pupil completing a year? His or her test scores? How much he or she has learned? While these specific outcomes can be specified, it is hotly debated whether they cover all aspects of quality. Where it is difficult to specify a more amorphous concept such as quality and where new issues may regularly arise that cannot all be specified in advance, it is difficult to construct contracts

[5] Equally, many insurance markets (e.g. health, care), face risks of 'adverse selection,' where only people with higher risks choose to purchase insurance, raising costs and ultimately reducing the total scope of coverage. Conversely, where third-party payers cover much or all of the costs of services, many economists argue that there is a risk of 'moral hazard' leading individuals to over-consume services (Barr 2004). These features add to the complexity of creating an 'optimal' public private balance.

that stipulate how actors should act in unforeseen circumstances (Hart 1997; Tirole 1999). Where there are problems of 'incomplete contracts', varying contractual structures allocate control between 'principals' and 'agents' differently, structuring incentives and ultimately outcomes in varying ways. Finally, unlike many market situations, with one 'principal' (the contractor) and 'agent' (the producer), in public services there are three sets of actors: payers, users, and producers of services. The presence of separate payers and users fragments demand across two actors, raising the question of who is the principal to whom the agent is supposed to respond (Lowery 1998).

Each of these market 'problems' means that absent some type of public intervention in financing and regulation, the service is likely to be either over or undersupplied generally, and in particular to weaker consumers. Moreover, depending on how information, contracts, and demand are shaped, the incentives that producers face in the delivery of services will differ. There is not a single free, competitive, benchmark against which to assess the introduction of market incentives in the public sector. Efficient production may require much regulation, improving consumer choice may necessitate monitoring producers, and introducing market incentives absent this regulation or clear contractual specification can lead to non-competitive outcomes.

Given this malleability in the system of financing and production, markets in public services can structure incentives differently. These differences vary along two dimensions, how they *allocate benefits* to citizens and how they structure control over *production* among the state, citizens, and producers of services. Different packages of reforms shape these dimensions differently.[6]

First, markets differ in how they shape the balance between individual and collective responsibility; market reforms may directly or indirectly privatize responsibility and shift costs onto individuals, thereby using market mechanisms to *allocate* services to individuals. This move occurs through reforms that make individuals more responsive to the 'price' of a good (e.g. through fees or co-insurance) or create new costs of accessing high quality goods (e.g. by relaxing regulation on access). By contrast, competition among producers may be accompanied by a robust financial and regulatory

[6] While the claim here is not that the link between reforms and market outcomes is seamless, but rather that the core features of market reforms shape the basic character of the emerging market.

structure that maintains strong collective guarantees, meaning the risks and costs of accessing high quality services are spread across everyone and not borne by individuals.

Second, the introduction of market forces in the *production* of welfare services fundamentally reshapes incentives for those producing services (e.g. schools, hospitals). But who sets these incentives? The state who buys services but does not use them, the users who consume services but pay only indirectly, or the producers themselves? Because there are multiple principals (the state and user) to whom the agent (the producer) should respond *and* because it is difficult to ensure that producers actually do respond to the state or the user, incentives in the production of services can vary substantially and can give one set of actors more scope to exert its preferences.

These difference matter because the state as the payer and regulator of services, individuals as users of services, and public and private producers of services have different preferences for efficiency, quality, and profits respectively. The *state* as the payer of services would like to achieve value for money in production. Where the state is an effective 'principal', it will structure the costs and benefits of competition to give producers incentives for *efficient production*.[7] For the state to control production, competition must be introduced through contracts that the state has the capacity to clearly specify, allow managers the autonomy to achieve these outcomes, and to monitor and discipline non-compliant producers.[8] By contrast, users of services are less concerned about costs than *quality*.[9] Users experience services directly, taking all the benefits from high-quality production, while paying primarily indirectly through taxation. Where users are effective principals, producers gain by appealing to their preferences for high-quality, responsive, production. For users to be effective principals, a quasi-contractual set of rules must exist, which clearly specify their right to 'exit', link funding to users' choices, and monitor and discipline producers who fail to respond to these choices. Finally, producers of services often seek either *profits or rents*.[10] While many producers are genuinely dedicated to service delivery, in a market-oriented environment with little

[7] The term efficiency has a number of meanings. The usage here follows the logic of 'value for money', or the lowest cost possible at a fixed quantity and given level of quality of production.
[8] Although these contracts may be incomplete, the state's ability to renegotiate contracts is crucial to maintaining control power over the production process.
[9] The concept of quality in services is contested. The term here is meant to refer to the non-economic aspects of production.
[10] The term profit here refers to the returns to a firm's shareholders, following costs and depreciation.

regulation they have incentives to seek profits by inflating their income and/or cutting costs.[11] When the state or users are ineffective principals because they lack the ability to specify and monitor producers, these producers have the space to pursue their interests without necessarily responding to the desires of the state or users. Thus, while differences in the structure of fees and regulation determine what incentives users face in consuming services, differences in how *competition* is configured (through contracts or user choice) and *control* over providers (through contract specification, regulation and monitoring) shape the incentives in the production of services.

