Exploring the Rube Goldberg Welfare State

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In recent years, scholarship on the American welfare state has increasingly focused on what some have called the "private welfare state" of employer-provided benefits and individual self-servicing that are subsidized through the tax code.[1] This work has opened our eyes to the complex mix of public and private action that constitute the American approach to social welfare. There is, however, another way in which public and private action is entwined. Even in seemingly "public" social programs, private actors often play a critical role in the delivery of benefits and services, and even in the administration of programs themselves. In the case of Medicare, for instance, responsibility for administering the program has always been largely in the hands of private insurers and other non-governmental entities, overseen by only a small number of federal civil servants. Similarly, in most states, managed care firms have most of the responsibility for delivering Medicaid benefits. And since the 1996 welfare reform, a number of localities and one state government have contracted out the administration of their welfare programs to for-profit firms. As these examples show, by looking closely at the actual governance of the welfare state, we can see that much responsibility for social provision is delegated from federal authorities to state and local ones, and from public authorities to the private sector.

How extensive are these arrangements, and does it matter whether programs are administered by public or private agencies? This paper addresses these questions, developing the concept of delegated governance, mapping the different forms this has taken over time and in different policy areas, and providing a comparative perspective on the phenomenon. As this paper will show, the US is not alone in relying on private actors

[1] This paper is chapter two of a book manuscript in progress, *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy* (Oxford University Press).

in the delivery of social programs, but is distinctive in the degree to which it does so and its enthusiasm for profit-making welfare providers. The US also is almost alone among OECD countries in its reliance upon for-profit firms in publicly-funded health insurance programs. The nature of delegated governance in the US has varied over time: in its earliest phases the emphasis was on delegating responsibilities to non-profit organizations and trusted professionals, both of which were viewed as public-regarding in their motives. Since the 1980s, however, there has been a policy shift towards encouraging for-profit actors, market competition in social welfare provision, and consumer choice. Along with this has come a change in the locus of decision-making and risk. Whereas previously, governments made decisions about contracting out and bore risk for cost overruns, more recent forms of delegated governance put decision-making responsibility on individuals and shift risk from government to profit-making firms and individual consumers.

The paper also surveys some of the implications of delegated governance. The way programs are actually administered is no mere technical factor, but affects the real-world functioning and effectiveness of social programs, their redistributive effects, and their political consequences (or "policy feedbacks"). This paper offers no definitive statements about these issues – these complex questions will be treated in a book-length monograph, currently in preparation – but offers an overview of some of the main issues that arise when we think about the governance of the welfare state. In addition, for academics less concerned with the nitty-gritty of social policy regimes, delegated governance has importance for how we conceptualize the nature of the American state – an issue that has received growing attention in recent years. We argue that scholars need

to get away from abstract conceptualization of "the state" and look more concretely both at what states actually do and how they do it. Being attentive to different forms of governance and their consequences for effectiveness, redistribution, and accountability will help us to better grasp the real-world meaning of state action.

Conceptualizing the Delegated Welfare State

Delegated governance is the delegation of responsibility for publicly-funded social welfare provision to non-state actors. Rather than set up bureaucratic agencies to directly achieve a particular set of objectives, such as distributing benefits or providing public services, collective goals are realized through private entities that may be profit-making or non-profit organizations. The government role is one of financing, regulation, and oversight, but not direct provision. By contrast, in a situation of direct governance, government agencies directly provide benefits or services. Some examples of direct governance include Social Security, which is administered by a federal agency, the VA health care system – a domestic example of "socialized medicine" (Stevens 1991) – and, at the local level, public schools.

Why do we use the term "delegated governance"? "Delegation" is employed to highlight the deliberate act that is involved in assigning responsibility for social welfare to non-state actors. This is not something that simply evolves in the private sector; rather, a decision is taken to shift the provision of a social welfare benefit or service to the private realm (Savas 2000). The term also grows out of the legal "non-delegation doctrine" that limits the ability of Congress to delegate its lawmaking power to other public or private entities (Sunstein 2000). Although often invoked around the delegation

of power to executive agencies, some courts have imposed greater scrutiny on the delegation of governing authority to private actors whose self-interest may conflict with public objectives (Stevenson 2003). In practice, however, delegation has occurred with great frequency, leading some scholars to conclude that the non-delegation doctrine is not an effective way to limit the granting of authority to private actors (Freeman 2000; but see Stevenson 2003 for a contrary view). Regardless of where one stands on the legal question, the non-delegation doctrine embodies a similar notion to that which we're studying –the shifting of public responsibilities to non-state actors.

The term "governance" has many uses and thus also requires some explication. Governance has become a trendy term in the scholarly literature on public administration, yet it has many meanings (Frederickson 2005). For some scholars, the word "governance" conveys the idea that governing power is not confined to public authorities but is often exercised through private firms, international organizations, and other non-state entities. Scholars writing from this perspective often emphasize the decline of hierarchical, command-and-control governing relationships, and their replacement by networks and other forms of horizontal relationships (Newman 2004; Pierre and Peters 2005; Frederickson 2005, p. 285). However, others use governance in a narrower and more traditional sense – the act of governing – which leaves the site and nature of this governing to be specified, e.g. public sector governance, corporate governance, networked governance, etc. We would like to reclaim the original use of the term, which can then be qualified and made more precise. Rather than assume governance involves diffused authority, extensive private involvement, and negotiated contracts, we assume

only that governance involves governing and then examine whether and how this governing takes place.

Why not simply describe delegated governance as other scholars frequently have, as "privatization" or "contracting out"? There are several reasons why we think delegated governance is an improvement on these two terms. Privatization has been used to describe quite distinct phenomenon, ranging from the complete shedding of state responsibility for social provision, the selling-off of state-owned enterprises, or the contracting out of the provision of public services (Kolderie 1986; Starr 1989; Seidenstat 1999). Given these disparate meanings, we find that the concept has been stretched to the point that it tends to obscure the object of study rather than clarify it. In addition, privatization connotes the withdrawal of public responsibility in a particular area, such as complete load-shedding by public authorities. This more aptly describes phenomena such as the sale of state-owned enterprises, but fails to capture that which most commonly occurs in countries such as the US – the intertwining of public and private responsibility. Moreover, administering public programs through private actors often entails substantial government involvement through financing, oversight, and regulation, contrary to what the term "privatization" implies. Finally, privatization has acquired ideological connotations related to the free-market movement that emerged in the 1970s and 1980s in many Western countries (Starr 1989; Savas 2000). This renders the term less useful to describe the larger phenomenon of delegated governance, which predates the market reform movement and lacked that ideological orientation.

A term that is closer to that of "delegated governance" is the idea of "contracting out" – contracting with private providers to deliver public benefits or services.[2] Although this more accurately captures the phenomenon of interest to us, and we use it at times, we still believe that delegated governance adds something to the existing social policy lexicon. In the arena of social provision, the government is doing more than simply contracting out service provision, as a municipal government might do for garbage collection, or the Defense Department might do in the procurement of weaponry. When responsibility for administering social welfare programs is contracted out, this effectively shifts power and authority over the lives of program beneficiaries from the state to non-state actors. Governance, and governing, is ultimately about power: the ability to make people do what they otherwise might not be able or inclined to do. Delegating governance is about moving this power from public to private actors. Thus, although contracting out may technically describe the practice, it fails to convey the wider implications of it the way delegated governance does.