Table 1: Different Forms of Markets

		Who Sets the Market Incentives? (Production Dimension)		
		State "Efficiency Aims"	**Users "Quality Aims"**	**Producers "Profits and Rents"**
Responsibility for Access Allocation Dimension	Collective	Managed Market	Consumer Controlled Market	Pork Barrel Market
	Individuals	Austerity Market	Two Tiered Market	Retrenched Rights Market

Differences in the degree of market incentives on the *allocation* dimension and the structure of market incentives on the *production* dimension, lead to six qualitatively different 'ideal-types' of markets. Each of these markets restructure traditional bargains over who gets what and who pays for it, but also over who makes decisions over how services are produced, what type of services are produced, and how the costs of benefits of production are distributed. As such, these different incentives not only shape the logic of competition in varying ways – privileging efficiency, quality, or profits – but they also distribute *power* in fundamentally differing ways. Table One sets out the typology of market variation that draws on these differences.[12]

[11] These incentives are amplified when providers are privately owned and responsive to share-holders; however, there is evidence that both non-profit providers and publicly owned providers also respond to incentives (Eggleston and Zeckhauser 2002).

[12] The typology set out in Table 1, is meant to capture *ideal types* of market competition. The following discussion will argue that this typology captures the core features of variation in market in public services.

Managed Markets and *Austerity Markets* both lead to greater state control over production leveraging the state's power as the payer of services to force producers to be more responsive to costs, efficiency, and performance. In these markets, competition among incumbent providers – or new providers – unsettles providers' traditionally entrenched position, and allows the state to set clear incentives. This type of competition leads to an emphasis on the government's preferences for efficient production, often at the cost of professional or producer autonomy as they must compete to satisfy the state's preferences. These markets also create few incentives for producers to directly respond to users. While *Managed Markets* insulate individuals from any direct costs, *Austerity Markets* do not. At their best, both types of markets introduce strong incentives for productive efficiency and improved basic performance, with less direct emphasis on ameliorating responsiveness or innovation. While reforms intended to produce these markets risk less cost-inflation, quality erosion, or decreases in public accountability than other types of market reforms, they do risk being less effective in achieving real change. Thus, these markets distribute power to the state, often at a cost to users and producers.

Consumer Driven and *Two Tier* markets, like those working through state contracting, challenge the position of producers and force them to compete, but what is distinctive is that they structure competition among producers by offering individuals choice among service producers and link this choice to financial incentives to producers to respond to it. This competition puts an emphasis on high-quality production that is responsive to users' needs; however, these markets have potentially inflationary outcomes as producers respond to cost-insensitive users. Individual users are the core group of potential winners in these markets, as they gain direct, tangible benefits in terms of greater choice and responsiveness. Whereas *Consumer Controlled* markets spread these benefits across all individuals, in *Two Tiered* markets, higher-income, lower-cost, or lower-risk individuals are at an advantage. The state and producers are in a more ambiguous position. The state may gain from greater competition unsettling the position of entrenched producers, but may lose control over the cost structure and face new demands from an increasingly powerful citizenry. Equally, producers must now compete to appeal to parents, but may benefit from the emphasis on responsiveness and quality.

Finally, *Pork Barrel* and *Retrenched Rights* markets effectively delegate control to producers (e.g. the schools and hospitals), giving them residual power to produce public services in line with their private goals. *Pork Barrel* markets combine greater producer control with strong collective responsibility for financing, creating a looser fiscal environment that gives producers incentives to seek funds from the state. By contrast, *Retrenched Rights* markets emerge in a tighter fiscal environment with more opportunities for cost-shifting onto individuals, giving producers the space and incentives to cut costs as way of accruing profits. In both cases, producers compete only to receive contracts or custom, rather than on actual performance. The state has little ability to renegotiate contracts or regulate outcomes, and users are limited in their ability to exit. In allowing producers to operate with fewer constraints, these markets promise more innovation by producers but they may also allow rent-seeking and uncontrolled cost-cutting at the expense of efficient or high quality production.[13] Firms that receive contracts are the clear winners in these markets, although incumbent producers who risk losing contracts are potential losers and state and users lose control.

Markets redistribute power in the system; however, this occurs differently across differently types of markets. The production dimension determines whether the state, firms, or consumers, have more control over how services get produced. The allocation dimension determines whether the outputs of services are distributed collective or based on individual's resources. These differences matter for the character of emerging markets, fundamentally impacting some of the core features of public services themselves – what responsibility do individuals or families have for financing the services they receive, how should workers in the sector be 'commodified', what autonomy should users have, and to what extent should the state patrol the market?

While this typology was developed to discuss market reforms in the OECD countries, the following section shows it has significant traction outside the OECD universe by demonstrating differences in market reforms and consequent market

[13] Hart et al. (1997), argue that in cases of incomplete contracts, private providers demonstrate greater ability to pursue cost-cutting innovations, but are also more likely to do so at the expense of quality. These authors argue that the conditions of incomplete contracting are often intrinsic to particular goods. While this is certainly true, the argument here is that careful contractual specification in state driven markets increases the residual rights of control for the state, whereas in producer driven markets, producers retain these rights. As in producer driven markets, there may have more room for innovation, but these reforms also risk quality shading.

structures in Singapore, Colombia and Chile. While this discussion does not exhaust the variation across all six types of markets, it does demonstrate the importance of differences on the *production* dimension, showing how markets can enable the state, producers and users differently. In so doing, it shows that in shaping the market structure in particular ways, domestic politicians in these three countries were able to create particular sets of winners and losers in a manner that most benefited their political goals.

Singapore

In recent years many American scholars have turned to examining Singapore's use of medical savings accounts, which combine forced individual saving for medical care with competition among hospitals. These reforms are famous largely for changing the allocation dimension, forcing individuals to save for their health care costs and therefore changing the incentives of individuals to consume medical services and allegedly reducing the role of the state itself (Pauly 2001). However, markets in Singapore have also been deployed in particular ways on the production dimension, creating a logic of competition that has actually *increased* the state's power.

Social services in Singapore have long been financed in a relatively unique way. In 1955, the British colonial powers established the Central Provident Fund (CPF), a self-financing social security system that operates through mandatory individual savings. Initially, this fund was largely directed at savings for pensions and housing, and before the early 1980s, care was provided largely free of charge in subsidized hospitals (Barr 2001). Reforms in 1984 introducing a new medical savings program, 'Medisave', changed this system. This program drew on the existing logic of the CPF, providing individuals with medical coverage through forced savings in dedicated savings accounts while also introducing patient fees, ostensibly fully individualizing the system of financing. In practice, the government continued to subsidize care for much of the population particularly in the more basic wards, and in 1993 the government created another program, Medifund, which gives direct subsidies to hospitals to cover the indigent. Alongside these two funds, in 1990 the government introduced a voluntary savings program for catastrophic care, 'Medishield.' For both Medisave and Medishield,

individuals contribute a fixed portion of their income into a fund that is managed by the government and covers hospital fees.[14]

Initially, individuals could use these funds as they wished with the money following the patient to his/her preferred provider – creating a *Two Tier* market where providers competed for patients and patients faced heavy financial incentives.[15] In response, during the 1980s costs rose more rapidly than they had before the introduction of Medisave, as competing hospitals duplicated services and invested in expensive technologies (Hsiao 1995; Phua 2003). During this time, waiting lists evaporated and hospitals reoriented production to appeal to patients rather than competing on price, providing services like In Vitro Fertilization and Magnetic Resonance Imaging despite the government's disdain of this spending as wasteful (Hsiao 1995; Phua 2003).

In response to growing costs and rising demand, the Singaporean state began to reinsert control over the system, moving in the early 1990s to exert price caps, fixed subsidies, and fixing the supply of beds and hospitals (Barr 2001). While much of this move was regulatory and involved direct command and control instruments, the government also moved to introduce incentives for hospitals. Alongside the initial Medisave reforms, a less noticed set of changes altered the way hospitals themselves operated. In 1985, the government began the process of 'corporatizing' hospitals by turning them into autonomous organizations with more financial responsibility as well as scope for responding to market conditions. In 1987, the government established the Health Corporation of Singapore, a publicly owned but independent holding company responsible for managing corporatized hospitals (Phua 2003). These hospitals have increased control over staffing, budgets, and exposure to the market itself. In forcing hospitals to be more fiscally independent, in combination with price controls, this use of financial incentives for hospitals mirrors the logic of strong purchasing. Indeed, the

[14] Individuals pay between 6-8% of their monthly income, depending on their age, up to a fixed ceiling (Barr 2001). These savings do not cover the full cost of hospitalization, and individuals must also meet part of the costs directly. If patients do not have sufficient savings or funds available, they must pay the bill out of future contributions or apply for assistance (Barr 2001). Moreover, a number of treatments are now excluded from Medisave, such as dialysis, chemotherapy and assisted reproduction (Barr 2001).

[15] Even though individuals were paying part of the costs of the care directly, they were not paying the full costs, meaning providers were competing for patients who were not fully cost-sensitive. This allowed the market to take on a *Two Tiered* character where hospitals competed for patients who were quality sensitive.

government, in setting conditions around the operation of wards that it heavily subsidizes, altered the incentives facing hospitals, making them respond to its preferences.[16]

What have these moves meant? While all individuals face heavy price signals that do impact their consumption of services, competition among hospitals occurs on two levels. For the wealthy who are able to pay additional private fees, there are a number of hospitals and wards that compete directly for their business, thereby maintaining the basic aspects of the *Two Tier* market. This type of competition also occurs in primary care, where much outpatient care is provided by physicians who freely set fees and where individuals have a wide choice of care. However, in many cases there are strong price signals for individuals combined with hospitals aiming to appeal to a cost conscious central government, creating something more along the lines of an *Austerity Market*. In these situations, the incentive is to produce at a lower cost and focus less on appealing to patients. While money does, to some extent, follow patient choices, fees in Class C wards form only 20% of the total costs (and Class B wards are also heavily subsidized) meaning hospitals must be responsive to the real buyer, the government itself.[17] In this light, the government's emphasis on more basic quality and on cost-efficiency in production has emerged as its central goal (Hsiao 1995). The government will now cut funding if hospitals produce over a set level, has limited 'excess profits,' and has moved towards setting fees through a modified case-mix formula (Phua 2003) This situation is not a perfect exemplar of an *Austerity Market* but nonetheless is close in character.

In both shaping the incentives for individuals and enforcing the state's preferences for lower cost and more efficient production (through both purchasing and regulation), the health care market in Singapore operates in a particular way. Hospitals compete for patients at the top end of the market with responsive care, while producing at lower cost for the mass market. The luxury wards in public hospitals and private hospitals catering to the wealthy offer extra amenities and rapid responsive care and have highly paid physicians (Barr 2001; Phua 2003). The bulk of the population though, attends the more subsidized wards. Here the financial incentives set by the central government have

[16] Hospital wards include a number of classes (A, B1, B2 and C), which vary in how many people share a room and whether air-conditioning is provided (Hsiao 1995).