We see delegated governance as a subset of a larger phenomenon in the United States – the reliance upon non-state actors to provide for collective welfare. By now, this phenomenon is well known: in the 1980s, scholars began noting that private firms bear much of the responsibility for social welfare provision in the United States through employee benefits systems (Rein and Rainwater 1987; Stevens 1988; Esping-Andersen 1990). This "hidden welfare state" is subsidized by features of the tax code, as is individual self-servicing in private markets for, among other things, housing (mortgage interest deduction), child care (dependent care tax credit), and health care (tax break for

[2] Still other terms include "purchase-of-service" (Demone and Gilbelman 1989) and "public-private partnerships" (Rosenau 2000).

medical expenditures) (Howard 1997; 2007). In more recent years, scholars have more fully explored the origins and evolution of the public-private divide in social welfare, focusing on employer-provided pensions and health insurance benefits (Hacker 2002; Klein 2003). More recent research has examined the system of subsidies via government-sponsored enterprises (e.g. Freddie Mac or Sallie Mae) and tax credits to the provision of higher education and housing (Mettler 2007; Conley and Gifford 2006).

The result is what might be called, adapting a term developed by Elisabeth Clemens, the "Rube Goldberg" welfare state. In looking more broadly at the American state, Clemens (2006) argues that it functions less like the Weberian ideal-type found in Western Europe and more like one of the complex machines dreamed up by Rube Goldberg. Thus, instead of directly exerting authority through centralized, hierarchically organized public bureaucracies, the American state has frequently relied upon non-governmental actors to achieve its objectives. This blurs the boundaries between public and private while obfuscating lines of authority and accountability. The same is clearly true of the American welfare state, as evidenced by the above-mentioned means by which social policy objectives are attained. Tax expenditures, government-sponsored enterprises, tax-subsidized employer-provided benefits – all involve indirect governmental involvement to secure social welfare aims.

We view delegated governance as one subset of this Rube Goldberg welfare state that has been neglected thus far by students of social policy. One reason for the research lacuna is that, in general, political scientists tend to end their analysis with the passage of policy, paying only limited attention to the way in which programs are actually implemented and administered. On the other hand, scholars of public administration

have been highly attentive to program administration and have long been charting the development of what they have called "third party government," "government by proxy," or "the hollow state." (Salamon 1981; Kettl 1988; Brinton 1996; DiIulio 2003). These scholars have not looked specifically at redistributive politics, however, and many have been less concerned with analyzing the politics of delegating governance than with probing its implications.[3]

What Does the Delegated Welfare State Look Like?

In Table 1, we have categorized programs into a spectrum that reflects both the degree of delegation in various arenas and the spread of delegated forms of governance over time. Some programs have always had delegated elements, such as Medicare, which since its inception in 1965 has delegated administration to the non-profit Blue Cross/Blue Shield system and the actual delivery of health care to private-sector doctors and hospitals (as opposed to say the Veterans Health Administration which has its own system of hospitals and salaried physicians). A second category of programs includes those to which delegated elements have been added over time: welfare, social services, the JOBS program, child support enforcement, and Medicaid (specifically the use of HMOs). These are programs that began with traditional government provision (although Medicaid, like Medicare, always used private doctors and hospitals), but that have delegated administration and/or service delivery to private actors increasingly over time. The third category consists of programs that have been characterized by delegated

[3] There has, however, been some important work on the role of non-profit organizations in delivering social welfare services (e.g. Kramer 1981; Smith and Lipsky 1993; Salamon 1995), including an important book by historian Andrew Morris (2008). Much of this research focuses on the consequences of contracting out service provision to non-profits, but Morris explores the origins, evolution, and political dynamics around this process.

governance from the outset: Medicare Advantage, Part D drug plans, Section 8 housing vouchers, school vouchers, and private prisons. Temporally, these programs tended to come later than the other programs as policymakers have increasingly embraced delegation as a mode of governance.

Program administration and service delivery

A quick glance at the first two rows of Table 1 reveals how heterogeneous delegated governance is in practice. We differentiate between program administration and service delivery and find that different entities do each of these functions for different programs, and for a given program different entities may perform each function. We also find that for-profits are more common in service delivery than in program administration, and are more common for both service delivery and administration among the programs that are created later and that have always been delegated.

Hence we have non-profits administering Medicare, welfare, and social services, government administering housing vouchers, and a mix of government and private actors administering the small number of extant school voucher programs.[4] For-profits administer Medicaid HMOs, Medicare Advantage, and private prisons. Service delivery is performed in some cases by a mix of government, non-profits and for-profits (as in social services and JOBS programs), but mostly government stays out of service delivery in the other areas, delegating responsibility either to private providers (as with Medicare, housing and school vouchers) or to for-profit firms (child-support services, Medicaid HMOs, Medicare Advantage, Part D plans, and private prisons).

[4] There have been publicly-funded voucher programs in a handful of cities and states since the early 1990s, as well as several privately-funded voucher initiatives. Selection into either is typically by lottery.

There are two main points to take away, besides an appreciation for the complexity of these arrangements. The first is that there has been a movement toward for-profit providers over time, both because older programs, whose benefits were originally provided by government or non-profits, are now using for-profits, and because newer programs have utilized for-profits from the outset. The second is that for-profits are particularly common in service delivery, with implications for the quality of provision. Compared to government and non-profits, profit-making entities may have more incentives to meet consumer demand, but they also face incentives for cost-cutting and cream-skimming (serving only the "easiest" or "cheapest" customers).

Locus of decision making

An important aspect of delegated governance is the locus of decision-making: who makes the decision to engage a certain provider, the government or the beneficiary? In several of the programs, government contracts with a provider. The government solicits bids, prospective providers compete to gain the contract, and government selects a contractor, with that decision in place until the next contracting period. This is the pattern we see in Medicare administration, the JOBS program, child support enforcement, Medicaid HMOs and private prisons. This differs from programs in which individuals, typically holding vouchers for services, select a provider on their own. Individual clients select their own Medicare Advantage and Part D plans, their own apartment under Section 8, their own private school under the education voucher programs, their own doctor and hospital under traditional fee-for-service (FFS) Medicare, and sometimes their own social services

providers.[5] Traditional FFS Medicare differs from a true voucher program, however, in that there is no fixed subsidy within which individuals have to work: they choose a physician, and the physician is reimbursed as much as the government is willing (Savas 1982). Risk then is borne by the physician. In the more recent "consumer choice" variants of public programs, individuals have a fixed amount to spend and will bear the consequences for poor choices.

Individual choice of provider is more common among programs that come later, when the concept of delegated governance was adopted more broadly. Moreover, shifting the decision-making locus from government to individuals has consequences for the nature, quality, and comprehensiveness of information brought to the decision-making process. On the one hand, when government chooses a service provider, clients are stuck with that provider, which may not be to their liking. But in theory the government choice is a considered one, with much data and important, relevant criteria brought to bear. With individual choice, beneficiaries may be pleased with their autonomy, but they may be paralyzed by too much choice or fail to bring the most salient considerations to bear. For example, Americans cherish choice of physician, but studies show that individuals tend to ask friends for recommendations rather than consult experts or use objective data, and that they tend to use criteria like bedside manner rather than actual health outcomes (Frank 2004). Individual choice has its downsides as well as its appeal.