[17] Indeed, the government finances 39-52% of health care expenditures, with the Medisave program amounting to under 8% of total health expenditure and Medishield for under 1% (Ramesh 2000).

had a different effect. Hospitals have increasingly aimed for cost-efficiency, moving towards hiring more non-physician staff and support personnel and rationalizing labor practices (Phua 2003). While quality is high across hospitals, the competition on quality at the top-end (on medical technology and more prestigious physicians) is not as prevalent in the market as a whole. Not surprisingly, this reorientation in production has been matched by changes in the allocation of services. There are a number of inequities within this system, with many low income individuals and the elderly lacking adequate savings or access to public funds (Barr 2001).

This market, then, has reoriented power in the system dramatically. While the initial move to the market in the early 1980s meant the state lost power, as money purely followed consumer choice, the combination of more financial incentives for hospitals and stronger government purchasing and regulation have been *complementary* as the market evolved. The Singaporean state, in forcing providers to compete and take more financial responsibility and enforcing its preferences as a major buyer of services, has been able to reorient health care production to match its own goals of greater cost-consciousness and efficiency. As a result, the state itself has been the major winner of these reforms. While patients are generally satisfied, these movements have not dramatically expanded benefits for users, and while hospitals have gained in terms of financial autonomy, they have less professional autonomy in terms of providing care as they must appeal to the government's cost-concerns.[18]

Why these differences? The initial move towards change on the allocation dimension was largely ideological – aimed at specifically placing more direct costs on individuals (Barr 2001; Ramesh 2000). The President, and leader of the People's Action Party, Lee Kwan Yew, explicitly saw greater individual cost-sharing as attractive, and promoted it as a way to enforce greater incentives for work and effort (Barr 2001). However, by the early 1990s, it was clear that this system had not extricated the government from the provision or financing of health care – the public continued to place strong demands on the government and yet the *Two Tier* market had not led to const-

[18] For instance, corporatized hospitals have moved towards paying professionals based on performance, and increasingly are responsive to modern management techniques.

control. As the government began to recognize that it could not shift all responsibility for financing onto the public it also began to reconsider its market strategy.

The strong Singaporean government then, initially used markets as part of ideological project aimed at recasting the role of the state and individuals. However, as the consequences of this project emerged, it jettisoned ideology for pragmatism, expanding its own control over the health care sector in the face of rising costs. As a quasi-democracy, the PAP had much control over the policymaking process but was not fully insulated from the public. The PAP had to respond to public concerns over access to care, and therefore continued to play a role in financing the system (Ramesh 2000). This involved guaranteeing the future of Class C wards, and in so doing, expanding the state's role as a buyer and regulator of health care services. Thus, the problem of dealing with health care for the mass of population in a cost-effective manner became a major issue for the government. The existing state infrastructure though, offered it the ability to re-exert control over the market itself. As a result, the government was able to maintain a system that offered more differentiated benefits for the elite while guaranteeing a basic and highly controlled system for much of the population. Co-opting aspects of the market as part of the state's regulatory drive offered the PAP a way of addressing concerns about cost control and the need to secure a viable medical system for the bulk of the population.

Colombia

In the late 1980s, health care coverage in Colombia was highly fragmented and incomplete. Wealthier citizens bought insurance or care privately, some employed individuals were covered under the social security system, many indigent citizens received care directly from public hospitals, and about 20% of the population had no coverage (De Vos, De Ceukelaire, and Van der Stuyft 2006). Care was provided by a range of public and private physicians and hospitals, of uneven quality, cost and geographical accessibility. Since this time, the Colombian system has been transformed along market lines, but in contrast to Singapore, this market has undercut state control rather than enhanced it.

The first major changes in this system were introduced in 1990 when partial responsibility for health care was decentralized in an attempt to improve its quality and

access. These shifts were followed by a more radical set of reforms in 1993, which drew on the World Bank blueprint for market reforms advocated throughout Latin America in the early 1990s. These reforms had the dual aim of creating universal coverage by 2001, and recasting the role of the state as an arbiter of an increasingly competitive market.

First, the reforms created a universal social insurance system operating through both a contributory and subsidized system. In the contributory system, the employed and self-employed pay a fixed portion of their income as insurance premiums. Those not eligible for this system receive coverage through a separate fund that is financed through both general taxation and solidarity contributions from the contributory system.[19] Individuals in the contributory system are given a choice of third-party insurers (Health Promotion Enterprises or EPSs), with those in the subsidized system also able to choose an EPS or a state purchaser. The EPSs are required to cover basic services and are funded through contributions from a general fund through risk-adjusted capitated payments, meaning that they are financed for higher risk or higher cost members thereby reducing the incentives for the EPSs to cream-skim more attractive patients. The capitated payments of those in the subsidized system equal only 50% of those in the contributory system, and this group receives a more restricted package.

Second, the EPSs contract with the private and public providers, paying them on performance not historical or actual running costs. This contracting is meant to stimulate competition among hospitals, forcing down costs. In return, public hospitals have been 'corporatized,' giving them new autonomy to respond to the insurers. Individuals have a free choice of EPS, but the EPSs can limit choice of provider to those contracted (it must offer at least two choices). In short, the reforms aimed to expand coverage, but rather than funding hospitals and physicians directly they aimed to finance insurers who would then buy these services for their enrollees. The logic of the reforms draws on the principles of managed competition, where competing insurers act as strong payers and create incentives for productive efficiency.[20]

[19] Those in the contributory system pay 12% of their wages, of which 2/3 is financed by the employer and 1/3 by the employee, with the self-employed paying the full 12%. 1/12 of this funding is transferred to the subsidized system.