[5] By FFS Medicare, we mean the program in its original incarnation, which had beneficiaries choose a provider that was then reimbursed on a fee-for-service basis. This contrasts with the use of private managed care firms to deliver Medicare benefits, as they do not pay on a FFS basis, but instead receive capitated payments and then negotiate with providers over reimbursement, and try to "manage" beneficiary care so as to hold down utilization and cost.

Risk bearing and service denial

Some of the ramifications of individual choice become apparent when we consider who bears risk under these various governance scenarios and whether services can be denied due to the nature of the providers allowed in each program. In most of the "older" programs, the government ultimately bears the financial risk of provision – if services cost more than projected, the government absorbs the cost. Contrast that with the newer programs, in which the provider bears market risk: if Medicaid or Medicare Advantage capitated plans fail to deliver care under the budget they are allotted for each patient, they must absorb the cost. Similarly, private prisons must run their facilities under the contracted budget from the state or their profit margin will suffer. Private landlords and private schools bear the risks of taking in Section 8 or education voucher holders.[6]

In the most recently-developed forms of delegated governance, individual clients bear risk. These programs offer their clients choice, but they also impose upon the clients the risks of poor choices. If a prescription drug that a senior citizen needs is not covered by the Part D plan they chose, or if their plan imposes unanticipated costs, that person has to remain in the plan until the annual open enrollment period rolls around at the end of the year. Individuals must similarly bear the risks of poor choice of Medicare Advantage plan, apartment, or private school.

Services also can be denied under delegated governance. Doctors can refuse to take Medicare patients (few do, but more threaten to every time reimbursement levels are cut). Private landlords and schools can refuse voucher holders. Under Medicare HMOs,

[6] Originally, landlords who took one Section 8 voucher holder were mandated by law to accept all others who came along, and there was an "endless lease" provision that prohibited the termination of a lease with a Section 8 client except for good cause. These "risks" to landlords limited the supply of housing, and both were eliminated in 1998 legislation (Schussheim 2003).

Medicare Advantage, and Part D drug plans, care is "managed" and channeled in the most cost effective way for the provider, which may be experienced as service denial by patients who wish to get a test or see a specialist or to get a brand name rather than a generic drug but are prohibited from doing so.

A Cross-National Perspective on Delegated Governance

How unique is the governance of the American welfare state when viewed in cross-national perspective? The US is not alone in having "Rube Golbergesque" arrangements for the delivery of social programs. The Weberian ideal-type of bureaucratic governance is just that – an ideal-type that is frequently violated in practice by the concrete practices of social welfare regimes across the advanced industrialized world. In many countries, we find complex mixes of public and private social provision and blurring of boundaries between these two sectors. Although that has long been the case, it has become more so with the adoption of marketizing reforms in some countries since the 1980s, which have further broken down state monopolies in health, education, and welfare; increased the role of private actors in the delivery of social programs; and promoted consumer choice in social welfare markets.

At the same time, however, it is important not to lose sight of the ways in which the US has been, and remains, distinctive. Although a number of European countries long relied on voluntary associations to deliver social programs, these entities were often highly coordinated and served essentially as state appendages. In the US, the voluntary sector has always been less structured, more decentralized, and thus less supervised than that in Western Europe. Although marketizing reforms and other forces have challenged

voluntary association monopolies in Western Europe, the same tendencies have done even more to fracture the sector of social welfare providers in the US. In addition, the US remains distinctive in the extent of its reliance upon private actors. Although completely satisfying cross-national data on this point is lacking, it appears that the US has relied more on non-state actors to deliver social programs than other advanced industrialized countries. That is particularly the case in the health care arena, where the US is almost alone in the degree to which it has delegated governance to non-state – and particularly for-profit – actors.

Delegated Welfare States Abroad

In the popular press, European welfare states are often lumped together and tagged as state-run socialism. In fact, direct governance of social programs – in which the state not only funds but also directly provides social benefits and services – is most comprehensively found in the Scandinavian countries, where social benefits and services are funded through general taxation and provided by public bureaucracies (although reforms in recent years have changed aspects of this; see below). For example, day care centers are largely publicly-run, and these countries long had integrated health care systems in which government not only funds health care but also provides it.[7] A number of other countries, including the UK, New Zealand, Australia, and a number of the Southern European countries, also created integrated health systems – often called national health services – in which public authorities dominate the delivery of care

[7] Norway has long been exceptional, as the non-profit sector has long played a significant role in delivering social welfare services, such as child care. In Sweden, municipalities are responsible for nursing homes and home care, and while some directly provide this, others contract with private providers (Bergmark 2008, 243). How widespread is this? Some also have noted that Swedish day care has become more private, with more centers being run by parental cooperatives and non-profits.

(Docteur and Oxley 2004).[8] In the original incarnation of these systems, individuals could not even choose their physician or hospital; they would use that which was locally available to them (much as the Veterans Administration health care system works in the United States). In these countries, however, direct state provision of social services did not extend to most other areas of social welfare, which effectively left these responsibilities to families and voluntary organizations. One important exception was the British public housing system, which in addition to being quite extensive was directly administered by local authorities (Pawson 2006). Primary and secondary school education also has been, much like in the US, publicly-provided.

In much of continental Europe, non-state actors have long played a vital role in the administration of health, education, and welfare programs. In countries such as Germany and the Netherlands, non-profit welfare associations have long been the preeminent providers of educational and social welfare programs (Gidron, Salamon and Kramer 1992). In the Netherlands, for instance, 70 percent of primary and secondary school students are in publicly-funded, privately run schools (Dekker 2004). Moreover, the "Bismarckian" welfare state model found in countries such as Austria, Belgium, France, Germany, and the Netherlands, employs non-state insurance funds to distribute benefits such as pensions, health insurance, and family allowances. In Germany, there are hundreds of non-profit sickness insurance funds that are governed by representatives of business and labor and provide coverage to all. Similarly, in France, people receive their health coverage through private health insurance funds that collect payroll taxes and

[8] In these systems many health care personnel are public-sector employees, although some may be private contractors receiving public funds. The hospital sector is largely public.

pay providers, and family allowances are distributed through non-state entities – family allowance funds.

In these countries, as well as in Canada, the national health service model was rejected in favor of a system of publicly-funded insurance coverage and privately-delivered care. Thus, medical facilities are largely privately-run and physicians are not salaried public employees as they would be in a national health service, although hospitals may be publicly-run. Individuals choose their own health care provider that is then reimbursed by the insurance fund. Each country differs in its public-private mix, however; France, for instance, has both an extensive, public hospital system as well as the largest private hospital sector in Europe (Dutton 2007, p. 23). France also has a large sector of private, supplemental health insurance that covers gaps in public insurance plans, and in Germany, formally private insurance funds serve higher-income clientele. In short, in continental Europe, the governance of social programs has long been distributed across a wide array of state and non-state actors.