[20] One of earliest and most well-known models of managed competition comes from Alain Enthoven.. Enthoven (1978) presented managed competition as an alternative to unmanaged competition – with his

A series of compromises and administrative decisions accompanying the reforms, though, meant that the actual role and responsibilities of the EPSs were only weakly developed and the EPSs and the providers themselves were able to maintain a relatively secure position. For instance, EPSs were given wide latitude on contracting practices but were encouraged to fund providers based on patient choices and volume. This principle made it difficult for the EPSs to hold down costs and in practice, some EPSs simply paid providers on a fee-for-service basis, giving them an incentive to increase production (De Groote, De Paepe, and Unger 2005).[21] However, because the weaknesses in contracting were not offset by greater central or local regulatory control, unlike a consumer driven market, this system did not guarantee responsiveness to patients. The reforms were introduced on the heels of a decentralization and administrative reform agenda that had reduced the number of central government staff and combined with the Colombian practice of rotating government staff in line with changes in the Minister. This situation meant the central government's capacity for monitoring the market was compromised (Bossert et al. 1998). In order to achieve its goals of increasing efficiency and equity, the central government would need to gather sufficient information, ensure the system of risk adjustment to the insurers was adequate, monitor providers for basic quality and provide citizens with information about coverage and their choices. These features were underdeveloped, and a Harvard University team involved in evaluating the reforms found that the staff at the national level was not adequate to carry out the tasks (Bossert et al. 1998). As a result, monitoring of both the behavior of the insurers and providers has been weak, and competition among them has tended to reduce government control over the sector. The outcome was a weakly competitive market, where both insurers and hospitals reap the benefits of new spending at the cost of the state and users – a *Pork Barrel* market that benefits the producers but without necessarily shifting costs onto users.

While many view the Colombian health care system and recent reforms as highly successful, there have in face been more mixed results. The most prominent outcome has

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analysis suggesting that strong purchasers in health care (e.g. insurers) are more effective than unbridled consumer choice of provider in achieving cost control and quality.

[21]The public Institute of Social Insurance (ISS) is also an EPS in this system, and by 1997 it had enrolled over 60% of recipients. The ISS was only incompletely separated from health care providers, and was allowed to enter the market without addressing its long-standing problems of organization and corruption, which further entrenched its position rather than submitting it to competitive pressures (González-Rossetti and Bossert 2000)

been an explosion of expenditure since the introduction of these reforms, from 2.4% GDP in 1990 to 7.4% in 2000 (Rosa and Alberto 2004). This extra spending was part of the drive to increase coverage and, indeed, coverage did increase, with a doubling of those covered by 2000 (from 26% to 52% of the population) and a particularly rapid rate of increase among the poor (De Groote, De Paepe, and Unger 2005). However, De Groote et al (2005) argue that this ostensible increase in insurance coverage masks serious emerging problems in access. The increase in coverage rates exaggerates the actual changes, as many of those newly covered did have access to health services before and some of those covered have been double counted (De Groote, De Paepe, and Unger 2005; De Vos, De Ceukelaire, and Van der Stuyft 2006). Even those with coverage often do not receive clear health care services, with insurers sometimes failing to deliver proof of coverage or information on care. As a result, De Groote et al. (2005) find that the number of citizens with insurance reporting access to care actually dropped through the 1990s, although access in the population as a whole improved.

Where has all the spending gone then? First, private insurers have been able to gain key benefits. Rates to insurers considerably increased through the 1990s and early 2000s, and spending on administration within the EPS and providers has reached upwards of 30% of health care expenditure (De Groote, De Paepe, and Unger 2005; Rosa and Alberto 2004). Some insurers have vertically integrated with providers, taking many benefits for themselves while offloading the costs of provision on other parts of the health care system (Rosa and Alberto 2004). Private insurers have also been able to cream-skim, leaving the public insurers to cover the most expensive patients (Bossert 2000). Second, alongside the insurers, the providers (clinics and hospitals) have also benefited. While some providers in vertically integrated insurers have lost out, on the whole, new funding has gone to these groups. Private providers have become very profitable, and while public hospitals have large deficits some have been able to use this situation to 'double dip' and receive money from both the EPSs and the government (Bossert 2000; De Vos, De Ceukelaire, and Van der Stuyft 2006). For instance, Homedes and Ugalde (2005) report that between 1996 and 1998 costs in hospitals increased 24% but production rose only 4%. Overall, both the number of staff and their salaries have increased, giving significant new gains to providers, and some services have been over-

produced (Jaramillo 2002; Rosa and Alberto 2004). This extra funding to providers and insurers, though, has not necessarily meant improved quality or responsiveness to citizens. Some hospitals are producing more and at a higher level of quality with these increased funds (McPake et al. 2003). However, this is variable and other studies have found that hospital efficiency and quality have been reduced (Homedes and Ugalde 2005). Moreover, some preventative services, which are not funded as generously, have deteriorated, creating a resurgence of public health concerns.[22]

Thus the emerging market is one in which private insurers and private and public providers themselves are in a strong position – deciding where and when to enter the market, how to provide care, and often setting high prices at a cost to the state itself. While coverage has improved and overall equity has been enhanced, users have not 'won' as much as might be expected given the aims of achieving universal coverage and the dramatic increase in spending. Finally, the state has 'lost' in this market. While the initial increases in expenditure occurred alongside economic growth following the discovery of petroleum reserves, as spending has increased and the economy has deteriorated, serious structural deficits have emerged. The government's response has often been to simply not pay for some services, leading to fiscal strain through the system and jeopardizing some of the equity gains that have occurred (Rosa and Alberto 2004). As a result, in contrast to Singapore, the market has not strengthened the state, and in contrast to Chile (see below) it has not strengthened the user. Rather, the structure of competition has funneled a number of benefits to the new insurers and providers.