Even so, the delegation of governance in the American welfare state does differ from that found in other countries. In continental Europe, the non-state welfare and educational sector has been more centralized and structured that that found in the US, and these states have exerted considerable influence over these groups. Thus, non-profit welfare associations in Germany have long been members of centralized peak associations that are have been described as "functional equivalents of public sector institutions" (Zimmer 1999) or a "branch of government" (Bauer 1990). The same has been true of Dutch non-profit social service providers, which originally were independent of the state but gradually became "quasi-public" entities in the post-World War Two

period (Brenton 1982, p. 68). Similarly, the social insurance funds are semi-public entities whose actions have been increasingly subject to state constraints, such as global budget caps in health care (Altenstetter 2003). As will be discussed later in the paper, the system of delegated governance to non-profits in the US is considerably more decentralized, which undercuts the coherence of policy interventions.

Perhaps a closer parallel to the US is the adoption of market-based reforms in many OECD countries since the 1980s, which altered the governance of some social programs by increasing the role of non-state (and often for-profit) actors in service delivery (Blomqvist 2004; Gilbert 2004). Probably the most-publicized reforms along these lines were in the UK under conservative governments. For instance, starting in the 1980s, public housing was sold to tenants and the remaining system was converted from a largely state-run affair to one in which non-profit housing associations play a growing role (Pawson 2006). The long-term care sector in the UK also has been significantly transformed, with a significant increase in the role of for-profit care providers. For instance, private institutions account for 88 percent of users of residential facilities are in private institutions, and in home care, 31 percent of care hours were provided by public providers in 2004, compared to 95 percent in 1993 (Pavolini and Ranci, p. 254).

In a number of European countries, the sectors of child care and old-age care have been shaped by shifting mixed of government, non-profit, and for-profit providers and a growing emphasis on consumer choice and voucher-type support. In Germany, the long-term care insurance program created in 1994 allowed for-profit providers into the system, and for-profits make up about half of long-term care providers (Pavolini and Ranci 2008, 254) – a clear departure from the past practice of directing subsidies to the dominant

voluntary organizations. In France, rather than continue developing expensive, municipally-run child care centers, successive governments have subsidized parents who purchase care (and other domestic services) on their own. In 2006, the Netherlands converted its child care subsidy system into one that reimburses parents through the tax code for the care they purchase care in private markets.

Perhaps more startling are the reforms that have taken place in Sweden, where there was always a strong commitment to direct state provision of services in order to assure equal access to high-quality programs. Since the 1980s, however, the role of non-state (and often for-profit) actors has been augmented in health care, old-age care, child care, and education. The public school system has been converted to a voucher system, allowing private schools to receive public funds and compete for pupils, and old age care has been transformed from an almost entirely state-operated sector to one in which for-profits play a significant role in running residential facilities and home care services (Blomqvist 2004; Klitgaard 2007). The child care sector also has been altered somewhat since the 1990s, as private providers now account for about 20 percent of centers, most of these being parental cooperatives or other non-profit associations. Finally, since 2003 when a "radical" reform to the pension system was fully implemented, a portion of an individual's pension contributions goes into an individual investment account, with individuals able to choose between a large array of funds (Anderson and Immergut 2007).

How pervasive are these new governance arrangements? The lack of comparable data precludes a definitive answer to that question, but existing sources lead us to conclude that in many countries these practices have been rather limited. Figure one shows one way to capture public spending that is channeled through private actors: social

transfers in kind via market producers. Unfortunately, countries such as the US, UK, and Canada, which are especially likely to use forms of delegated governance, fail to report this measure in their national accounts. In the countries that do report this data, however, social spending through private actors is dwarfed by total spending. For example, despite the many changes that have taken place in the governance of Swedish education and social welfare programs, relative to total social spending, figure one shows that the degree of spending through private actors remains limited: less than two percent of GDP compared to 31 percent of GDP spent on all social programs. This picture of limited reliance on non-state actors is born out in other data: in the voucherized school system, for instance, only 5 percent of primary and 6 percent of secondary school students in 202 were in private schools. In the case of Swedish long-term care, in 2004 about 13 percent of institutional long-term care and home health care is provided by for-profits – a significant increase from only ten years ago when there were virtually no for-profits operating in this area, but still a small percentage (Pavolini and Ranci p. 254).

In addition, although there have been some shifts in the governance of the welfare regimes in nearly all countries, in most places they come nowhere near the kinds of reforms that took place in the UK. Neo-liberal reform movements have held much less sway in continental Europe (Prasad 2006), and thus only minimally altered the governance of welfare regimes in Austria, Belgium, France, Germany, or Italy, for instance. In many countries, the nature and role of the voluntary sector has changed, but this is not necessarily due to a drive towards marketization rooted in neo-liberalism. In France, for instance, a leftist critique of bureaucracy spurred the drive to decentralize governance from Paris to regional and local governments, and to augment the role of the

non-profit sector (Schmidt 1990; Ullman 1999). In Germany, there also have been changes in the nature of the German voluntary sector, but not due to marketizing reforms. Instead, new organizations have successfully challenged the privileged status of the traditional voluntary groups, thus opening up equal funding opportunities for these challengers and rendering the voluntary sector more pluralistic (Zimmer 1999, 43-4; Bode 2006).

In sum, when one digs into how government programs are actually delivered, one can discover a wealth of on-going changes that contradict expectations we might have of "frozen" welfare regimes unable to retrench or move. However, outside of the UK, there is little evidence of deep reforms in recent years that change the basic architecture of social welfare systems along the lines of the US model of not just delegated, but highly decentralized, governance.

The Lack of Market-Based Reforms in Health Care

Another notable observation that emerges from a comparative perspective on governance is the lack of marketizing or privatizing reforms in the health care arena. Instead, the rhetoric surrounding privatization and marketization of health care generally exceeds the realities of what has taken place, as few countries have enacted (and stuck with) reforms that significantly increase the role of private actors in this arena (Morone 2000; Hacker 2004). In some countries with national health services, such as the New Zealand, Sweden, the UK, and much of Southern Europe, governments created an internal market by dividing purchasers from providers, so that the governmental entities that previously were responsible for both are now choosing services from an array of competing

providers. Although this introduces some degree of competition into these systems, it has not led to the empowerment of private actors in the delivery or purchasing of health care; instead, most actors in these health care systems remain public. As figure two shows, even in countries that are said to have enacted major reforms to their public sectors (Czech Republic, Netherlands, New Zealand, Sweden, UK), the public sector remains, by far, the largest payer of health care.

In the Bismarckian systems, in which health insurance funds were already non-state actors, a number of countries required those funds to compete for beneficiaries' business. In general, this did not spur the growth in for-profit insurance entities or generate strong competitive pressures that fundamentally changed the architecture of these systems. In Germany, legal constraints on private plans – about 90 percent of benefits are set by law and not negotiated between funds and providers – truncate the development of market forces in the system (Pfaff and Wassener 2000). In Belgium, reforms sought to change the incentives facing the insurance funds towards more cost control but also limited the degree of competitive pressures on the funds (Doorslaer and Schut 2000, pp. 881-2). A number of these countries also have overall spending caps or targets on health care spending that are set at either the national or regional level (Docteur and Oxley 2004, p. 53).