Why these reforms? The reforms were introduced in 1993, following a period of radical political change in Colombia. In 1991, the Colombian constitution was reformed, strengthening the role of the legislature vis-à-vis the executive and liberalizing parts of the economy in an attempt to create more transparency and broker peace with radical groups who had long threatened Colombia's political stability. Social security reform emerged as part of the Constitutional reform agenda, and the technocratic Graviria government took up these proposals for reform. The Graviria government favored a market model for change, drawing on both World Bank proposals and the experience of

[22] For instance, a study of tuberculosis control in Colombia, found a deterioration in quality and coverage following the introduction of competitive pressures, which the authors link to both strong financial incentives on the ground and weak state oversight (Arbeláez et al. 2004)

Chilean health care reform to argue in favor of reforms that included both extensive individual cost-sharing and means-testing and competition among insurers and providers. However, these proposals ran up against both opponents within the administration and the Congress who supported developing a model more akin to a single-payer health care system, expanding coverage to the whole population, with few or no direct price signals, and with integrated provision run by public hospitals (Gonzalez-Rossetti 2000). This brought a highly technocratic and motivated set of reformers in the executive in conflict with an increasingly strong and galvanized legislature.

The conflict between these visions led the compromise proposal, that both expanded coverage and competition. However, in order to broker this compromise and introduce the reforms rapidly, the legal changes (Law 100) left many details to be worked out through executive decrees and bureaucratic implementation. This second stage of reform occurred under the Samper administration, which took a less technocratic stance and aimed at compromise with major societal groups (Gonzalez-Rossetti 2000). The result was more direct negotiation with a range of actors – including producer groups. This situation combined with continued weaknesses of parts of the central and local administrations in monitoring the system to leave a relatively weak system of public control over the system. In contrast to Singapore then, where an already strong government was able to deploy markets as a way of consolidating more power over the medical sector, in Colombia, a weakened government trying to paper over serious policy disagreements introduced a market model. This lack of initial capacity and failure to build up new capacity, combined with the need to negotiate with major players in the field, meant that the market reforms were introduced in ways that undercut the state. [23]

Chile

Prior to 1980, Chile had a highly centralized and relatively developed education system.[24] The central government had a long history of direct control in the provision and financing of education, with early founders of the system building on the French model

[23] While the end result was not fully intentional, the government's use of the market to recast the state and promote the private sector was. Thus these new winners and losers emerged from specific choices over how to structure the market.

[24] In 1980, primary school enrollment was nearly universal, and 65% of pupils attended secondary education, a relatively high figure compared to other Latin American countries (Delannoy 2000).

of strong central guidance in education. In this system, it was the central government that directly owned most of the country's schools, employed and trained teachers who had the status of civil servants, determined the curriculum, and inspected schools for compliance with these goals (Gauri 1998). Some private schools were publicly funded, but to a limited extent. While the role of the government remains strong, over the past three decades the Chilean education system has been transformed into a market that empowers the users of services in new ways and has brought private producers in the public system.

A series of decrees from the authoritarian Pinochet government in 1979 and 1980 radically altered the structure of Chilean education. First, the reforms decentralized control of public schools to the municipalities, shifting responsibility for employment, building, and financing schools downwards. This move was accompanied by a changed relation to teachers, with both direct repression of teacher's unions and payouts to teachers to ease them out of their status as civil servants.[25] Second, the Pinochet government introduced school vouchers in Chile, allowing private schools to receive full subsidization and compete with municipal schools. All schools were now paid on the basis of pupil numbers, with fixed 'subventions' for public and private schools based on local conditions. These rules also significantly eased market entry for private schools, giving the central government the ability to approve a wide range of private schools. In so doing, the reforms dramatically altered how schools were paid, moving away from historic costs to per-capita funding.[26] Third, these reforms were accompanied by massive cuts in education spending, with real expenditure on the per pupil voucher falling 25% in the early 1980s (Delannoy 2000). Over the course of the 1990s, spending on education fell from 4.5% to 2.9% of GDP (Gauri 1998). Despite the decentralization, marketization, and spending cuts, the central government did not abdicate all control over the education system. Indeed, it maintained control over aspects of the regulatory process, for instance, parts of the curriculum, teacher training, employment practices, market entry and mergers, and school fees. Moreover, it actually increased its regulation of the private sector through the 1980s, imposing more regulations and monitoring of quality and

[25] As part of the decentralization to the municipalities, teachers were offered severance pay. However, the Pinochet government also eliminated their right to collective bargaining and legal protections of wages (Carnoy and McEwan 2003).

[26] Municipal schools could either operate under municipal control or have an independent corporate status, with most following the model of municipal controls (Carnoy and McEwan 2003)

financial practices, and in 1988 it introduced a new standardized performance test (SIMCE) (Gauri 1998).

What did all these reforms amount to? In the area of allocation, the core thrust was towards placing some new costs on parents. The combination of cuts in public spending and support for private schools meant that parents faced direct and indirect costs in procuring high-quality education. As municipal schools faced cuts, those who could afford it had an incentive to opt into the private sector, sometimes paying additional fees.[27] This feature meant that high-quality education was increasingly rationed to those able to pay, with an elite set of fully privately funded schools, a middle set of publicly funded private schools (which although not meant to charge fees could ask for some additional contributions), and a third set of fully publicly funded private and public schools.[28] Alongside these changes in allocation, came quite radical changes in the production of services. Schools were now paid based on pupil numbers, and their survival depended on attracting pupils. In contrast to Colombia, direct competition among schools occurred in an environment with some central regulation and oversight, meaning that schools did have an incentive actually appeal to the preferences of users. Production, then, was aimed at producing school competition in a highly regulated environment, with the state backing up the parental choice and ensuring competition did not simply cede control to the private sector. The combination of more costs for individuals and greater competition around pupil choice gave the market a *Two Tiered* character, reorienting the system around the preferences of parents but also benefiting higher income users.

While a number of features of the reforms were contradictory or incompletely implemented, competition did begin to develop.[29] Prior to the 1981 voucher reforms, over 80% of students attended public schools; by 1994, this number had fallen to 54% (Carnoy 1998). What has this particular market meant for the production of education?

[27] Moreover, municipalities varied greatly in their expenditure on education, with wealthier municipalities able to devote extra resources to their schools (Kubal 2006).
[28] The vouchers also did not compensate for potentially higher costs among some populations of pupils.
[29] Gauri (1998) compares the practice of the reforms with a range of theoretical propositions about markets, arguing that the actual market fell short of the theoretical markets models and that the particular reforms created a number of weak or contradictory incentives for actual improvement. For instance, the reforms both decentralized education to the municipalities and introduced school choice. As more parents became active choosers, mayors actual had fewer incentives to listen to the demands of their local population, and sometimes became less attentive to quality in schools. Despite these contradictions, the core thrust of this market was towards creating real competition for parental choice.

Two Tier markets privilege competition on quality not costs, delegating power to users and creating an emphasis on responding to their preferences. At first glance, these predictions seem out of the touch with the reality of the Chilean reforms. The drastic cuts in spending meant that costs, far from rising, fell through the 1980s and private schools often emerged as lower cost (Carnoy and McEwan 2003). The effect on quality is also ambiguous. Numerous studies of Chilean schools have failed to find a dramatic improvement in test scores (Carnoy and McEwan 2003; Hsieh and Urquiola 2003).

However, when we look closer, we see a logic of competition that looks dramatically different to that seen in either Singapore or Colombia. The initial move to the market was desperately underfunded. New schools were entering the market and attempting to gain pupils as the Chilean economy collapsed and education funding was cut. As a result, they had to pay attention to costs but appeals to parents on these grounds were limited. In response, private schools marketed themselves on the quality of their pupils, while creaming off some of the most attractive (lower cost) pupils in an attempt to raise revenue by attracting more pupils (Carnoy and McEwan 2003). As a result, more educated parents, who were more active in exercising their right to school choice, flocked to the private sector responding to its purported advantages (often using pupil composition as a proxy for quality). Equally, private schools, especially for-profit schools, flocked to high-achieving parents, establishing themselves in wealthier urban neighborhoods and marketing themselves to these parents (Carnoy and McEwan 2003). Thus, while there is evidence that some newer private schools (e.g. those established after the introduction of the voucher) did cut costs through lower pay to teachers and were not always effective, even these schools were aggressive in competing on enrolment, engaging in practices such as grade inflation, requiring uniforms, or offering new programs to attract pupils (Carnoy 1998).

In this competitive environment public schools were left behind and, as municipal schools lost pupils, municipalities began to face the consequences of greater competition. The rationalization of labor at the school level was difficult, and many municipalities funneled extra money to these schools to keep them open. As a result, the pupil teacher ratio in municipal schools was only 21-1 compared to 45-1 in private schools (Gaury 1998). Despite cost cutting then, serious inefficiencies emerged in the system, as rather

than rationalizing production, private schools scaled it up to appeal to users and public schools turned to local politicians to guarantee their position. Furthermore, new inequities emerged among pupils. Among the lowest 40% of the income spectrum, 72% attended public school in 1990, compared with 51% in the next 40% of the income spectrum, and 25% in the top 20% percent of the income spectrum (Carnoy 1998). In contrast to the heavy emphasis on financial results in Singapore and the scope for providers to inflate costs to pad their bottom lines in Colombia, the basic competitive structure was not geared around costs nor did it allow private sector rent-seeking. Rather, the result was a schools market where schools competed on attracting higher-income parents through both performance and cosmetic features, and serious inequities began to emerge.