If anything, resistance against market-oriented reforms in health care has impeded the drive to delegate governance to private actors. In New Zealand, for instance, policy-makers in the early 1990s sought to transform their integrated health care system such that public and private purchasers (insurers) would compete for business – not unlike some of the market-based reforms that have been proposed for Medicare. After strong

opposition was voiced, including fears that the "Americanization" of the health care system would result (by which was meant a system based in markets that is both wasteful and exclusionary), the plan was dropped (Fougere 2001, p. 1236). Thus, after all the hoopla surrounding the reform proposals, the New Zealand health care system ended up being only "marginally more private" than it was before the reforms (Krieble 2000). In the UK, resistance to turning more of the health care sector over to private forces actually came from the Conservative government in power, which ultimately prioritized fiscal austerity over market-based reforms. Allowing consumers more choice and/or decentralizing decision-making to non-state actors threatened to *increase* costs, not reduce them, in the immediate-term. Jacobs (1998, p. 21) sums up the UK experience well, concluding, "Consumers would have a voice in the new NHS. But it was to be a faint whisper, muffled by the thunderous engine of public administration." As Doorslaer and Schut (2000 p. 886) conclude more generally about the drive to shift more authority to non-state purchasers of health care:

> Are the respective governments willing to hand over some of their traditional supply-side regulatory tools (contracting, fee setting, quality control) to individual insurers? In the logic of the managed competition model, the answer self-evidently has to be "yes," but in practice there appears to be substantial reluctance of the part of governments and regulatory agencies to give up these [regulatory] instruments and 'jump in[to] the competitive dark.' This reluctance seems to be fueled primarily by the fear that insurers individually may be less successful in resisting new demands by patients and providers for more resources, and that such a weaker negotiation position may result in cost increases.

Ultimately, cost control would be the driving force shaping health care reforms, which often produced *more* government intervention through regulatory and spending controls, not less (Hacker 2004, p.701).

The one country outside of the US that has instituted far-reaching market-based reform in health insurance is the Netherlands.[9] The old Dutch health insurance system consisted of a mix of privately-managed, non-profit sickness funds that enrolled 65 percent of the population, combined with a smaller sector of insurers in which people of higher incomes would voluntarily enroll. The new system resembles the managed/regulated competition model championed by Alain Enthoven with a twist of Massachusetts-style reform: individuals are required to buy insurance, but they may now select from any of the available private plans. Unlike most other countries but much like the US, the health insurance sector contains a number of for-profit entities. They are subsidized and heavily regulated to prevent cream-skimming: companies must offer a basic plan of benefits, cannot turn any applicants away, and must charge community-rated premiums. Given the limits on competition in the main insurance program, insurers have more liberty in how they structure supplementary insurance, and this is where insurers expect to make profits. There also is a risk equalization scheme to compensate funds that end up with a sicker patient load. Finally, individuals with incomes below a certain level receive income-adjusted subsidies to help them cover the cost of health insurance.

In short, the Dutch health insurance model resembles the premium-support model advocated in the US for Medicare, in which beneficiaries would receive subsidies to purchase care from a regulated, private insurance market of plans. The insurance market in the Netherlands is more tightly regulated than would be likely in the United States, however, and the Dutch still depend on a fairly heavy state role in negotiations over the

[9] The following paragraph is based on Bartholomée and Maarse (2006); Helderman 2007; and Rosenau and Lako (2008).

price of medical care, rather than looking to insurance plans to achieve this (Helderman 2007). Still, as a model of market-based reform involving consumer choice, the Dutch reform offers lessons for the United States that we will make use of in several chapters of our book. For now, suffice it to say that outside of the Netherlands and the United States, there is a striking *lack* of delegated governance to private insurance companies in health care systems.

Does It Matter How Social Programs Are Administered?

The question of how social programs are delivered has important real-world and theoretical implications. In the case of the former, how social programs are administered impacts the effectiveness of public policies, the form of redistribution that follows, and the extent to which the providers of services are accountable to the mass public. All of these questions are hotly contested and are at the crux of debates about state versus non-state social provision. We do not aim to definitively settle these debates for all policy areas, but in the succeeding section will lay out some of the competing arguments that we test in the case of Medicare in several chapters of our forthcoming book. The nature of program administration also has important implications for academic debates in the social sciences, particularly those concerning the nature of the American state. Political scientists have paid insufficient attention to what public policies actually look like, on the ground, as most analyses tend to stop with a policy's passage. By looking concretely at the implementation and effects of policies, we can gain insight into the nature and functioning of the American state.

Real-World Consequences of Delegating Governance for Social Provision

Does it matter how social programs are administered? One could argue that whether one administers programs through local governments, private actors, or federal bureaucracies is less important than the existence of a program, its eligibility parameters, and its generosity. Perhaps social policy ends justify whatever administrative means are necessary to make a program work. Yet, for many programs, the devil lies in the details: how programs are actually administered and experienced on the ground by stakeholders and beneficiaries can be tremendously consequential for program effectiveness, equity, and democratic accountability. Given the importance of these questions, much of the political heat generated around particular social policy reforms concern modes of governance.

One major question about program design and implementation concerns effectiveness: are program goals met in a relatively efficient and effective manner? Or do governing arrangements impede the effective delivery of promised benefits and services? This issue has featured prominently in debates about privatization, with advocates arguing that government is an intrinsically poor provider of most benefits and services. Government employees receive salaries that are not tied to their performance in delivering services to the public, and bureaucratic organizations are funded through budgetary appropriations instead of having to prove their worth in a competitive environment. As a result, some argue that there are few organizational incentives for good performance (Savas 1982). Moreover, in many areas, civil servants tend to be paid more than people working in the private sector, in part due to their high degree of

unionization. This may make it more expensive to directly administer government programs than to contract them out to private agencies.

Finally, government bureaucracies are said to be rule-bound and rigid, focused more on meeting legal requirements than innovating in their service provision. By contrast, advocates of market- or community-based organizations argue that these organizations are more likely to deliver high-quality services in a low-cost manner. In the case of market actors, as long as the contracting relationship is structured such that their profits at stake, they should work to survive in a competitive marketplace, which means delivering quality services while holding down costs. In the case of community-based actors, some argue because they are closer to the people they serve, they are better able to respond to the needs of particular communities. In both cases, contracting with private actors may also enable greater governmental flexibility in responding to specific needs, as contracts can quickly be arranged or terminated as needs wax and wane.

An opposing view challenges whether private sector actors are generally more effective in providing services than government agencies. First, some argue that contracted government services rarely represent a real market (Smith and Lipsky 1992). In many social welfare areas, for instance, there are only a small number of potential services providers – and sometimes only one in a given area – which limits the degree of competition (Stevenson 2008, 129). Providers who successfully procure contracts also tend to have them renewed, perhaps because they gain political influence over the contracting agency, or simply because they develop expertise that is valued and cannot immediately be acquired by new providers. These realities may vitiate the theoretical effects of market competition on the quality and cost-efficiency of service delivery. In

addition, many have noted that relying on private agencies for the delivery of programs and services rarely leads to the elimination of any role for government in this area. To the contrary, there may be the need for a more *muscular* set of government agencies that can establish, regulate, and monitor the social welfare marketplace (Drucker 1969; Morone 1992). The effect may be to multiply the number of people working in a particular social welfare field in both the public and private sector, leading to *less* efficient production than if there were simply one set of actors involved. Finally, some critics of contracting find that it tends to produce *less* flexibility, and not more, as agencies get locked into relationships with particular contractors (Smith and Lipsky 1992, 243-4).

A second question concerns the effect of program administration on democratic accountability. This is a concern for any system of bureaucratic administration: civil servants are unelected and only indirectly accountable to the public through the oversight of democratically-elected officials. Moreover, their actions can never be perfectly legislated: program execution inevitably requires some degree of bureaucratic discretion that cannot be fully overseen by elected politicians. In the course of using this discretion, agency officials may not only make inefficient choices about program delivery, but may prove indifferent to the population they should be serving. Concerns about this have been raised on both the left and the right: on the left, starting in the 1960s community activists assailed the indifference of local school boards and public agencies to the needs of vulnerable populations, such as the poor, ethnic minorities, or mentally ill. On the right, free-market reformers argued that government agencies lack incentives to respond to consumer preferences. In light of these problems, advocates of community- or market-

based provision argue that such arrangements improve democratic accountability. Community organizations are not elected bodies but may nonetheless contain members of the community who can hold them accountable to the public. In the case of for-profit firms, because their survival is tied to their ability to attract clients, they should scramble to respond to the diverse needs and preferences their users. Thus, even though the chain of accountability from elected officials to service providers is lengthened in a system of delegated governance, this may improve democratic accountability, not weaken it (Pascal 1972).

Critics of these arrangements worry about lodging administrative discretion in the hands of non-public institutions. Problems may especially arise in the case of publicly-traded firms, whose fiduciary responsibility is to shareholders and not to program beneficiaries. A more general issue concerns whether or not social welfare markets actually work to make firms accountable to their customers. For instance, when beneficiaries have a choice between competing service providers, are they able to effectively navigate between options, making optimal (or at least not ruinous) decision? Some argue that consumers are notoriously bad at decision-making in commercial markets, with paradoxically more choices leading to paralysis and decisions based on the wrong criteria (e.g. glossiness of marketing materials). Perhaps even more important is whether or not people leave bad service providers, forcing the kind of market accountability that advocates theorize should exist. If people fail to "exit" bad providers, or use "voice" to contest poor service provision, then markets will fail to convey the right information to firms, thus weakening the accountability mechanisms in private welfare markets (Hirschman 1970).

The governance of social programs also has important redistributive consequences. The left has often championed the ideal of direct governance in the belief that when benefits and services are highly heterogeneous, inequalities of access will develop. Particularly when markets deliver services, people of a higher socioeconomic status will likely benefit by having their preferences catered to, while less educated and lower income people will have inferior services. This has been borne out in the Swedish experience with more private provision: people of a higher socioeconomic status are the ones who have most benefited from the development of private day care centers, schools, and nursing homes. On the other hand, defenders of markets might point to failures in government-provided services to the poor – inner-city school systems in the US, for instance – and argue that markets can do a better job of responding to these disempowered citizens.

Yet another question concerns how the administration of public programs affects the politics of social provision. Some critics of contracting out public services argue that it gives power to private organizations that then use this power to further enrich themselves. One consequence may be corruption, as public officials develop cozy relationships with private firms whose campaign contributions, or outright bribes, ensure their continued access to valued public contracts. A softer version of this dynamic may simply be to increase the voice of private provider groups in the political process. Consumers are a notoriously difficult group to organize, and while consumer groups may work hard to insert the perspective of program beneficiaries into policy debates, they may be outgunned by well-financed private groups who have a strong stake in protecting their interests. How the relative power of these groups plays out in the political process is an

empirical question, likely to vary in different social policy arenas. It may be that giving private actors a stake in public programs promotes the *expansion* of spending on these programs, contrary to what market-reforms might desire (Smith and Lipsky 1992, 249). Delegated governance may be the distinctive way that welfare states develop in societies and polities marked by antipathy towards public officials and "direct" forms of government.

One final question is more clearly normative and concerns the suitability of giving private actors power over the lives of individuals. This is part of what makes the social welfare sphere distinctive from other areas of government contracting. There is a difference between employing private firms to provide routine office services or deliver products to federal agencies, and delegating responsibility for programs that affect people's health, welfare, and livelihood. When firms have the ability to determine eligibility for welfare programs and to mete out sanctions for failure to meet certain requirements, these firms are exerting power over these individuals. Similarly, when a private drug plan uses its formulary to "manage" a beneficiary's use of prescription drugs, this is again a form of power being exerted over that beneficiary's life. Of course, we all live in a world of public and private institutions that exert power over us, and over which we do not have full control. Yet, in public provision there is a principle of democratic accountability that exists at least theoretically if not empirically: governing arrangements are structured to that bureaucrats are accountable to elected officials in some way, and elected officials are periodically accountable to the public. That sense of accountability may be diminished in a system of delegated governance to private actors.

Theoretical implications

This study also has implications for debates in American politics about how best we should conceptualize the nature of the American state. This has long been a source of scholarly puzzlement. When measured in terms of public sector employees or public spending, the federal government in the United States is smaller than the national states of many other West European countries, and this has been true since the founding of the American Republic. This fact has long inspired claims about the relative "statelessness" of the US (Novak 2008). By most objective measures, the 19th century federal administration was miniscule in size, and the dominant institutions in the American polity were courts and parties, not federal bureaucrats (Galambos 1987; Skowronek date). Although the 20th century brought the rise of "bureaucratic autonomy" in key domains, the overall size of the federal government remains fairly truncated (Skocpol and Finegold 1982; Carpenter 2003), particularly when compared to other advanced industrialized countries. For instance, measured in terms of total tax receipts, including taxes collected at all levels of government, US tax revenue as a proportion of GDP is nearly nine percentage points lower than the OECD average – 27.3 percent compared to 36.2 percent, and is notably lower than countries we tend to think of as similarly market-oriented, such as the UK (36.5 percent) or Canada (33.4 percent) (OECD 2008).[10]

At the same time, however, the 20th century American state has been one of the most powerful actors in the world. Even in the 19th century it would be misleading to focus excessively on bureaucratic incapacity: The federal government created public land system, propelled the settlement of a vast territory – which involved the forced removal of native peoples – engaged in internal improvements to develop the nation's public

[10] Data are from 2005, *OECD in Figures* (2008).

infrastructure, and upheld the institution of slavery (Jenson 2008). In the social policy sphere, the federal government did not develop the social insurance programs that were emerging in Britain and Bismarckian Germany at the time, yet did institute a large-scale system of veterans pensions and created a progressive income tax – a tax that the federal government did a far better job collecting during and after World War I than did the allegedly "strong" French state at the time (Skocpol 1992; Morgan and Prasad 2009). In the 20th century, the US fought and won two world wars, a cold war, and is now the dominant superpower in the international arena – hardly what we might expect from a "weak" state (Friedberg 2002).