More than this though, the Pinochet reforms radically altered the educational landscape by reorienting power in the system in specific ways. As in Singapore, market competition directly challenged incumbent providers. Markets were one arm of a broader strategy to challenge the teachers' unions and reduce their power. However, unlike the reforms in Singapore where this move largely increased the power of the state or in Colombia where it ceded power to new providers, in Chile the reorientation in power was more fragmented across the state, users, and providers. This meant that as the country moved towards a more democratic system, new political parties had to accept the choice orientation in the system and appeal to an increasingly choosy set of parents. In 1990, a democratically elected center-Left wing government emerged. The parties in the Concertación alliance were critical of aspects of the education reform while in opposition, and were concerned about the inequities and the lagging performance of Chile's poor. However, rather than turn the system back, when they came to power they maintained the basic choice orientation in the system and continued to allow the possibility of public funding going to private schools (Gaury 1998). The new government though modified some of the divisive aspects of the market, most notably by increased spending, targeting resources at low-income schools, and also improving the pay and conditions of teachers (Carnoy and McEwan 2003).[30] While looking to blunt some of the

[30] While teacher's unions reemerged as more powerful players following the democratic transition, and were able to secure new wage and tenure guarantees, the market continued to shape their position in particular ways. For instance, the teacher's unions advocated a recentralization of control over the educational system, something that the newly elected government refused (Kubal 2006)

inequities in the system, it maintained the basic choice orientation, showing the power of the entrenched position of users.[31] Thus the initial reforms were successful in creating new vested interests in the market itself – the parents and private schools.

Why this approach? When the Pinochet government came to power in Chile it was on the heels of a democratically elected socialist government and it faced a (relatively) expansive welfare state. Part of Pinochet's early governing strategy involved widespread privatization of state owned industries and liberalization of the domestic economy, including rapid state divestment from strategic industries and significant privatization of social benefits such as public pensions and health care. The move towards market reform in education was part of this general shift, and the Minister of Education was strongly inspired by academic models of educational vouchers developed by the 'Chicago boys' (e.g. Milton Friedman) (Castiglioni 2001).

While the Pinochet government claimed to prefer a model that allowed for a more minimal role for the state and that followed an economic logic (see Castiglioni 2001), it built a market that served its political aims The government had long aimed at breaking up the teacher's unions, taking direct action against leftist activists in the unions following its coup in 1973. In this light, reforms that directly targeted their power by eliminating their status as central government civil servants and forced competition from the private sector (which faced fewer restrictions on employing teachers) were attractive. Equally, one of the broader goals of the Pinochet government with respect to the welfare state was to fragment its universal character, and in this light, markets that allowed users new benefits outside the state were attractive (Castiglioni 2001). These goals then, meant that unlike in Singapore, the aim was not to consolidate central power and accountability, but to fragment it. Despite this desire to disperse power and the government's own claims of wanting to reduce the size of the state, it in fact did not do so in the form we saw in Colombia. Indeed, as Varun Gauri (1998) writes, through the 1980s 'the government monitored private schools more closely and frequently than at any other time in Chilean history.' This occurred because the central government continued to have both a number of pedagogical and financial goals, and straightforward abdication of public

[31] One counter movement - however, in 1994 the government expanded the ability of private schools to charge fees and sharpened some of the competitive incentives in the system.

responsibility was not attractive.[32] As a result, the chosen market maintained some state control while also creating competition that in delegating power to municipalities and parents reduced the role of teachers and fragmenting support for the public system.[33]

When the Left came to power, it faced the playing field this initial market had created – with new sources of inequity but also new benefits to (primarily middle class) parents. It responded to this situation by seeking to gain and maintain, the support of this middle class constituency, but also to improve education so as to combat inequity and reshape support towards a more inclusive system. In so doing, it modified the market by spending up to 200% more on education, but also promising 'Change within Continuity' and maintaining school choice (Delannoy 2000; Kubal 2006). Once again, we see the *particular* type of market was not just a reflection of an abstract market model or the slightly bungled introduction of a perfectly competitive market, but took a specific form in response to domestic political imperatives.

Conclusion

In looking at market reforms in Singapore, Colombia, and Chile, this paper has argued that not only does the typology developed in the analysis of developed welfare states travel but that it illuminates a key part of the reform process in other countries. Markets in these three cases were deployed for different purposes, creating different systems of winners and losers. These 'textbook' or 'blueprint' examples of market reform have not operated in uniform ways, with uniform effects, but differently depending on their design. As such, attention to the politics of *particular* market choices is as important when looking at the process of market formation in the developing world as elsewhere.

What are the implications of this argument for understanding the dynamics of social policy in the developing world? First, it suggests careful attention must be paid to the details and political dynamics of reform in the developing world. While international organizations or NGOs may promote particular packages of reforms or ideas about

[32] For instance, Castiglioni (2006) argues that the strong ideology of militarism was reflected in the government's pedagogical initiatives. Equally, the government wanted to maintain control over spending.
[33] The decentralization to the municipalities also had a particular character. Local mayors were appointed through the central government and military, not locally elected. Thus the decentralization offered a way of off-loading some responsibility for education to local governments, without giving local citizens increased participatory control (Kubal 2006).

markets, the way markets work is powerfully conditioned by the particular choices domestic reformers make in structuring markets. Second, constructing markets built around state contracting and user choice takes a high level of state capacity. Markets and the state can be antithetical (as we saw in Colombia), but they are not necessarily so (as we saw in Singapore and Chile). As a result, markets can be part of the process of building welfare states in the developing world, but only if they are structured in particular ways. The emerging structure of the welfare state depends critically on the emerging structure of the welfare market. Finally, examining the experiences of the developing world illuminates reform in the OECD world. In looking at how countries facing multiple resource constraints have sought to build services through markets, with varying outcomes, it focuses attention on the importance of market design in developing new services (e.g. child care, care for the elderly) through markets in the OECD world. Attention to the *way* markets work across both the developing and the developed world is central to understanding what markets mean for the welfare state.

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