How can we reconcile these two images of the American state? Part of the problem lies in the difficulty scholars have in getting away from a dichotomous, "strong versus weak" understanding of states (Baldwin 2005; King and Lieberman 2009). Thus, in the laudable effort to combat images of perennial state weakness, scholars have sought to prove that the American state was in fact *stronger* than we might think by pointing to pockets of bureaucratic development of effectiveness. Yet, this hardly helps us make sense of the many other instances or indicators we can find of bureaucratic failure. The social policy arena offers numerous examples of both strength and weakness. To take the example of health care, analysts from across the political divide agree that the Center for Medicaid and Medicare Services that oversees Medicare, Medicaid, and other health policy is undermanned, under-resourced, and frequently outmatched by powerful organized interests in the health care sector. Yet, the same organization has been able to implement a complex system of price-setting in the health care sphere, and somehow,

despite its lack of resources, manages to oversee the processing of around one billion health care claims a year.

Instead of asking whether the American state is strong or weak, we need a vocabulary that better captures how the American state actually works in practice. Here, we take inspiration from William Novak's view that scholars should reclaim the tradition of American pragmatism that developed over a century ago but has often been displaced in the social sciences by abstract European theory. Rather than start with an ideal type and see how the phenomenon of interest measures up, we should instead seek to understand how the object of study actually functions, letting the concrete realities we can observe and describe inform our categories and drive our conclusions about it. Such an approach has often been lacking in political science analyses of public policy, which tend to stop with passage of the law rather than examining how programs and policies are actually implemented on the ground. Yet, a lot of the conflict around public policy concerns implementation – precisely how services or benefits are going to be delivered. Thus, debates over universal health coverage have not only been over philosophical questions of economic redistribution, but have centrally been concerned with who is going to deliver this insurance, who will provide health care services, and precisely how all of these actors will be paid. The answers to these questions, in turn, determine the structure of governing institutions – the nature of the state and how it actually functions. When we are attentive to how, on the ground, abstract programs are turned into concrete realities, we gain a better understanding of the political stakes around many redistributive programs, but also can see more clearly how it is that American governing institutions actually work.

What does such an approach yield in looking at the American state? We believe that the American state is better described not as institutionally strong or weak, but as a system of delegated and diffused authority. Contrary to the Weberian ideal-type of the centralized, hierarchically-organized bureaucratic structure characterized by clear lines of authority and accountability, the contemporary American state is, as Elisabeth Clemens (2006) says quite bluntly, "a mess." This was true in the first decades of the 20th century when, at a time of expanding governmental responsibility, program administration was achieved through heavy reliance upon private actors for the delivery of social services and the use of intergovernmental grants (Clemens 2006; Johnson 2007). The tremendous expansion of federal responsibilities in the post-World War Two era created ever greater dependence upon non-federal actors for the implementation of federal programs (Mosher 1980; DiIulio 2003). Federally-funded programs are delivered by state and local governments through intergovernmental arrangements, such as grants-in-aid. Many functions are contracted out to private actors: in 2005, the number of contract employees has been estimated to be four times the number of civilian employees (Light 2006), rendering the "true size of government" significantly larger than we might think when looking only at government employees. There also are hybrid governing institutions that defy simple categorizations as public or private, including governments-sponsored enterprises, such as Fannie Mae and Freddie Mac, and loan guarantee programs such as Sallie Mae that rely on private banks to provide loans to college students (Salamon 1981). As Frederick Mosher wrote in 1980 (p. 543):

> "The use and the extent of all of these tools have grown enormously in recent years—even as federally performed operations virtually stood still. Few new policies and programs failed to rely upon other governments or institutions in the private sector for a major part or all of their execution. The extension of federal interest and intervention

> into the nooks and crannies of our economic, social, cultural, and even personal lives seems almost unlimited. And most of this is being done through others, not strictly a part of the federal government itself. The growth of federal influence defies precise quantitative measurement, but there can be no question that it has been pervasive…"

Do these governing arrangements produce a "strong" or "weak" state? A better way to frame the question is to explore the implications of delegated governance along the lines we described above: the effectiveness of state action – can the state achieve its goals in a cost-effective manner; its redistributive consequences; and its effects on democratic accountability? The answers to these questions are empirical and hinge on the nature of the governing arrangements developed in different sectors of public policy. Were we able to cumulate studies of a large number of different areas, we could paint a more realistic picture of the American state, how it functions, and the political forces that have shaped it development. We can only do this in one domain – the welfare state, which we winnow down even further to the area of Medicare – but we hope to demonstrate the merits of analyzing how programs are governed, why they are governed that way, and what consequences this has for societies and polities.

Conclusion

The American welfare state intertwines public and private authority in pervasive ways. We develop the concept of delegated governance – the delegation of administrative authority for publicly-funded programs to private actors – to describe some of these arrangements. Although the US is not alone in relying on private actors for the implementation of public programs, it does so pervasively and in some unusual ways. Historically, the US often turned to non-profit organizations to deliver social welfare benefits and services. In more recent decades, however, the emphasis has shifted to

building social welfare marketplaces comprised of competing, for-profit actors in the social welfare field. Along with this change has come a shift in the locus of decision-making and risk. Hitherto, the government made decisions about who would provide services and bore risk for these decisions. Increasingly, individuals are expected to choose from a menu of competing providers, and both for-profit providers bear risk (their profits are at stake), and individual bear risk (for their choice of welfare provider).

The ways in which programs are administered are hardly technical details deserving only of attention in public administration textbooks. Yet, political scientists have generally ignored these arrangements, ending their analyses with the passage of policy. This is unfortunate, given that much of the political conflict generated by public policy concerns how programs will actually be put in place, such as who will provide them, and how they will be paid for. Can we really understand the political stakes around public policies if we don't the implications of policy design and implementation for government bureaucrats, interest group stakeholders, and beneficiaries? We believe that you cannot, and thus argue that scholars of the welfare state should give attention to its governance.

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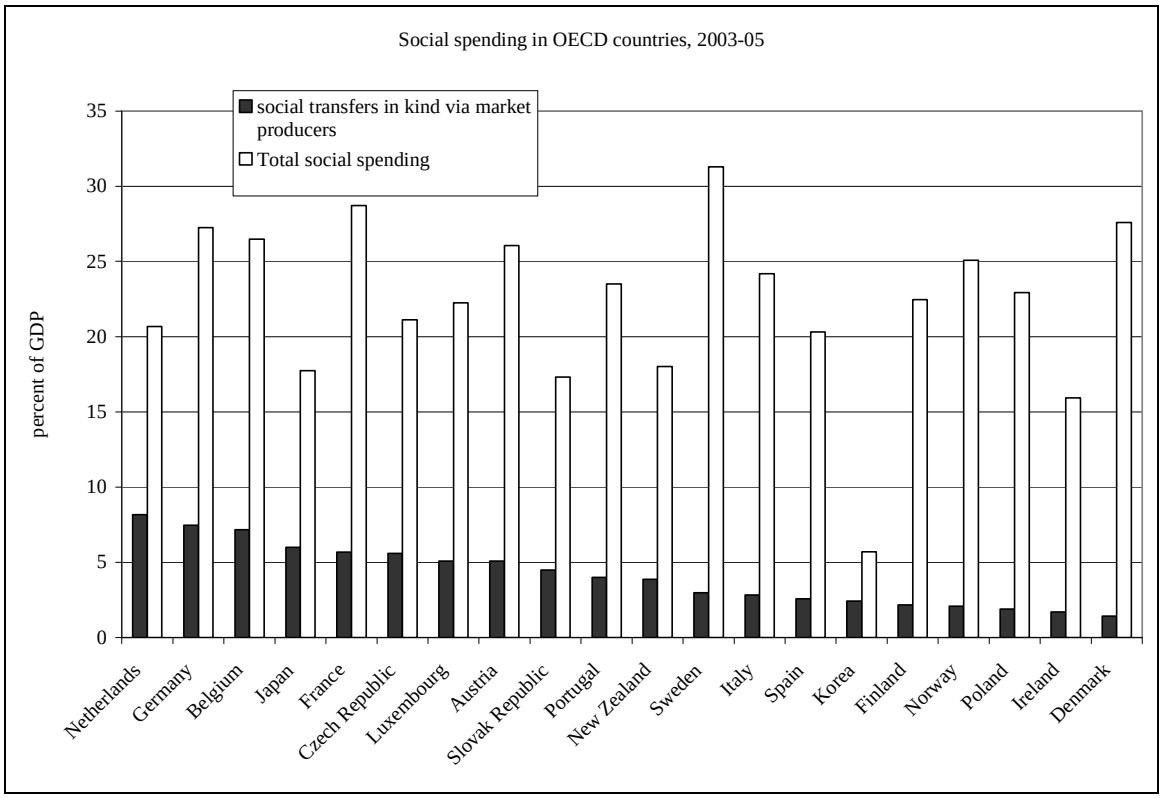
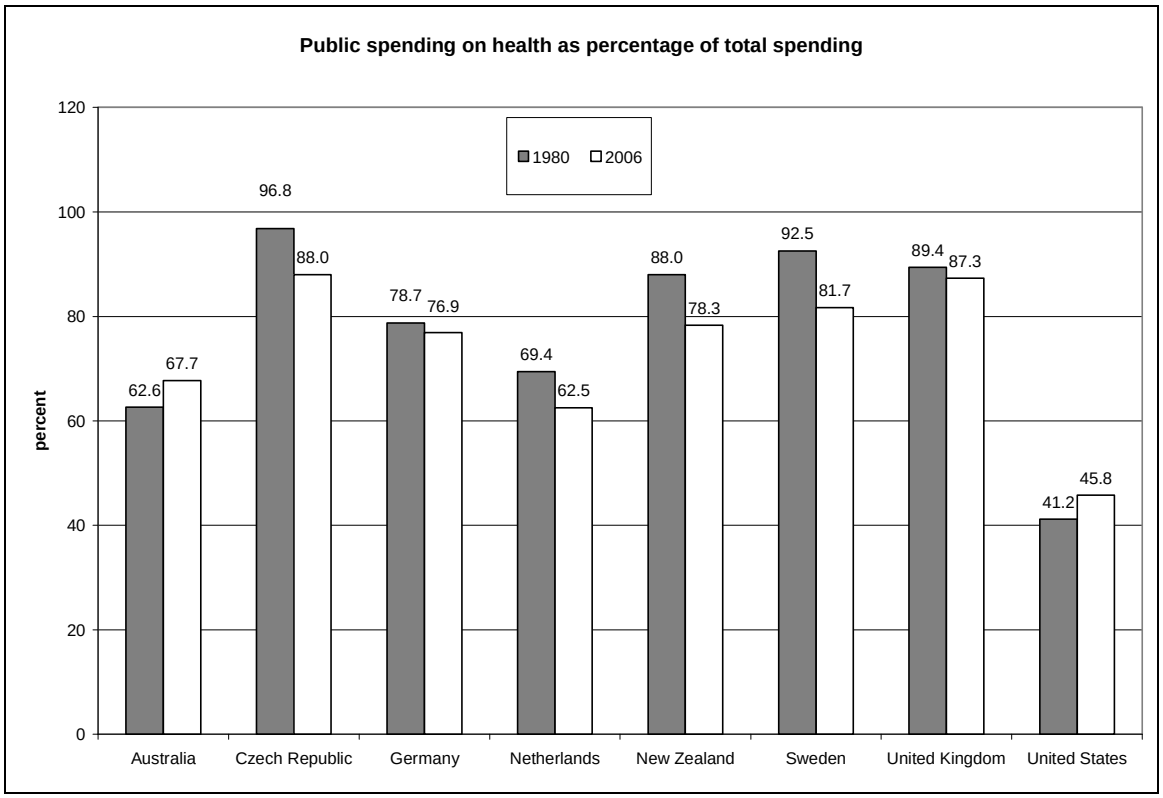
Figure 1. Social Spending in OECD Countries, 2003-05



Sources: OECD SOCX and XYZ Report.

Figure 2. Public spending on health as a percent of total spending



Dutch and New Zealand data are from 2002 and 2003, respectively.
Source: OECD.

Table 1. Forms of Delegated Governance

	Programs with DG elements	Programs with DG added over time					DG Programs				
	FFS Medicare	Welfare benefits (pre-post-TANF)	Welfare services	JOBS	Child support enforcement	Medicaid (HMOs)	Medicare Advantage	Part D drug plans	Section 8 housing vouchers	School vouchers	Private prisons
Who administers program	Non-profit (BCBS); for-profits (esp in Part B)	Pre-TANF: state/local govts. Post-TANF: some non-profits, for-profits	State and local govts. Post-TANF, some non-profits, for-profits.	Federal government	State and local governments [I need to check]	State govts. [need to check]	Federal govt.	Federal govt.	Govt.	Public, private lottery programs	For-profits
Who delivers service	Private providers; non-profits or perceived as non-market actors	Local governments, non-profits, for-profits.	Mostly non-profits, for profits.	Mix of government, non-profit, for-profit centers.	Local governments, For-profits [check on this]	For-profits	For-profits	For-profits	Private landlords	Private schools (non-profits)	For-profits
Locus of decision making	Govt contract with intermediaries; Indiv chooses provider.	State, local govt contract	State/local govt contract; individuals w/ vouchers	Govt contract	Govt contract	Govt contract	Indiv chooses provider	Indiv chooses provider	Indiv chooses provider	Indiv chooses provider	Govt contract
Who bears risk	Govt; providers.	Govt.	Govt.; indiv. for costs above voucher amount.	Govt.	Govt.	Provider; beneficiary for poor choice of plan.	Indiv. for poor choice of MA; Provider bears market risk	Indiv. for poor choice provider; Provider bears market risk	Indiv. for poor choice provider; Provider bears market risk	Indiv. for poor choice of provider; Provider bears market risk	Provider bears market risk
Can services be denied	Yes, but rare (doctors refuse Medicare patients)	Yes: sanctions imposed.	Yes: sanctions imposed.			Care is "managed," services may be denied.	Care is "managed": services, therapies may be denied	Drug use is "managed": therapies denied (or more expensive)	Yes	Yes	